MIDDLETOWN
FOOT & ANKLE

NEW PATIENT INTAKE FORM

How did you hear about us? ☐Google / Internet ☐Another patient ☐ZocDoc
☐My Primary Care Physician ☐Family/Friends ☐My insurance's website
☐Other Physician:_____ ☐Other:_____

Full name_____Date of Birth_____
Gender: ☐Male ☐Female ☐Transgender ☐Nonbinary

Caregiver full name (if under 18) _____Date of Birth: _____
Gender: ☐Male ☐Female ☐Transgender ☐Nonbinary

Email _____Home Phone _____

Mobile Phone _____Work Phone _____

Address_____

City _____ State:_____Zip Code _____

Emergency Contact_____Phone Number_____
Relationship_____

Primary Insurance Company_____Member ID_____
Group Number_____

Secondary Insurance Company_____Member ID_____
Group Number_____

Patient Relationship to Insured _____

If not self, what is the First & Last name, Date of Birth & Gender of the Insured Person?

Is the Insured Person's Address the same as yours? _____If not, what is the Insured Person's

Address:_____

Primary Care Physician _____PCP Office Number _____

Pharmacy_____ Pharmacy Phone number _____

Have you ever been treated for?

☐Acid Reflux
☐Anxiety
☐Arrhythmia
☐Asthma
☐Cancer Breast
☐Cancer Colon
☐Cancer Lung
☐Cancer Prostate
☐Cancer Skin
☐Cancer Other _____
☐COPD
☐Depression
☐Diabetes Type 1
☐Diabetes Type 2
☐Fibromyalgia
☐Glaucoma
☐Gout
☐Heart Attack
☐HIV/AIDS
☐Hypercholesterolemia
☐Hypertension
☐Hyperthyroidism
☐Hypothyroidism
☐Liver Disease
☐Osteoarthritis
☐Neuropathy
☐Peripheral Vascular
☐Disease
☐Radiculopathy
☐Rheumatoid Arthritis
☐Sciatica
☐Stroke
☐Varicose Veins
☐Vein Problem

Other Medical History_____

Surgical History (Procedures & Year) _____

_____

Please list any major health conditions in your family (parents/siblings/grandparents

_____

Do you smoke cigarettes?_____How many packs/day? For how many years?_____

Alcohol Consumption? _____How many drinks/week?_____

Allergies_____

Medications and Dose _____

_____

_____Height _____ Weight _____ Shoe Size_____

Reason for Visit _____

_____

How long have your symptoms been present? _____

Patient/Guardian Signature _____Date_____

HIPAA POLICY

TREATMENT: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you, As another example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.
PAYMENT: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.
HEALTHCARE OPERATIONS: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as needed, to contact you to remind you of your appointment.
USE REQUIRED BY LAW: We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health Issues as required by law, Communicable Diseases: Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners; Funeral Directors; and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Worker's Compensation; Inmates. Under the law, we must make disclosures to you and when, required by the Secretary of the Department of Health and Human Services.

YOUR RIGHTS
The following is a statement of your rights with respect to your protected health information.
You have the right to inspect and copy your protected health information: Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.
You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your healthcare provider is not required to agree to a restriction that you may request. If the healthcare provider believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.
You have the right to request to receive confidential communications from us by alternative means or at an alternative location.
You have a right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.
You may have the right to have your healthcare provider amend your protected health information.
You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.
If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our office of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with out HIPAA Compliance Officer listed below in person or by phone/email:
Dr. Mithun Sivadasan 732-790-5599 info@axispodiatry.com

Patient/Guardian Signature _____Date_____

Consent to Treatment and Office Policies

I do hereby seek and consent to take part in the treatment by the podiatrists at Middletown Foot & Ankle. If the patient is a minor, I hereby give my consent as a parent/legal guardian for my child to be treated by the podiatrists at Middletown Foot & Ankle.

Please go through our policies and give consent to start treatment with us. Please consider this a legal-binding document and go through these policies carefully.

Payment:
The policy of Middletown Foot & Ankle is to collect all co-payments at the time services are rendered. I acknowledge that I am responsible for any applicable copayments, coinsurance or deductibles associated with my visit. We will bill all insurance companies we are contracted with. The remaining balance will be billed to the patient. I understand it is my responsibility to know the details regarding my individual deductible ahead of my appointment. For your convenience we accept most major credit cards and all debit cards but may be subject to a processing fee.

CANCELLATION POLICY: To protect the time of our doctors we ask that you give us 24-hour notice for appointment cancellations or to reschedule so that we can use the reserved time to treat other patients. Multiple cancellations without notice may lead to a discharge from the practice.

TREATMENT ATTENDANCE: If you are regularly missing or late to appointments, you are at risk of being discharged from the practice. We do understand that life is complex, and things arise. We ask you to be transparent with us if you are experiencing challenges with treatment attendance, so we can work together to figure out a solution.

MEDICATION: Refills should be requested directly to the patient portal rather than the pharmacy. Please give us at least 5 days' notice for refill requests so that you don't run out of medications on a weekend or holiday. Refills for medication are meant to occur during your visit with the doctor. The doctor puts a lot of thought into prescribing medications each and every time and this is the reason it should be done at the time of your appointment. Patients must be seen within one year for a refill of a medication for a chronic condition.

CONSENT TO TREATMENT FOR MINORS: Consent for treatment with a child under the age of 18 years old must be provided by either parent. Exception is sole custody in which case documentation must be provided and placed into file.

Patient/Guardian Signature _____Date_____