

# OFFICE POLICY & GENERAL INFORMATION



## INSURANCE

Please have your insurance card and a photo ID with you for your appointment. If you show up without proof of insurance, you will be fully responsible for all charges and will be charged for the visit. There will be no exceptions. If your insurance changes, it's your responsibility to bring in your new insurance card so we can update our records and verify your coverage.



## CANCELLATION POLICY

Our patients' time is very important to us, so if you need to cancel or change your appointment, please call us within 24 hours to do so. We will make every effort to get you rescheduled as soon as possible. By not calling in advance, you might incur a cancellation fee to your account of \$30.00. If you do not show up for your appointment at all, your account will incur a no show fee of \$30.00.



## PRESCRIPTIONS

In order to efficiently refill your prescription that was written by Dr. Rosen, have your pharmacy fax a request to our office at 321-267-5141. Allow a minimum of 3-4 business days for our office to process your request and your prescription to be filled.



## HIPPA

Our office is compliant with all mandated Hipa privacy requirements. Please make sure when you fill out the privacy form, that you include all persons' you would want to release your medical information. If the name does not appear on your privacy form, we will not divulge any of your information.



## MEDICAL RECORDS

A medical release form must be signed by you in order to release your records to another facility. Allow 2-3 business days for this request once the form is signed.

If you want copies of your medical records, the charges are, .50 cents a page for medical records, \$10.00 for each x-ray film (if available) and \$5.00 for each digital x-ray disc. Allow 3-4 business days for pick of your records. For film x-rays allow 3-4 weeks for pick up.



## CO-PAYMENTS

All co-payments will be collected at the time of your arrival prior to being treated. All services rendered without coverage of insurance will be collected at check out.

\_\_\_\_\_  
Initial

\_\_\_\_\_  
Date

Dr. Rosen and his staff thank you for your understanding and cooperation and will do everything possible for your visit to our office be a pleasant one!

# Brevard Podiatry

Robert G. Rosen, DPM, FACFAS, CWS

850 Garden Street

Titusville, FL 32796

321-267-3233 ● 321-267-5141 Fax

## CONFIDENTIAL PATIENT INFORMATION SHEET

If you would like us to file your charges with your insurance company you must provide us with a copy of your current insurance card.  
All others are expected to pay for services when they are rendered unless prior written financial arrangement have been made.

TODAY'S DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

PATIENT #: \_\_\_\_\_

### 1. PATIENT INFORMATION

LAST NAME: \_\_\_\_\_ FIRST NAME/MI: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ WORK PHONE: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE: \_\_\_\_\_

SEX:  MALE  FEMALE MARITAL STATUS:  SINGLE  MARRIED  DIVORCED  WIDOW(ER)

EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

### 2. EMERGENCY CONTACT

LAST NAME: \_\_\_\_\_ FIRST NAME/MI: \_\_\_\_\_

HOME PHONE: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ WORK PHONE: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

### 3. RELATIVE WHO LIVES CLOSEST TO YOU

LAST NAME: \_\_\_\_\_ FIRST NAME/MI: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ WORK PHONE: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

4. RESPONSIBLE PARTY (IF OTHER THAN PATIENT):  HUSBAND  WIFE  PARENT  OTHER \_\_\_\_\_

LAST NAME: \_\_\_\_\_ FIRST NAME/MI: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ WORK PHONE: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ SEX:  MALE  FEMALE DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

EMPLOYER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

### 5. CURRENT PHYSICIANS

NAME OF FAMILY DOCTOR: \_\_\_\_\_ DATE LAST SEEN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

