



Podiatry
Associates
of the
Palm Beaches

Richard S. Schorr, DPM, FACFAS
David B. Feder, DPM, FACFAS

*Fellows of the American College
of Foot & Ankle Surgery*

PalmBeachPodiatry.com

Podiatry Associates of the Palm Beaches

Name: _____

Day

Date of Appt.

Time

Dr. Richard S. Schorr

Dr. David B. Feder

715 W. Boynton Beach Blvd., Suite C - Boynton Beach, FL - 561.734.3100

12983 Southern Blvd., Suite 205 Bldg. 4 - Loxahatchee, FL - 561.791.7773

2401 Frist Blvd., Fort Pierce Medical Park, Suite 1, Fort Pierce, FL - 772.468.0089

Podiatry Associates of the Palm Beaches

David B. Feder, D.P.M.
Diplomate of the American
Board of Podiatric Surgery

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Boynton Beach
715 W. Boynton Beach Blvd.
Boynton Beach, FL 33426

Loxahatchee
12983 Southern Blvd.
Suite 205
Loxahatchee, FL 33470

Fort Pierce
2401 Frist Blvd.
Fort Pierce Medical Park
Suite 1
Fort Pierce, FL 34950

HIPPA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient Rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- The practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information, but the practice does not have to agree to those restrictions.
- The patient may revoke this consent, in writing, at any time and all future disclosures will then cease.
- The practice may condition receipt of treatment upon the execution of this consent.

This consent was signed by:

PRINTED NAME – PATIENT OR REPRESENTATIVE

SIGNATURE

____/____/_____
DATE

RELATIONSHIP TO PATIENT (IF OTHER THAN PATIENT)

Witness:

PRINTED NAME – PRACTICE REPRESENTATIVE

SIGNATURE

____/____/_____
DATE

STATEMENT OF FINANCIAL RESPONSIBILITY

I _____ understand that services provided to me by Dr. Schorr, Dr. Feder are my responsibility to pay.

Insurance is a contract between my insurance company and myself; Dr. Schorr, Dr. Feder, are only a third party to this arrangement. I understand that as a courtesy, Dr. Schorr, Dr. Feder, will file claims for me. If payment is denied, suspended, below community standards, or is not provided DIRECTLY to us within 45 days of the date of treatment, I am responsible for immediate payment in full on my account. I understand that payment is due upon receipt of any billing statements from the office. I understand that it is my responsibility to verify that my account is current. My account will be considered past due if it is not paid in full within 15 days of the closing date listed on the billing statement..

Patients who are covered under an HMO plan are only responsible for any applicable co-payments or non-covered services. You will be notified prior to any non-covered services being rendered. Patients who are not covered under an insurance plan are responsible for payment in full at the time that the services are rendered.

Payments may be made with any valid Visa, Mastercard, American Express or Discover card. We also will accept local checks with a current drivers license, money orders, cashiers' checks or cash. A bank charge plus the amount of the check will be assessed for any returned checks.

I understand the failure to comply with the above will result in my account being sent over to a collections agency. I understand that I will assume all collection fees associated with the collection of my unpaid balance, in addition to my balance. I also understand that these measures are necessary, they may damage my personal credit rating.

By signing below, I am attesting to my understanding of my financial responsibility to this office for services rendered.

X _____

Signature of patient, Parent, or Gaurdian

X _____ Date _____

Podiatry Associates of the Palm Beaches

Richard S. Schorr, DPM
Diplomate American Board of Podiatric Orthopedics
David B. Feder, DPM
Diplomate American Board of Podiatric Orthopedics

Patient Medical History

Your Name: _____

Age: _____

Sex: Male Female

Name of Family Doctor _____

What is your approx. height and weight? _____

What is your shoe size? _____

Have you ever been treated for:

<input type="checkbox"/> Low Back Pain	<input type="checkbox"/> Ankle Injuries	<input type="checkbox"/> Arch Pain	<input type="checkbox"/> Heel Pain
<input type="checkbox"/> Broken foot/ankle bones	<input type="checkbox"/> Knee Pain	<input type="checkbox"/> Calluses	<input type="checkbox"/> None of these
<input type="checkbox"/> Bunion	<input type="checkbox"/> Ingrown Nail	<input type="checkbox"/> Childhood Foot Problems	
<input type="checkbox"/> Hammertoes	<input type="checkbox"/> Corns	<input type="checkbox"/> Neuroma	

Approximately how many hours per day are you on your feet? (circle one)

2 4 6 8 10 12

Do you smoke? _____ packs/day _____ how many years? _____

Do you drink alcohol? (circle one) Never Rarely Moderately Daily Quit

Are you active in sports or dancing? Yes No

If so, what type? _____

Do your feet hurt at night? Yes No

Do you have difficulty walking? Yes No

Do you get leg cramps when walking? Yes No

If so, is it relieved by rest? Yes No

Do you have or have you ever been treated for:

<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Nerve Disorders	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Depression	<input type="checkbox"/> Stomach ulcer	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Stroke	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Trauma	<input type="checkbox"/> Phlebitis	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Cancer
<input type="checkbox"/> Anemia	<input type="checkbox"/> Gout	<input type="checkbox"/> Psychiatric Disorder
<input type="checkbox"/> Asthma	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> None of these

Do you have any joint implants? Yes No

Do you have mitral valve prolapse or replacement heart valves? Yes No

Have you been hospitalized in the past five years? Yes No

Why? _____

Have you had surgery in the last five years? Yes No

What type? _____

Do any of your family members have: Diabetes Arthritis Cancer Foot problems High Blood Pressure

Are you pregnant? _____

Do you take Insulin? _____

Please list the medications that you take: _____

Are you allergic to(circle if Yes): Penicillin Codeine Local Anesthesia Aspirin Sulfa Drugs Adhesive Tape Shellfish

Any other drug or treatment? _____

If yes, what happens? _____