Barry M. Tuvel, DPM.

Doctor Podiatric Medicine
Foot & Ankle Surgery *Vein Specialist*
9075 SW 87th Ave Suite 402
Miami, Fl. 33176
305-279-2499 Fax: 305-279-6647

Patients Name:

_____
(Nombre del Paciente)

Sex: _____ Name Of Spouse: _____
(Sexo) (Nombre de Esposa/Esposo)

Address, City, State, Zip Code: _____
(Direccion)

Home # _____ Work # _____ Cell # _____ E-mail _____
(Telefono Casa) (Telefono Trabajo) (Telefono Celular)

Date Of Birth: _____ SS #: _____ Marital Status: Married Single Divorced Widow
(Fecha De Nacimiento) (Seguro Social) (Estado Civil)

Occupation : _____ Employer : _____
(Ocupacion) (Empleador)

Guardian's Name: (If Patient Is Minor) _____
(Padre O Guardian)

Emergency Contact: _____ Phone : _____
(Persona En Caso de Emergencia) (Telefono)

Referred By : _____

Primary Care Physician:_____ Phone:_____Fax:_____
(Medico Primario) (Telefono)(Fax Del PCP)

Pharmacy Name & Address: _____Phone: _____
(Nombre De La Farmacia Y Direccion) (Telefono)

(Por Quien Fue Referido)

Describe Your Foot Problem : _____ (Right) (Left) (Both)
(Describe su problema de sus pies o piernas) (Indique cual pies es Derecho Isquierdo o Ambos)

Accident Related : YES / NO Accident Type : Auto / Worker's Comp / Other
(Relacionado con un accidente) (Tipo de accidente)

How Did It Happen :_____
(Como Sucedio El Accidente)

When did the problem start : _____ Have you had foot treatment before: YES / NO
(Cuando comenso el problema) (Has tenido tratamiento para los pies anteriormente)

By Whom: _____ What Was The Treatment :_____
(Por Quien) (Que Tratamiento)

Height : _____ Weight : _____ Shoe Size : _____
(Estatura) (Peso) (Talla Del Zapato)

Are you subject to prolong bleeding or healing difficulties: _____
(Problema de sangramiento prolongado o dificultades en sanar?)

What medication are you taking at this moment : _____ _____
(Nombre de medicamentos que usted esta
tomando en estos momentos) _____ _____

_____ _____ _____

_____ _____ _____

Do you : Smoke: _____ Drink Alcohol : _____ Coffee / Caffeine : _____ (Usted)
(Fuma) (Toma Bebidas alcoholicas) (Café, Te, Cafeina)

Surgeries in the last 5 years : _____
Cirugias en los ultimos 5 años?)

( ) IM NOT ALLERGIC TO ANYTHING TO MY KNOWLEDGE
(NO SOY ALÈRGICO A NADA)

( ) I AM ALLERGIC TO THE FOLLOWING : (PLEASE CHECK ALL THAT APPLY)
(SOY ALÈRGICO A LAS SIGUIENTES COSAS)

_____ ASPIRIN _____ LOCAL ANESTHESIA _____ CODEINE _____ ADHESIVE TAPE

_____ PENICILLIN _____ SULFA _____ IODINE _____ OTHER'S

I have or have had the following : (Please check all that applies)
(Tiene usted alguna de las siguientes enfermedades?)

_____ DIABETES TYPE I or II _____ ASTHMA _____ ANEMIA

_____ CANCER _____ EPILEPSY _____ LEG CRAMPS

_____ HIGH BLOOD PRESSURE _____ ANXIETY /DEPRESSION _____ STROKE

_____ HEART DISEASE _____ GLAUCOMA _____ KIDNEY TROUBLE

_____ ARTHRITIS _____ VARICOSE VEINS _____ ALZHEIMERS

_____GASTRO-INTESTINAL DISORDER _____ STOMACH ULCERS _____ GOUT

_____ NO MEDICAL CONDITIONS _____ MITRAL VALVE PROLAPSE _____ HIV

Family History: Mother, Father, Grandmother, Grandfather on both side of the family anyone has or had Diabetes, Cancer or Heart Disease?
(En su familia Madre, Padre, Abuelos de ambos partes han tenido o tienen problemas de Diabetis, Cancer o Cardiovascular?)

_____

Do you get burning, tingling or numbness in your feet or legs? ( ) YES ( ) NO
(Usted se le duermen o siente quemason en los pies o dedos?)

