NOAH M. BLUM, DPM, PA
2316 NEBRASKA AVENUE
FORT PIERCE, FL 34950
P: 772-489-4343
F: 772-489-4543

First Name: _____ M.I.: ____ Last Name: _____

Date of Birth: _____ /_____ / _____ Sex: _ Male _Female Preferred Phone: _____

Home Address: _____ City _____ State _____ Zip _____

Email Address: _____

How did you hear about us?

□ Google/Internet Search □ Existing Patient/Friend/Family: _____
(please provide name so we can thank them)

□ Physician Referral: _____ □ Other: _____

Race/Ethnicity (Optional)

Race: □ Caucasian □ African American □ Asian □ Hispanic □ American Indian □ Other □ Prefer Not to Answer
Ethnicity: □ Hispanic/Latino □ Not Hispanic/Latino □ Prefer Not to Answer
Marital Status: □ Single □ Married □ Divorced □ Widowed

Employment Status: □ Employed FT □ Employed PT □ Unemployed □ Retired □ Disabled

Patient's Employer: _____ Occupation: _____

Insurance Information

Primary Insurance:_____ ID #: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Relationship to Patient:_____ Insured Person's Phone #: _____

Do you have a secondary insurance? YES NO

What is your preferred pharmacy? _____ Phone Number: _____

Location: Street:_____ City _____ Zip _____

Who is your family doctor? _____ Location: _____

Date you last saw your physician: _____ / _____ / _____

Emergency contact information

Name: _____ Relation: _____ Phone: _____

I hereby give my permission to Dr. Noah Blum to administer treatment, as may be deemed necessary in the diagnosis and/or treatment of my foot or ankle condition.

Patient Signature: _____ Date:_____

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Family History (please mark each that apply)
[ ] Diabetes [ ] Heart Disease [ ] Cancer [ ] Arthritis [ ] Kidney Disease [ ] Peripheral Vascular Disease

Medical History
Have you been ever been hospitalized for surgery or illness: ◯ Yes ◯ No

If within past five years, please list when, and for what reason(s):
_____

Please list any medications you are presently taking: _____
_____

Allergic to any Medications: Yes/No List any allergies to medications: _____

Do you smoke: Yes/No/Former If so, how many packs a week_____ When did you quit_____

Do you Drink alcohol: Yes/No How much_____ How often_____ Received Yearly Flu shot Yes/No

Have you ever had any of the following? Please circle all that apply:

Anemia	Arthritis	Asthma	Blood transfusion	Blood clots
Cancer	Diabetes	Drug addiction	Epilepsy	Edema
Glaucoma	Gout	Joint replacement	Heart disease	Hepatitis
Liver disease	Neuropathy	Kidney disease	Poor circulation	Stroke
Tumors	Difficulty in healing	Ulcers	HIV positive	
High blood pressure	Serious infections	Rheumatic fever	Excessive scarring	

Other: _____

Today's Visit
What is your foot complaint today: _____

Location of your problem (be specific):_____

Length of time you have had this problem:_____

How did it occur? _____ Injury _____ Gradual onset _____ Rapid onset _____ Pain off and on

Describe your pain: __ Burning __ Aching __ Throbbing __ Sharp __ Stabbing __ Shooting __Numbness

What would you rate your pain, with 10 being severe pain? 0 1 2 3 4 5 6 7 8 9 10

What makes the pain worse?_____

What makes it better?_____

What have you tried to treat the condition?_____

Have you seen anyone else for this condition?_____

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REQUEST FOR CONFIDENTIAL INFORMATION

I hereby request NOAH M. BLUM, DPM to contact me by: (Please check all that apply)

[ ] Cell Phone May leave message: Yes_____ No_____

[ ] Home Phone May leave message: Yes_____ No_____

[ ] Work Phone May leave message: Yes_____ No_____

I also authorize NOAH M. BLUM, DPM to speak with the following people in regards to my diagnosis and/or treatment options or any other related healthcare issues:

Name:_____ Relationship: _____Phone: _____

Name:_____ Relationship: _____Phone: _____

Name:_____ Relationship: _____ Phone:_____

I understand that NOAH M. BLUM, DPM is not required by law to agree to this request but every attempt will be made to abide by my restrictions unless I am in need of emergency treatment. This agreement is valid until revoked by me in writing.

SIGNATURE: _____ DATE: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT GUARANTY OF PAYMENT OF MEDICAL SERVICES

I hereby authorize NOAH M. BLUM, DPM to furnish information to insurance carriers, other physicians and any other facilities involving the treatment/care of illness/injuries and for services provided as a patient of NOAH M. BLUM, DPM. I also hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I authorize payment of benefits to the physician or supplier. I understand that I am financially responsible for all medical and related charges incurred by me and/or my dependent in my/his/her medical treatment provided by my physician or other persons or facilities acting with or in the place of my physician, whether or not such charges are covered by insurance, including any and all collection fees, costs and attorney fees incurred by the physician or facility in collecting my or my dependent's medical bill. This authorization applies to all occasions of service until it is revoked by me in writing. I also hereby authorize photocopies of this authorization form to be as valid as the original.

SIGNATURE: _____ DATE: _____

NOTICE OF PRIVACY PRACTICES / PATIENT RIGHTS AND RESPONSIBILITIES ACKNOWLEDGMENT

I acknowledge that I am aware of NOAH M. BLUM, DPM's Notice of Privacy Practices and consent to the use of disclosure of my Protected Health Information (PHI) by NOAH M. BLUM, DPM for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, to conduct health care operations of NOAH M. BLUM, DPM and as required by law. I also acknowledge that I was offered the entire notice and that I understand I may obtain a full version of the notice at any time. I understand my rights as a patient of this practice concerning my PHI, as it is outline in this notice and in addition I have received a copy of NOAH M. BLUM, DPM'S Patient Rights and Responsibilities. I am aware that NOAH M. BLUM, DPM reserves the right to change the privacy practices that are described in this Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by contacting the office.

SIGNATURE: _____ DATE: _____

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Patient Financial Policy

We are dedicated to providing the best possible care and service to you and regard your complete understanding our financial policies as an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, cash or check.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all-insurance changes and authorization referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are certain elective surgical procedures that we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.
- Past due accounts are subject to collection proceedings. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due this office.
- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

Signature of Patient/Responsible Party: _____

Printed Name: _____ Date: _____

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Notice of Privacy Practices

The department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purpose of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under the law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that any event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.