NAME OF OTHER PHYSICIAN: \_\_\_\_\_ DATE LAST SEEN: \_\_\_\_\_

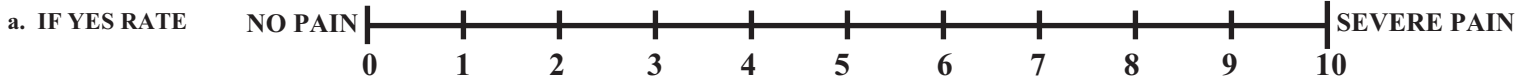
NAME OF FAMILY CHIROPRACTOR: \_\_\_\_\_ DATE LAST SEEN: \_\_\_\_\_

6. WHAT IS YOUR MAJOR COMPLAINT? \_\_\_\_\_

7. WHAT ACTIVITIES ARE YOU HAVING DIFFICULTIES WITH BECAUSE OF THIS CONDITION? (CHECK ALL THAT APPLY)

WALKING  WORK  RUNNING  SLEEPING  SITTING  GOING OUT  OTHER \_\_\_\_\_

8. DOES YOUR CONDITION CAUSE PAIN?  YES  NO



b. WHEN IS THE PAIN WORST?  MORNING  AFTERNOON  NIGHT  ALWAYS  OTHER \_\_\_\_\_

c. PLEASE DESCRIBE PAIN? \_\_\_\_\_

9. HAVE YOU SEEN A PODIATRIST BEFORE?  YES  NO IF YES PLEASE LIST \_\_\_\_\_

10. DO YOU HAVE ANY FEARS OR CONCERNS ABOUT PODIATRIC CARE?  YES  NO IF YES PLEASE LIST \_\_\_\_\_

11. MEDICAL HISTORY DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? PLEASE EXPLAIN:

- |  |                          |  |                             |
|--|--------------------------|--|-----------------------------|
| <input type="checkbox"/> YES <input type="checkbox"/> NO | ASTHMA _____             | <input type="checkbox"/> YES <input type="checkbox"/> NO | KIDNEY TROUBLE _____        |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | LIVER TROUBLE _____      | <input type="checkbox"/> YES <input type="checkbox"/> NO | NERVOUS BREAKDOWN _____     |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | TUBERCULOSIS _____       | <input type="checkbox"/> YES <input type="checkbox"/> NO | STOMACH TROUBLE _____       |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | COLITIS _____            | <input type="checkbox"/> YES <input type="checkbox"/> NO | INTESTINAL ULCERS _____     |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | BLACKOUTS _____          | <input type="checkbox"/> YES <input type="checkbox"/> NO | HEART TROUBLE _____         |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | DIZZY SPELLS _____       | <input type="checkbox"/> YES <input type="checkbox"/> NO | STROKE _____                |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | BACK TROUBLE _____       | <input type="checkbox"/> YES <input type="checkbox"/> NO | CURRENTLY PREGNANT _____    |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | CANCER _____             | <input type="checkbox"/> YES <input type="checkbox"/> NO | RECENT WEIGHT LOSS _____    |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | HEADACHES _____          | <input type="checkbox"/> YES <input type="checkbox"/> NO | FAINTING _____              |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | DIABETES _____           | <input type="checkbox"/> YES <input type="checkbox"/> NO | CONVULSIONS _____           |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | TROUBLE w/ HEARING _____ | <input type="checkbox"/> YES <input type="checkbox"/> NO | ABNORMAL BLEEDING _____     |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | TROUBLE w/ VISION _____  | <input type="checkbox"/> YES <input type="checkbox"/> NO | ANEMIA _____                |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | ARTHRITIS _____          | <input type="checkbox"/> YES <input type="checkbox"/> NO | SKIN RASHES OR CANCER _____ |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | THYROID (GOITER) _____   | <input type="checkbox"/> YES <input type="checkbox"/> NO | HIGH BLOOD PRESSURE _____   |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | CIRCULATION _____        | <input type="checkbox"/> YES <input type="checkbox"/> NO | GOUT _____                  |

12. SHOE SIZE \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

13. ARE YOU PRESENTLY TAKING ANY MEDICATION?  YES  NO

IF YES PLEASE LIST (IF YOU HAVE A LIST WE WOULD BE HAPPY TO PHOTOCOPY IT FOR YOU) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

14. ALLERGIES TO MEDICATION(S), FOOD(S) ETC?  YES  NO (IF YES PLEASE EXPLAIN): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