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HIPPA Acknowledgement and Consent Form

I understand that under the Health Insurance Portability and Accountability Act of 1996(HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from designated third-party payers
- Conduct normal health care operations such as quality assessments or evaluations and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information (available in the office in print form). I have reviewed such Notice of Privacy Practices prior to signing this consent, and acknowledge that I have studied the Privacy Practices prior to signing this consent, and acknowledge that I have studied the Privacy Practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the Notices of Privacy Practices. I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is abounding to abide by such restrictions. I understand that I can revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

Patient's Name _____ DOB: _____

Signed _____

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FINACIAL POLICY (Please Read & Sign)

Welcome to my practice!!! The doctor evaluation, time diagnostic testing and treatment are provided to you our valued patient. Our fees are based on "USUAL & CUSTOMARY" rates for Dade County, Fl. You may ask questions' concerning our fees at any time before treatment is rendered. Certain services, include SURGERY & ORTHOTICS will require that you sign a form advising you that a fee has been discussed and agreed upon.

PLEASE PRESENT ALL INSURANCE CARDS TO OUR RECEPTIONIST FOR VERIFICATION OF COVERAGE.

It is the patient's responsibility to provide our office with accurate up to date insurance information. A photo ID is also required. Please remember, verification of coverage is NOT a guarantee of benefits, and the patient is responsible for the amount not paid by their insurance carrier.

- **NO INSURANCE**, payment is due when services rendered.
- **MEDICAID**, Limited to services if available
- **MEDICARE**, patient is responsible for annual deductible and 20% co-insurance (Unless covered by a supplemental insurance). IF YOU HAVE SIGNED UP FOR ANY MEDICARE, REPLACEMENT POLICY, ITS YOUR RESPONSIBILITY TO VERIFY THAT WE ARE PARTICIPATING WITH YOUR INSURANCE PLAN. If services are provided, and we are not on your plan, you will be responsible for the bill.
- **HMO, PPO, POS, PPC, ETC.,** ---- verify that we are participate with your plan! Deductibles & co-pays will be collected, as established by your plan. You must provide our office with any necessary REFERRALS/PRIOR AUTHORIZATION, as established by your insurance plan.
- **PRIVATE INSURANCE** deductibles & co-insurance will be collected at the time of service. Disputes with your insurance company regarding coverage or payment of a claim are your responsibility.
- **BILLING,** we attempt to avoid monthly billing by collecting appropriate amounts at the time of service. However, if it is necessary for us to send you a bill, please pay promptly. Repeat billing of past due accounts will result in referrals to our independent collection agency. Collection fees will be charges to patient.
- **RETURNED CHECKS**, A return check fee is $35.00 will be charged.

_____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN **DATE**

CO-PAYMENTS ARE DUE AT EACH VISIT

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PATIENT CONSENT FOR US AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent to Barry M. Tuvel D.P.M. to use and disclose health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

Notice of Privacy Practices provides a more complete description of such use and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent Barry M. Tuvel D.M.P. reserves the right to revise its Notice of Privacy Practices at any time. A revise Notice of Privacy Practices may be obtained by forwarding a written request to Barry M. Tuvel D.P.M.

With this consent, Barry M. Tuvel D.P.M., PA. may call my home or other alternative locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results, among others.

With this consent, Barry M. Tuvel D.P.M., PA. may mail to my home or other alternative locations any items that assist the practice in carrying out TPO, such as appointment reminders cards and patient statements, as long as they are marked Personal & Confidential.

With this consent, Barry M. Tuvel D.P.M., PA. may email to my home or other alternative locations any items that assist the practice in carrying out TPO, such as appointment reminders cards and patient statements.

I have the right that Barry M. Tuvel D.P.M., PA. Restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Barry M. Tuvel D.P.M., PA. use and disclose of my PHI to carry out TPO.

I may revoke my consent in writing expect to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Barry M. Tuvel D.P.M., PA. may decline to provide treatment.

_____ _____

SIGNATURE **DATE**

The following pages are for medical records request. In the event that you need your medical records released to another doctor, or party for any reason, we will have your authorization on file to release your records, for your convenience. Otherwise you can come into the office in person with a photo id and sign a medical records release at that time.

Las siguientes páginas son para solicitud de registros médicos. En el caso de que tenga sus expedientes médicos entregados a otro médico, u otro partido por cualquier razón , vamos a tener su autorización en sus archivos para liberar sus registros , para su conveniencia. De lo contrario, usted puede venir a la oficina en persona con una identificación con foto y firmar una autorización médica registros en ese momento.

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MEDICAL RECORDS RELEASE FORM

Please complete the following information:

Patient Name: _____

Address: _____

_____

Phone: _____

SSN: _____

Date of Birth: _____/_____/_____

I authorize the custodian of records of: or other person/entity (specifically describe) to disclose/release the following information* (check all applicable):

o All records

o Laboratory/pathology records

o X-ray/radiology records

o Billing records

o Abstract/Summary

o Pharmacy/prescription records

o Other (describe specifically)_____

***Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.**