YITZCHAK D. COHEN, D.P.M. AACFAS

COHEN FOOT & ANKLE NEW YORK/NEW JERSEY

NEW PATIENT REGISTRATION

*PATIENT INFORMATION

Date:_____
Name_____
Address:_____
_____
City State Zip
Sex:_____ Age:____
Birth Date:_____
Marital Status:_____
SS#:_____
Spouse's Name:_____

Occupation:_____
Employer:_____
Employer Address: _____
_____

Medical Doctor: _____
Address:_____

Referred by: _____

*CONTACT INFORMATION

Home#: _____
Cell#: _____
Work#: _____
Email Address: _____

*IN CASE OF EMERGENCY. CONTACT

Name: _____ Relationship: _____
Home#: _____
Cell#: _____

*PREFERED PHARMACY:

Name: _____
Location: _____
Phone #: _____

INSURANCE INFORMATION

Insurance Co. _____
Policy Holder Name:_____
Birthdate:_____ SS#: _____
ID #: _____

Secondary Insurance Co. _____
Policy Holder: _____
Birthdate: _____ SS#: _____
ID #: _____

Required Information for Electronic Medical Records

Race
__Asian __African American/Black __White
__American Indian __More than one race
__ Hispanic/Latino __Refused to report

Preferred language
__English __Spanish __other:_____

PODIATRIC HISTORY

Chief Complaint: _____

Please indicate with a checkmark any problems you have had before:

___ Ankle Pain ___ Athlete's Foot
____Bunions ____ Corns & Callouses
____Cramps/Numbness ____Flat Feet
___ Heel Pain ____ Ingrown toenails
___ Plantar's Warts ____ Swelling
___ Tired Feet ____Fracture
____Ankle sprain
Other: _____

Duration of Problem:_____

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CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to Yitzchak D. Cohen D.P.M. to administer and perform such procedures as may be deemed medically necessary in the diagnosis and/or treatment of my feet.

*Patient's Signature _____ Date: _____

PATIENT'S NAME_____ AGE_____ DATE_____

WHO WERE YOU REFERRED BY? _____ LAST SEEN DATE BY PCP_____

CHIEF COMPLAINT: _____

HOSPITALIZATIONS	SURGERIES
_____	_____
_____	_____
_____	_____

HAVE YOU EVER HAD PODIATRIC CARE? YES / NO WITHIN THE LAST 60 DAYS? YES / NO
IF YES FOR WHAT PROBLEM? _____DOCTOR'S NAME_____

***ALLERGIES:**_____
_____

***MEDICATIONS:** _____ _____ _____ _____
_____ _____ _____ _____

SOCIAL HX: DO YOU SMOKE: YES / NO / FORMER _____ /PACKS A _____

Drug Use: Yes / No DO YOU DRINK ALCOHOL: YES / NO _____

FAMILY HISTORY:_____
_____
_____

***PATIENT'S MEDICAL HISTORY:**

HYPERTENSION: YES / NO BLOOD PRESSURE: _____ HEIGHT: _____ WEIGHT: _____
FLU SHOT: YES / NO DATE: _____

COVID19 VACCINATION YES/NO DATE_____
DIABETES: YES / NO/ BORDERLINE
HOW LONG_____
FASTING BLOOD SUGAR_____ A1C LEVEL_____

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HEAD

HEARING PROBLEMS: YES / NO _____

EYE PROBLEMS (CONTACTS OR EYEGLASSES): YES / NO _____

THROAT PROBLEMS: YES / NO _____

MENTAL DISORDERS: YES / NO_____

THYROID DISORDERS: YES / NO _____

CARDIAC

RHEUMATIC FEVER: YES / NO PALPITATIONS: YES / NO STENTS: YES / NO

SCARLET FEVER: YES / NO M.I.: YES / NO ADDITIONAL: _____

HEART MURMURS: YES / NO ANGINA: YES / NO _____

PULMONARY

S.O.B: YES / NO ASTHMA: YES / NO EMPHYSEMA: YES / NO

PNEUMONIA: YES / NO TB: YES / NO BRONCHITIS: YES / NO

ADDITIONAL: _____

GASTROINTESTINAL_____

RENAL / G.U.

