HISTORY AND PHYSICAL

INS
PCP
AGE/GENDER

PRINT CLEARLY

Patients Name:____ D.O.B________________

Weight (Lbs)_______ Height______Shoe Size______
Are You Currently Pregnant? Yes/ No

Smoking History
Never Smoked
Former Smoker Yrs Quit______
Current Smoker Packs/Day______

Reason for today's Visit: ______________________________ How long have you had this?______

Is this an injury? No/Yes Work/ Home/Auto

Circle any disorders ,diseases, or symptoms YOU have experienced EVER.

Migraines
Fatigue
Hypertension
Stroke
Diabetes
Renal Disease
Blood Clot

Arthritis
Gout
High Cholesterol
Liver Disease
Thyroid: HYPO/HYPER
Vascular Veins
Dizziness

Cancer
Rheumatic Fever
Circulation Disorder
Angina
Congestive Heart Disorder
Leg Pain: Walking/Resting/Standing
COPD

GI Disorder
Ulcer of Extremities
Throat Infection
Asthma
Anemia

Auto Immune Conditions:____

PRINT All Current Medications with Dosage and Quantity

NAME:	DOSAGE:	QUANTITY:	NAME:	DOSAGE:	QUANTITY:

List ANY Allergies(Write None if no allergies):____
____

FAMILY HISTORY

Circle No/Yes and list **who**?

Hypertension No/Yes__________
Diabetes No/Yes__________
Heart Disease No/Yes__________
Cancer Type No/Yes__________

Thyroid disorder No/Yes__________
Glaucoma No/Yes__________
Ulcer/Type No/Yes__________
Mental Illness No/Yes __________

Epilepsy No/Yes__________
Arthritis No/Yes__________
Stroke No/Yes__________

ZARATE PODIATRY, P.A.

Patient Acknowledgment Form

I,____________________________, hereby acknowledge that I may request a copy of the Notice of Privacy Practice. I am fully aware that the organization may use and/or disclose my protected health information for the purposes of treatment, payment, and health care operations. Our Notice of Privacy Practice is subjected to change from time to time. If changes occur, you may obtain a copy of the revised notice by contacting the doctor's office directly.

You have the right to request restrictions on how your protected health information may be used and/or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions, but if we do, we are bound by our agreement with you.

By signing this form, you consent to our use and/or disclosure of protected health information about you for treatment, payment, and health care operations during the term of your care with us. You have the right to revoke this consent, in writing, except where we have already made disclosure in trust on your prior consent.

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosure of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI made by alternative means, such as sending correspondence to individual's office instead of at the individual's home

I wish to be contacted in the following manner:

(   )______________________________ May we leave a message ? YES / NO

Phone Number (Home / Cell / Work)

______________________________ ______________________________

Name of Patient (PRINT) (date) Signature of Patient (date)

PATIENT REGISTRATION

CLEARLY PRINT information, sign date and return. Thank You.

Patient' Name:	Date of Birth:	Marital Status:	Gender:
Home Address:	City	State	Zip Code
Home Number:	Cell Phone Number:	Work Phone Number:	
Primary Physician:	Referring Physician:	Social Security#:	
EMERGENCY CONTACT NAME	Emergency Phone Number:	Relationship:	

1. **FINANCIAL RESPONSIBILITY**: I certify that the information I have provided regarding my insurance coverage is correct and that I authorize Zarate Podiatry P.A.& its affiliates to verify insurance coverage and benefits allowed in accordance with my insurance plan's policy.
I authorize that payments be made to Zarate Podiatry for all medical insurance benefits which are payable under the terms of my insurance policy for the services provided. X______________ (INITIAL)
I agree to pay my copayments, coinsurance, and/or deductible as required by my insurance plan for medical care provided to me or my dependent. X__________ (INITIAL)

I UNDERSTAND THAT I AM RESPONSIBLE FOR KNOWING THE TERMS AND REGULATIONS OF MY INSURANCE PLAN. I ACCEPT FULL RESPONSIBILITY FOR PAYMENTS IF MY INSURANCE COVERAGE IS NOT VERIFIED. X__________ (INITIAL)

