DANIEL BELL D.P.M.
FOOT & ANKLE
INSTITUTE

Thank you for choosing **Daniel Bell DPM, PA** as your podiatric provider. You will find enclosed the new patient paperwork. If you have any questions or concerns, please feel free to contact the New Patient Coordinator.

To help expedite your treatment, to ensure your privacy and to correctly file your insurance claims, we ask that you carefully read over the following information and provide the required identification.

1. Please provide our office with your correct insurance card (primary, secondary and tertiary) and photo identification, such as driver's license or other photo ID. It is required these items are to be submitted at the time you check-in.

   Please provide your most recent medical records, which would include any Immunizations, Flu shot, Pneumonia shot, Renal failure documentation, Diabetes Blood testing (HBA1C), and yearly physical documentation, imaging reports and images pertaining to your condition. If your PCP (primary care physician) referred you to our office, please contact them to request that they submit any medical records and/or imaging reports to our office. If you are a self-referred client, please obtain the medical records pertaining to your condition and either bring them to your appointment or have them faxed **(954-432-9446)**. It is your responsibility to ensure that these records are provided to our physician.

2. It is your responsibility to follow up and make sure that an authorization is obtained for any office visits including your initial consultation if your insurance requires said authorization. This would be obtained from your PCP (Primary Care Physician). Please ensure that your PCP has your correct insurance information when requesting an appointment to our facility. If an authorization is not obtained and is required, you may incur fees from your visits or have to reschedule your appointment for another day or time.
3. Finally, there may come a time when you require additional medical and/or insurance forms to be completed by our office. They may include, but are not limited to, Disability Forms, Workers' Compensation Forms, Attending Physician Statement, Leave of Absence forms, etc. **This will not apply to most patients.** However, in order to accommodate these requests, it will necessitate reviewing the chart, staff time and office resources. Therefore,

a reasonable fee for such services will be applied. Forms will not be completed until this fee is received.

4. Every effort will be made to have these forms completed within a 7-10 business day turn-around from the time the fee is received. Please note that if the provider is out of the office there may be a longer delay. This would only apply to completing and filling out above-mentioned forms and **NOT** for completing the enclosed paperwork you received as a new patient to our facility.

Please arrive at your scheduled appointment 15 minutes prior to your appointment time and bring the completed paperwork you received from our office, insurance cards and photo identification. Please note that photo identification and insurance cards are **REQUIRED** at the time of the appointment. If you have any questions, please feel free to contact this office. Thank you for choosing **Daniel Bell DPM, PA**.

In order to help us help you during your office visit, please review and use the following forms.

**NEW PATIENTS**

The "New Patient Packet" contains forms which you will be required to complete for your first visit. Please download the forms and provide the requested information. At the time of registration you will also be asked to present your driver's license and insurance cards for verification.

**NEW PATIENT PACKET INCLUDES:**

Welcome Letter; Information Demographics; Past Medical History; Illnesses; Notice of Privacy Practices; Patient Financial Policy; Patient Consent Form; HIPAA Authorization Form; Depending on the insurance there might be additional forms such as Doctors Lien; Assignment of Insurance Benefits.

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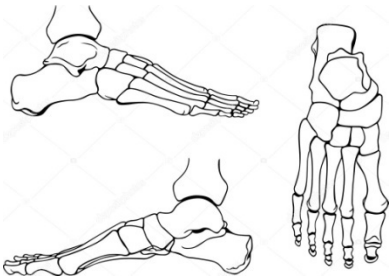
| **PATIENT INFORMATION** | **DATE:** | |
|---|---|---|
| **Patient's last name:** (*Apellido*) | **First** *(Nombre):* ***Middle (Segundo):*** | |
| **Birth date:** *(Fecha de Nacimiento.)* ***Age (Edad):*** | **Sex:** ❑ **Male** ❑ **Female** | **SSN:** *(Numero de Social Securidad)* |
| **Phone#:** *(Numbero de Telefono)* ***Cell#:*** *(Numero de Cellular)* | **Email** (*Correo electronico*)**:** | |
| **Street Address** *(Direccion):* | **Apt/Unit#** (Apartamento): | |
| **City***(Ciudad):* | **State** (*Estado):* | **Zip Code:** |
| **Employer** (*Empleador*)*:* | **Employer phone** (*Telefono Trab.):* | |
| **Referred by** (*Referido por*) | | |
| **Drivers License** (Numero de Licencia): | | |

| **INSURANCE INFORMATION** | **IS THIS PERSON COVERED BY INSURANCE? ❑ YES ❑ NO** |
|---|---|
| **Primary Doctor Name** (*Doctor primario*)**:** | |
| **Phone Number** *(Numbero de Telefono):* | **Fax no.** (*Telefono de fax*) |
| **Person responsible for bill** *(Persona responsible de cuenta):* | **Phone** (*Telefono*): |
| **Address if different from above**(*Direccion diferente de arriba*)**:** | **Birth Date**(*Fecha de Nac.*)**:** |
| **Primary Insurance** (*Seguro del primario*): | **Secondary Insurance** (*El nombre de seguro secundario*) |

| **IN CASE OF EMERGENCY** | |
|---|---|
| **Name** (*Contacto de emergencia*)**:** | **Relationship** (*Relacion*)**:** |
| **Home Phone** (*Telefono de casa*) | **Work Phone**(*Telefono Trab*) |