15. SOCIAL HISTORY:

a. DO YOU SMOKE TOBACCO?  YES  NO FREQUENCY? \_\_\_\_\_ PACKS A  DAY  WEEK  MONTH

b. DO YOU DRINK ALCOHOL?  YES  NO FREQUENCY? \_\_\_\_\_ DRINKS A  DAY  WEEK  MONTH

c. DO YOU TAKE RECREATIONAL DRUGS?  YES  NO TYPE: \_\_\_\_\_

16. FAMILY HISTORY:      Grandparent      Father      Mother      Siblings      Children      Spouse

CANCER \_\_\_\_\_

ARTHRITIS \_\_\_\_\_

HEART DISEASE \_\_\_\_\_

DIABETES \_\_\_\_\_

KIDNEY DISEASE \_\_\_\_\_

HIGH BLOOD PRESSURE \_\_\_\_\_

OTHER \_\_\_\_\_

17. SURGICAL HISTORY:

OPERATIONS	APPROXIMATE DATE	SURGEON	HOSPITAL

18. LOWER EXTREMITY HEALTH HISTORY:

a. ARE YOUR TOE NAILS INGROWN?  YES  NO HOW LONG? \_\_\_\_\_

b. ARE YOUR TOE NAILS THICK?  YES  NO DISCOLORED?  YES  NO

c. DO YOU EVER HAVE FOOT PAIN?  YES  NO PLEASE DESCRIBE: \_\_\_\_\_

d. DO YOU HAVE CORNS?  YES  NO CALLOUSES?  YES  NO

e. DO YOU HAVE HAMMERTOES?  YES  NO BUNIONS?  YES  NO

f. DO YOU HAVE ATHLETES FOOT?  YES  NO WHEN AND HOW OFTEN: \_\_\_\_\_

g. DO YOU HAVE SWOLLEN ANKLES?  YES  NO COLD FEET?  YES  NO

h. DO YOU HAVE HEEL PAIN?  YES  NO ARCH PAIN?  YES  NO

i. DO YOU HAVE KNEE PAIN?  YES  NO BACK PAIN?  YES  NO

j. DO YOU HAVE CRAMPS IN YOUR LEGS WHEN WALKING?  YES  NO SLEEPING?  YES  NO

k. HAVE YOU EVER HAD ARCH SUPPORTS?  YES  NO DO YOU PRESENTLY WEAR THEM?  YES  NO

l. HAVE YOU EVER HAD FOOT FRACTURE?  YES  NO TOE FRACTURE?  YES  NO

m. HAVE YOU EVER HAD FOOT X-RAYS?  YES  NO FOOT SURGERY?  YES  NO

n. DO YOU HAVE DIFFICULTY FINDING SHOES?  YES  NO

**19. HOW DID YOUR LEARN ABOUT OUR OFFICE** (PLEASE COMPLETE ALL APPLICABLE):

DOCTOR REFERRAL: \_\_\_\_\_ FAMILY/FRIEND REFERRAL: \_\_\_\_\_

INSURANCE COMPANY REFERRAL: \_\_\_\_\_ HOSPITAL REFERRAL: \_\_\_\_\_

NEWSPAPER: \_\_\_\_\_ PHONE BOOK:  BELL SOUTH  TALKING PHONE BOOK

HEALTH FAIR: \_\_\_\_\_ OTHER: \_\_\_\_\_

**20. PLEASE HELP US BY COMPLETING THE FOLLOWING QUESTIONS**

a. Do you use the phone book ?  NO  YES  
How Often?  Daily  Couple of Times a Week  Occasionally

b. Which One Do you use at home (check all apply)?  
 Bell South Yellow Pages  Talking Phone Book  Other \_\_\_\_\_

c. Which One Do you use at work (check all apply)?  
 Bell South Yellow Pages  Talking Phone Book  Other \_\_\_\_\_

d. Have you seen our Yellow Page Listing?  NO  YES

e. If you have seen Yellow Page Listing what did you like most & least? \_\_\_\_\_

f. Have you read the article from our doctors?  NO  YES

g. If you have seen our articles what did you like most & least? \_\_\_\_\_

h. Is there anything we could do to make your experience with our practice a better one? \_\_\_\_\_

i. Which other Brevard County Papers do you read (check all apply)?  
 Florida Today  Advocate  Advocate  Tribune  Times  
 Observer  Space Coast Press  Other \_\_\_\_\_

**MY CURRENT INSURANCE COVERAGE AND ANY FUTURE CHANGES**

I understand that it is my responsibility to furnish Brevard Podiatry, Dr. Rosen and/or assigns (referred to as "Practice") with my most current insurance information. I also understand that if my insurance coverage changes that I must immediately inform the Practice. Failure to do so may result in a significantly higher patient responsibility.