2. **Release of Medical Information For Billing:** I hereby authorize Zarate Podiatry systems to submit a claim to my insurance company, health and welfare fund, Medicare or Medicaid for medical services provided to me or my dependent. I also authorize Zarate Podiatry to provide a copy of this release and a copy of medical records related to such services if requested by the payer. Further, I authorize Zarate Podiatry to release medical information to my consulting or primary care physician to assist with continuity of my health care. X____________ (INITIAL)
3. **NON-COVERED SERVICES:** I agree to pay for medical services provided to me or my dependent which are not covered by the benefits in my insurance plan. X___________ (INITIAL)

PRIMARY INSURANCE INFORMATION		
Insurance Company Name:	ID#:	Group#:
Policy Holder Name:	Policy Holder Date of Birth	Policy Holder Social Security #:
Policy Holder Relation to Patient:		
SECONDARY INSURANCE INFORMATION		
Insurance Company Name:	ID#:	Group#
Policy Holder Name:	Policy Holder Date of Birth	Policy Holders Social Security #:
Policy Holder Relation to Patient:		

______________________________ ______________
Signature of Patient or Legally Responsible Person Date

ZARATE PODIATRY, P.A
Dr. Herman R Zarate, FACFAS
7610 Carroll Ave. Ste. 380 Takoma Park, MD 20912 Tel. 301.927.3668
6510 Kenilworth Ave Ste. 2300 Riverdale, MD 20737 Tel. 240.355.5823
20400 Observation Dr Ste. 102 Germantown, MD 20876 Fax.301.927.3667
www.zaratepodiatry.com email: zaratepodiatry@gmail.com

REQUIRED REFERRALS-PATIENT RESPONSIBILITY WAIVER

By signing this agreement, I____
acknowledge that I am responsible for obtaining referrals form my primary care physician, if required by my health insurance policy. My insurance policy may or may not require referrals. It is my responsibility to review and comply with my insurance requirements.

If my insurance carrier requires referrals for specialist consultations and treatments, and I fail to provide a valid referral at the time of service, I agree to be financially responsible for payments of all healthcare services provided by Zarate Podiatry and its Affiliates.

I am aware that expired referrals, referrals with no active visits remaining, or referrals that do not meet the requirements of my insurance carrier (for example, electronic referrals are required by some carries) are no longer valid and may result in my financial responsibility for payment of services rendered.

I acknowledge that my valid referral must be received by Zarate Podiatry one business day prior to my scheduled appointment time. Failure to provide a valid referral will cause my appointment to be cancelled constituting a $40 (forty) fee. If my referral is being faxed by my primary care physician, it is my responsibility to verify that it has been received by Zarate Podiatry one business day before my scheduled appointment time in order to avoid my appointment being cancelled.

In addition, I acknowledge that my explanation of benefits (EOB) from my insurance carrier, may or may not reflect this patient financial responsibility. Upon signing this waiver, I agree to pay for services, regardless of the amount reflected on the insurance carrier's explanation of benefits, if I fail to provide a valid consultation referral from my primary care physician.

By signing below, I agree to be financially responsible for all outstanding balances resulting from failure to provide a valid referral from my primary care provider for services at Zarate Podiatry and its affiliates as required by my health insurance carrier. The fee for consultation is $250.00 due prior to services being rendered.

Signature_________________________________ **Date**____________________

Dear Patient,

- In effort to keep our administrative costs down, we must enforce our Patient Administration Fee Policy. This covers the staff time and office expenses required of us to complete forms.
- We do NOT bill insurance companies or attorneys for these expenses. If you feel these fees may be reimbursable, save your receipt(s) and submit them to your insurance company/attorney. You are responsible for any litigation/attorney fees to collect outstanding bills for these services that are more than 90 days old.
- Payment is expected at the time the forms are picked up; office visit/procedure appointment cancellation fees are expected at the next visit or procedure visit.

