Perfect Steps Care Center

Healing Feet One Person at a Time

PATIENT SOCIAL DATA

First Name:_____ Middle Initial:_____ Last Name:_____

D.O.B: __/____/_____ SS#: _____-_____-_____ Gender: ◯ Female ◯ Male_____

Street Address: _____ Cell Phone: _____-_____-_____

City: _____ State: _____ Zip Code: _____

Marital Status :_____ Ethnicity:_____

E-mail: _____

Employer: _____ Phone: _____-_____-_____

How did you hear about us: _____

EMERGENCY CONTACT

Name: _____ Phone: ___-_____-_____

Address: _____ City: _____

State: _____ Zip Code: _____ _

PHARMACY INFORMATION

Pharmacy Name: _____ Phone: ____-_____-_____

Address: _____ City: _____ State: _____

Zip Code: ____-_____-_____

PRIMARY CARE PHYSICIAN INFORMATION

Primary Care Physician Name: _____ Phone: _____

Address: _____ City: _____

State: _____ Zip Code: _____

Perfect Steps Care Center

Healing Feet One Person at a Time

MEDICAL HISTORY

Place a mark on "Yes or "No" to indicate if you have had any of the following:

Anemia	❒Yes	❒No	Hemophilia	❒Yes	❒No
Arthritis	❒Yes	❒No	Hepatitis	❒Yes	❒No
Asthma	❒Yes	❒No	High Blood Pressure	❒Yes	❒No
Back Problems	❒Yes	❒No	Kidney Problems	❒Yes	❒No
Bleeding Disorder	❒Yes	❒No	Liver Disease	❒Yes	❒No
Cancer	❒Yes	❒No	Psychiatric Care	❒Yes	❒No
Chest Pain	❒Yes	❒No	Radiation Treatment	❒Yes	❒No
Circulatory Problems	❒Yes	❒No	Stroke	❒Yes	❒No
Diabetes	❒Yes	❒No	Swelling in Ankle / Feet	❒Yes	❒No
Foot or Leg Cramps	❒Yes	❒No	Tired Feet	❒Yes	❒No
Gout	❒Yes	❒No	Ulceration	❒Yes	❒No
Heart Disease	❒Yes	❒No	Varicose Veins	❒Yes	❒No

ALLERGIES HISTORY

❒Adhesive Tape	❒Latex	❒Anticoagulant Anesthetics	❒Aspirin
❒Local	❒Therapy	❒Novocain	❒Codeine
❒Penicillin	❒Demerol	❒Seafood	❒Iodine
❒Sulfa Other			

❒ Other: _____

MEDICATIONS:

_____

_____

_____

CONSENT OF TREATMENT

I certified that the above information is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform procedures as may be deemed necessary in the diagnosis and/or treatment of the any medical conditions within the doctor's scope of practice.

Patient/Authorized Signature_____ Date_____

PHOTO CONSENT:

I agree to allow Perfect Steps Care Center Inc, to take pictures of my feet, lower leg and/or ankles. I also understand that these pictures may be used for any of the following purposes: historical reference, diagnostic, teaching, research and/or presentations. I also understand that my face, name, and any other personal information will not be disclosed.

Patient/Authorized Signature_____ Date_____

Perfect Steps Care Center

Healing Feet One Person at a Time

VASTHY JEAN LOUIS, D.P.M
1665 Bedford Avenue Suite 2 Brooklyn NY 11225
Phone: 347 – 770- 9900 Fax: 718 – 819- 1318

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED

HEALTH INFORMATION

I hereby give my consent to the Podiatry office to use and disclose protected health information about me to carry out treatment, payment and healthcare operations. The office's 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 contract. The office reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Perfect Steps Care Center, 1665 Bedford Avenue Suite 2 Brooklyn NY 11225.

With this consent, the Podiatry office may text, email , call my home or other alternative location and leave messages on voice mail in reference to any items that assist the practice in carrying out Treatment Payment or Operation (TPO), such as appointment reminders, insurance information, and any calls pertaining to my clinical care, including laboratory results among others.

With this consent the office may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. With this consent the office may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that the office restrict how it uses or discloses my Protected Healthcare Information (PHI) or 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 the Podiatry office's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except 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, the Podiatry office may decline to provide treatment to me.

_____
Signature of Patient or Personal Representative

_____
Print Name of Patient or Personal Representative

_____
Date

Perfect Steps Care Center

Healing Feet One Person at a Time

VASTHY JEAN LOUIS, D.P.M
1665 Bedford Avenue Suite 2 Brooklyn NY 11225
Phone: 347 – 770- 9900 Fax: 718 – 819- 1318

PODIATRY OFFICE

ACKNOWLEDGMENT OF RECEIPT OF

HIPAA NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided a copy of the Office of Podiatry Notice of Privacy Practices, and I have therefore been advised of how the office may use and disclose health information about me and how I may obtain access to and control this information.

_____
Signature of Patient or Personal Representative Print

_____
Name of Patient or Personal Representative

_____
Date

_____,
Description of Personal Representative's Authority

****

(For use where signature above cannot be obtained)

Except in emergency treatment circumstances, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we make a good faith effort to obtain written acknowledgment of the patient's receipt of the Notice of Privacy Practices on the first date after April 14, 2003 we provide treatment, products or services to the patient. We must make a good faith effort to obtain written acknowledgment when reasonably practicable following an emergency treatment situation. If acknowledgment cannot be obtained, we must document our good faith efforts to obtain the acknowledgment and why it was not obtained.

Describe good faith efforts to obtain written acknowledgment (including your name and date):

_____

Name: _____ Date: _____