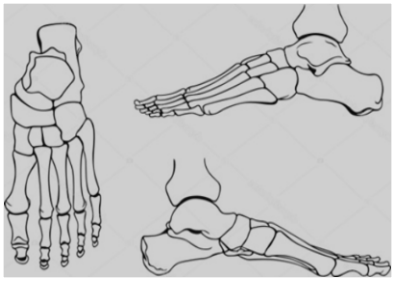
**RIGHT FOOT**



LENGTH OF PROBLEM:
❑ DAYS
❑ WEEKS
❑ MONTHS
❑ YEARS

PLEASE CIRCLE PROBLEM AREA

**LEFT FOOT**



The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Daniel Bell DPM, PA or insurance company to release any information required processing my claims.

**Patient/Guardian signature**(*El paciente / Firma de guardian*) **Date** (*Fecha*)**:**

_____ _____

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# PAST MEDICAL HISTORY

**Patient Name (Nombre del Paciente):** _____

**Current Medications List:**
**(Actual lista de medicamentos)**

| | | |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

## Are you currently taking any of the following?

**( ¿Está tomando alguna de las siguientes? )**

□Echinacea □Garlic □Ginger □Gingko Biloba □St. John's Wort
□Ginseng □Kava kava □Feverfew □Ephedra

## Allergies (Alergias):

□ Penicillin □ Sulfa drugs □ Aspirin □ Codeine □Iodine/shellfish □Tape □ Local / General Anesthetics
□ Latex

| MEDICATION ALLERGIES: | FOOD ALLERGIES: | ENVIRONMENTAL ALLERGIES: |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

| PREVIOUS INJURIES: | PREVIOUS SURGERIES: | PREVIOUS HOSPITALIZATIONS: |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Patient/Guardian Signature:**_____**Date:**_____
(Firma del paciente) (Fecha)

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# ILLNESSES

**Patient Name (Nombre del Paciente): _____**

## Major diseases:
□Diabetes
□Hypertension
□Angina
□Heart Attack
□Arrhythmia
□Murmur
□Stroke
□Chest Pain

## Arthritis:
□Osteoarthritis
□Rheumatoid
□Gout
□Sero-negative:

## Respiratory:
□Bronchitis
□Frequent Colds
□Lung Disease
□Shortness of Breath
□Tuberculosis
□Emphysema

## Heent:
□Headaches
□Eye Problems
□Hearing Problems

## Vascular:
□Anemia
□Sickle Cell
□Bleeding Disorders
□Poor Conditions
□Night Cramps
□Leg Pain when Walking
□DVT (Deep Vein Thrombosis)
□Varicose Veins
□Swelling Phlebitis
□Leg Ulcerations
□Blood Clots
□Transfusions

## Psychological:
□Anxiety
□Depression
□Psychiatric
□Drug Dependence
□Alcohol Dependence

## Gastrointestinal:
□Ulcers
□Bowel Disorders
□Stomach Problems
□GI or Rectal Bleeding
□Hiatal Hernia
□Acid Reflux (GERD)

## Miscellaneous:
□Epilepsy
□Thyroid Disease
□Muscle Disease
□Kidney Problems
□Bladder Problems

## Other:
_____
_____
_____
_____

## SOCIAL HISTORY:
□Single □Separated □Married □Divorced
Occupation: _____ Alcohol: _____oz/day/week
Athletic Activities: _____ Tobacco: _____pks/d for _yrs

## FAMILY HISTORY (Historia de Familia):
Maternal:_____

_____

Paternal: _____

**Patient/Guardian Signature:_____Date:_____**
(Firma del paciente) (Fecha)

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# NOTICE OF PRIVACY PRACTICES
# PATIENT ACKNOWLEDGEMENT

**Patient Name (Nombre del Paciente): _____**

**I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:**

- **A statement that this practice is required by law to maintain the privacy of protected health information.**
- **A statement that this practice is required to abide by the terms of the notice currently in effect.**
- **Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment and health care operations.**
- **A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.**
- **A description of uses and disclosures that are prohibited or materially limited by law.**
- **A description of other uses and disclosures that will be made only with my written authorization and that may revoke such authorization.**
- **My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:**

  **-The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.**
  **-The right to request restrictions on certain uses and disclosures of my protected health information and that this practice is not required to agree to a requested restriction.**
  **-The right to receive confidential communications of protected health information.**
  **-The right to inspect and copy protected health information.**
  **-The right to amend protected health information.**
  **-The right to receive an accounting of disclosures of protected health information.**
  **-The right to obtain a paper copy of the Notice of Privacy practices from this practice upon request.**

**This practice reserves the right to change the terms of its Notice of Privacy practices and to make new provisions effective for all protected health information that is maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.**