I also understand that if the Practice does not participate with my current or future medical coverage I will be personally responsible for all charges incurred by myself.

**ASSIGNMENT OF BENEFITS**

I authorize my insurer to make payments directly to my doctor. A copy or fax of this authorization may be used in place of the original and shall apply to all bills submitted by Brevard Podiatry, Robert G. Rosen, DPM and or their assigns. I authorize my doctor to release any information regarding my examination or treatment to my insurer.

**FINANCIAL OBLIGATIONS & POLICIES**

I understand and agree that all professional services rendered shall be charged directly to me and that I am personally responsible for payment. I understand and agree that the Practice will prepare forms to help me obtain benefits from my insurer but that I will be personally liable for my doctor bills unless my doctor notifies me in writing to the contrary.

I agree to make payment in full on all bills within 30 days of services rendered. I understand that any payment, which is 30 days, or more delinquent will be subject to late fees of \$20, plus after such date interest at a rate of 1.5% per month (or the highest percentage allowed by law) on the unpaid balance. If my doctor does not initially charge any late fees and/or interest I agree that this does not limit their ability to charge these fees in the future. In addition to my outstanding balance, plus fees and accrued interest I agree to pay all collection agency, credit bureau and /or attorney's fees and costs incurred in any attempt to collect the amount due. I agree to pay all attorney fees and cost incurred by my doctor in any attempt to collect the amount due. I understand that a \$2.00 per month statement postage and handling fee will be charged to all unpaid balances.

**MEDICAL RECORDS**

I understand my original medical records will remain with the Practice as part of my permanent medical record for duration not less than that prescribed by law. I agree that if copies of my records are desired I will provide a written request, minimum of 72 hours advance notice and the prepayment of \$0.50 per page and \$10.00 per x-rays.

**WELCOMES AND REFERRALS**

In an effort to make patients welcome and show our appreciation to patients for their referrals we do post a welcome and thank you board in our reception area. Unless I inform you to the contrary in writing I give the practice my full cooperation and allow them to use my name in this type of acknowledgment.

\_\_\_\_\_  
Print Name of Patient

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**GUARANTEE (Must be completed for all underage patients.)**

The undersigned guarantor(s) guarantee(s) payment of all obligations owed by patient to the doctor.

\_\_\_\_\_  
Print Name of Guarantor

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Signature of Guarantor

\_\_\_\_\_  
Date

# *Brevard Podiatry*

**Robert G. Rosen, DPM, FACFAS, CWS**

Fellow, American College of Foot & Ankle Surgeons • Diplomate, American Board of Podiatric Surgery • Diplomate, American Academy of Wound Management

## **Consent to Use or Disclose Information for Treatment, Payment, or Health Care Operations**

The patient hereby consents to the use or disclosure of his/her individually identifiable health information ("protected health information") and patient medical record information by RGR Venture, LLC dba Brevard Podiatry (the "Practice") in order to carry out treatment, payment, or health care operations. The Patient should review the Practice's Notice of Privacy Practices for a more complete description of the potential uses and disclosures of such information, and the Patient has the right to review such Notice prior to signing this consent form.

The Practice reserves for itself the right to change the terms of its Notice of Privacy Practices at any time. If the Practice does change the terms of its Notice of Privacy Practices, Patient may obtain a copy of the revised Notice. Patient retains the right to request that the Practice further restrict how his/her protected health information is used or disclosed to any out treatment, payment, or health care operations. The Practice is not required to agree to such requested restrictions; however, if the Practice does agree to Patient's request restriction(s), such restrictions are then binding the Practice.

At all times, Patient retains the right to revoke this Consent. Such revocations must be submitted to the Practice's Privacy Officer in writing. The revocation shall be effective *except* to the extent that the Practice has already taken action in reliance on the Consent.