		Fee
1.	Cancelled procedure less than 1 week prior to appointment No show for procedure or ABI (Cash/Check only)	$100
2.	Cancelled office visit less than 2 business days/ No show for appointment Cancel or reschedule same day (Cash/ Check only)	$40
3.	Returned check fee (Cash Only)	$50
4.	Lost, Misplaced prescription/Re-faxing of any office order fee (Cash/Check)	$15
5.	Faxing (Cash Only)	$1/Page
	Minimum of 5 business days are required for the following services:	
6.	Photocopies of office paper (Cash/Check)	$0.76/Page
7.	Medical records: HIPAA release required (Cash/ Check)	$22.88 + $0.76/page
8.	Disability Forms (Employer/ FSA/ FMLA) (Cash/Check)	$15- $45
9.	Department of Motor Vehicle Handicap Temporary Tag Form (Cash/ Check)	$15
10.	Other Forms/Letters/Misc (Cash/ Check)	$____________

***REFUNDS will be issued ONLY in our Riverdale Office and must be picked up by patient/designee with proper identification once billing department has verified refund amount an no prior balances are due.**

Payment for paperwork for a settlement evaluations/ expert witness/ court hearings/ other- if requested by an attorney or insurance/ litigation company will be billed directly to them.
IN THE EVENT of an emergency, inclement weather or other extenuating circumstances, **PLEASE CALL** and leave a message. Our office staff will contact you and follow up. If there are any questions or issues concerning these fees, you may ask to speak with our manager. We appreciate your cooperation and look forward to continuing to help you achieve a more functional, less painful, healthy and happy life.

I understand and acknowledge the above administrative office fees. I understand these fees may change as needed without my prior notification.

Patient signature:______________________________ Date_________________________

ZARATE PODIATRY, P.A

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Patient Name:________________________________ D.O.B.____________ CHART#____________

Introduction

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purposes of improving patient care. The information may be used for diagnosis, therapy, follow-up and/or education, and may include the following:

- Patient Medical Records
- Medical Images
- Live two-way audio and/or video

Possible Risk:

As with any medical procedure, there are potential risks associated with the use of telemedicine.

These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s)
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment
- In very rare instances, security protocol could fail, causing a breach of privacy of personal medical information

By signing this form, I understand the following:

- I understand that my health care provider wishes to engage in a telemedicine consultation.
- My healthcare provider has explained to me how telehealth conferencing technology will be used to affect such a consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my provider.
- I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties.
- I have had a direct conversation with my doctor, during which I had the opportunity to ask questions in regard to this procedure. *For patients seen in office only*
- I understand that billing will occur from Zarate Podiatry, P.A and as a facility fee from the site at which I am telehealth (presented).

Patient Consent to the use of Telemedicine

I have read and understand the information provided above regarding telemedicine. I hereby give my informed consent for the use of telemedicine in my medical care.

Patient Signature:____________________________________ Date:_______________

EMAIL:____

MARCH 25, 2020

PHOTOGRAPHS and VIDEOS

ZARATE PODIATRY

I, as the patient understand that during the course of my treatment, photographs, videos, and images may be taken while in the office for clinical or educational purposes by a member of Zarate Podiatry and/or its affiliates. These images are for the sole use of Zarate Podiatry and to better treat patients. Under the law, photographs, video/ audio recordings, images cannot be released to patients, nor can a patient/family member/ friend video/audio record or take pictures while at Zarate Podiatry facilities without prior authorization and expressed consent from **ALL** participating parties (i.e. Staff, other patients, doctors etc.) Cellphone or cameras may not be brought into treatment rooms or taken out during treatments unless consent is provided from **ALL** participating parties

Signature:________________________________ Date:____________________

CONSENT TO TREAT MINORS

We, at Zarate podiatry cannot legally treat any child under the age of 17 without a signed consent form from the legal guardian.

If you are not the parent, you will need to provide legal documentation that you are the legal guardian. This information will be kept in the patient's file.

Minor Information

Patient Name:	Patient DOB:

Parent/Legal Guardian Information

Name:	Last 5 of SSN#/Tax ID:
DOB:	Contact #:
Relationship to Patient:	

Special permission can be granted one (1) time under extenuating circumstances provided both legal guardian and attending physician consent. This excludes surgery/ consent for in office procedure(s)

*** See staff for arrangement***

(   ) No consent required. I will be accompanying patient to all future appointments. If anything changes, I will amend this statement in person prior to appointment.

*****FOR STAFF ONLY*****