**Patient/Guardian Signature:_____Date:_____**
(Firma del paciente) (Fecha)

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# PATIENT FINANTIAL POLICY

**Patient Name (Nombre del Paciente): _____**

**Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our office staff or supervisor.**

- **As our patient you are responsible for all authorizations/referrals needed to seek treatment in the office of Daniel Bell DPM, PA.**
- **Unless other arrangements have been made in advance by you, or your health insurance carrier, payments for office services are due at the time of services. We will accept VISA, MASTER CARD or CASH.**
- **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 Dr. Bell 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 certain 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 all non paid services/denials by your insurance carrier will be your responsibility to be paid in full.**
- **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 payments 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 or referrals; 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 for which 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 cost incurred including, but not limited to collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office. If the account is sent to collections an additional 35% of the outstanding balance will be added to the account.**
- **There is a service fee of $50.00 for all returned checks. Your insurance company does not cover this fee.**
- **Daniel Bell DPM, PA charges a $25.00 fee for failure to cancel your appointment within 24 hours of your scheduled appointment time.**
- **Financial policy is subject to change without notice.**

**Patient initials to indicate copy received. _____**

**Patient/Guardian Signature:_____Date:_____**
(Firma del paciente) (Fecha)

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# PATIENT CONSENT FORM

**Patient Name (Nombre del Paciente): _____**

I authorize the office of Daniel Bell DPM, PA to leave a message on my behalf with the number listed on my account

I fully understand that this is given in advance of any specific diagnosis or treatment.
I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I, the undersigned, authorize that Daniel Bell; D.P.M. will use and disclose my information for the purposes of treatment, payment and healthcare operations.

Treatment includes but is not limited to: the administration and performance of all treatments, the administration of any needed anesthetics, the use of prescribed medication; the performance of such procedures may be deemed necessary or advisable in the treatment of this patient, such as diagnostic procedures, the taking and utilization of cultures and of other medically accepted laboratory tests, all of which the judgment of the attending physician or their assigned designees, may be considered medically necessary or advisable.

Payment includes but is not limited to: the authorization of payment directly to: Daniel Bell, D.P.M. of benefits otherwise payable to me. I hereby authorize the release of my medical records to third party insurers or authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided, such as billing and collection services, insurance payers, auto accident insurers, or for work related injury, to my employer or designee understand that I am financially responsible for charges not covered. I understand that patient records may be stored electronically and made available through computer networks.

Healthcare Operations include but are not limited to: release of my medical information to any of my physicians and their offices or insurance companies participating in my care or treatment and the quality of that care.

I fully understand that this is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing. This consent specifically includes the release of medical information concerning drug-related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or infectious diseases including but not limited to blood-borne diseases.

A photocopy of this consent shall be considered as valid as the original.

If there is an exposure, and the patient's test is positive, the attending physician will notify the patient, any person exposed, and the Broward Health Department and appropriate counseling will be offered.

MEDICARE PATIENTS; I AUTHORIZE TO RELEASE MEDICAL INFORMATION ABOUT ME TO THE Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Daniel Bell, D.P.M.

I acknowledge that I have been given the Dr. Bell Notice of Privacy Practices. **PATIENT INITIALS:** _____

I understand that if I have questions or complaints that I should contact the Privacy Official.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

**Patient/Guardian Signature:_____Date:_____**
(Firma del paciente) (Fecha)

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# HIPAA AUTHORIZATION

**Patient Name (Nombre del Paciente): _____**
**DOB: (Fecha de Nacimiento):_____**

I hereby request and authorize_____to release my medical records and itemized billing statements, including protected health information ("PHI") to:

Dr. Daniel Bell D.P.M, P.A
601 N Flamingo Rd #208
Pembroke Pines, FL 33028
(954) 942 - 5005
Fax: (954) 432-9446

I understand that I may revoke this Authorization at any time, except to the extent that said medical provider has taken action in reliance on the Authorization. My revocation of this Authorization will only be effective if I submit my revocation to the medical provider in writing.

I understand that I am not required to sign this Authorization, and that my refusal to sign will not affect my ability to obtain treatment with said medical provider. However, I also understand that failure to sign this Authorization may prevent said medical provider from releasing my PHI to the above named office.

1. HAVE YOU HAD A PHYSICAL THIS YEAR YES/NO
    a. WHICH DOCTOR DATE_____
2. HAVE YOU HAD A FLU SHOT THIS YEAR YES/NO
    a. WHICH DOCTOR DATE _____
3. HAVE YOU HAD AN EYE EXAM THIS YEAR YES/NO
    a. WHICH DOCTOR,DATE_____
4. DO YOU HAVE RENAL FAILURE, YES/NO
    a. WHICH DOCTOR,DATE _____
5. ARE YOU DIABETIC YES/NO
6. HAVE YOU HAD YOUR HBA1C YES/NO
    a. WHICH DOCTOR,DATE _____
7. HAVE YOU HAD YOUR PNEUMONIA VACCINE THIS YEAR YES/NO
    a. WHICH DOCTOR, DATE_____

**Patient/Guardian Signature:_____Date:_____**
(Firma del paciente) (Fecha)