The Practice may refuse to treat Patient if he/she (or authorized representative) does not sign this Consent Form. If Patient (or authorized representative) signs this Consent and then revokes it, the Practice has the right to provide further treatment to Patient as of the time of revocation (except to the extent that the Practice is required by law to treat individuals).

**I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT. I HAVE RECEIVED A COPY OF THIS CONSENT, AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS SEALED DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.**

Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM

\_\_\_\_\_  
Signature of Patient (or Authorized Representative)

\_\_\_\_\_  
Please Print Name

**850 Garden Street • Titusville, FL 32796 • (321)267-3233 • 267-5141 Fax**

*Gentle care for your toughest foot & ankle pain*

# *Brevard Podiatry*

**Robert G. Rosen, DPM, FACFAS, CWS**

Fellow, American College of Foot & Ankle Surgeons • Diplomate, American Board of Podiatric Surgery • Diplomate, American Academy of Wound Management

## **ASSIGNMENT OF BENEFITS AND FINANCIAL POLICY**

I understand that it is my sole responsibility to inform RGR Ventures, LLC dba Brevard Podiatry Dr. Rosen and/or assigns (referred to as "Practice") of any changes in my insurances coverage. I authorize my insurer to make payments directly to my doctor. A copy or fax of this authorization may be used in place of the original and shall apply to all bills submitted by the Practice. I authorize my doctor to release any information regarding my examination or treatment to my insurer.

I understand and agree that the Practice will prepare forms to help me obtain benefits from my insurer but that I will be personally liable for my doctor bills unless lam notified in writing by the Practice to the# contrary. I agree to make payment in full on all bills within 30 days of services rendered. I understand that any payment, which is 30 days, or more delinquent will be subject to late fees of \$20, plus after such date interest at a rate of 1.5% per month (or the highest percentage allowed by law) on the unpaid balance. If my doctor does not initially charge any late fees and/or interest I agree that this does not limit their ability to charge these fees in the future. In addition to my outstanding balance, plus fees and accrued interest I. agree to pay all collection agency, credit bureau and /or attorney's fees and costs incurred in any attempt to collect the amount due.

I understand that it is my responsibility to furnish the Practice with my most current insurance information. I also understand that if my insurance coverage changes that I must immediately inform the Practice. Failure to do so may result in a significantly higher patient responsibility. I also understand that if the Practice does not participate with my current or future medical coverage I will be personally responsible for all charges incurred by myself.

I understand there will be a charge of \$0.50 per page for photocopies and \$10.00 per x-ray for duplication. Originals must remain in our office as part of your permanent record. Please allow a minimum of 3 business days for the duplication of records.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Print Name of Patient

\_\_\_\_\_  
Date

**850 Garden Street • Titusville, FL 32796 • (321)267-3233 • 267-5141 Fax**

*Gentle care for your toughest foot & ankle pain*

# AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

## SECTION A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my individually identifiable health information as described below for purposes other than payment, treatment and health care operations. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

I give my permission to discuss my medical care with the following people:

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_

**\*\*Please note\*\*:** If one of your loved ones calls our office and their name does not appear above, we WILL NOT be permitted to share any information pertaining to your treatment and/or condition. However, it is the preference of Dr. Rosen to speak directly to the patient.

This authorization is valid for one year. I understand that it is my responsibility to notify this office if there is any change.

## SECTION B: Only applies if the Practice is requesting the information for its own uses and disclosures

The information will be used/disclosed for the following purposes:

\_\_\_\_\_

I understand that this Authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign or my revocation of this Authorization will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law.

The person/organization authorized to use/disclose the information will receive compensation for doing so. Yes \_\_\_ No \_\_\_

## SECTION C: My Rights

I understand that I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I understand that I may revoke this Authorization at any time by notifying Brevard Healthworx, Inc. in writing. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.

I have the right to receive a copy of this Authorization.

This authorization expires on the following date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (dd/mm/yyyy)

## SECTION D: Signature

Date: \_\_\_\_\_

Time: \_\_\_\_\_ am/pm

\_\_\_\_\_  
Signature of patient or patient's representative

\_\_\_\_\_  
Relationship to patient