HEMATURIA: YES / NO U.T.I.: YES / NO LITHIASIS: YES / NO

NOCTURIA: YES / NO KIDNEY INF.: YES / NO ADDITIONAL: _____

HEPATIC

JAUNDICE: YES / NO CIRRHOSIS: YES / NO

HEPATITIS: YES / NO ADDITIONAL: _____

CIRCULATORY

PHLEBITIS: YES / NO PULMONARY EMBOLISM: YES / NO VARICIES: YES / NO

DVT: YES / NO ADDITIONAL: _____

OTHER

ARTHRITIS: YES / NO BLEEDING DISORDERS: YES / NO

ANEMIA: YES / NO CANCER: YES / NO _____

KELOIDS: YES / NO ADDITIONAL: _____

GOUT: YES / NO _____

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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or healthcare operation (TPO), and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you including demographic information that may identify you and that relates to your past, present, or future physical or mental health or condition and related healthcare services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office who are involved in your care and treatment for the purpose of providing healthcare services to you to pay your healthcare bills, support the operation of the physician's practice, and any other use required by law.

Treatment
We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare 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. For 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 you.

Payment
Your protected health information will be used, as needed, to obtain payment for your healthcare 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 who see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. 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 necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization: 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 Donations,

Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, and Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 64.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization, or opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

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 operation. 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 the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician 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 have the right·to then use another Healthcare Professional.

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You have the right to request to receive confidential communications from us by alternative means or at an alternative location.
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 alternatively i.e. electronically.

You have the right to have your physician amend your protected health information.
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 have the 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.

Complaints
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 privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of your legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement. That you have received this Notice of our Privacy Practices:

*Print Name_____Signature:_____Date_____

YITZCHAK D. COHEN, D.P.M. AACFAS
COHEN FOOT & ANKLE NEW YORK/NEW JERSEY
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GENERAL RELEASE REQUEST OF MY MEDICAL FILE FROM OTHER FACILITIES

I as your Patient/Client, do hereby formally request a copy of my complete medical file including but not limited to Physician notes, Diagnostic Tests and films. Op notes and dates of services rendered: sent/faxed to:

Cohen Foot & Ankle LLC
105 Union St Lodi, NJ 07644
Phone: 201-654-6507 Fax: 201-742-7001

_____ _____
(print) DOB

This is a signed authorization to release my information to the above facility.

_____ _____ _____
(print) (signature) (date)

AUTHORIZATION TO PAY PHYSICIAN

(A) I hereby authorize the _____Insurance Company to pay by check made out and mailed to :

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Cohen Foot & Ankle LLC
105 Union St Lodi, NJ 07644
Phone: 201-654-6507 Fax: 201-742-7001

the medical and surgical expense benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for Professional Services rendered. This payment will not exceed my indebtedness to the above mentioned assignee, and I agree to pay, in a current manner, any balance of said Professional Service charges over and above this insurance payment.

If my current policy prohibits direct payment to the doctor, then I hereby authorize you to make the check payable to me and mail it to the physician's office at:

Cohen Foot & Ankle LLC
105 Union St Lodi, NJ 07644
Phone: 201-654-6507 Fax: 201-742-7001

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THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY

(A) A photocopy of this Assignment shall be considered as effective and valid as the original.

AUTHORIZATION TO RELEASE INFORMATION

(B) I hereby authorize you to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, adjustor or any medical/diagnostic provider in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered. I hereby release you of any consequence thereof.

(C) I hereby authorize you to obtain or release any medical information you deem appropriate concerning my physical condition to/ from any insurance company, attorney, adjustor or any medical/diagnostic provider. I hereby release you of any consequence thereof.

Date_____

_____ _____

Signature Witness