Haro
Podiatry & Laser Center
Walk, live and play without foot pain

Personal Information

First Name _____ Middle Initial_____ Last Name_____

Sex: Male Female Date of Birth: _____/_____/_____ Social Security Number _____

Marital Status_____ Email Address _____

Address _____ Apt#_____

City_____ State_____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone_____

Emergency Contact Name_____ Relationship_____

Home Phone_____ Cell Phone_____

How did you hear about us? ☐ Primary Doctor ☐ Patient ☐ Google Search ☐ Facebook ☐Twitter

☐ LinkedIn ☐ Pinterest ☐ YouTube ☐ Other: _____

Primary Physician Information

Primary Care / Referring Physician _____ Last Visit Date_____

Street Address_____ City _____ State_____ Zip Code _____

Insurance Information

Who is responsible for this account? _____ Relationship to Patient_____

Primary Insurance _____ ID #_____

Secondary Insurance _____ ID # _____

Insured's Date of Birth_____ Insured Social Security Number _____

Insurance Assignment and Release

I certify that I have insurance coverage with _____ and assign directly to **Dr. Ibrahim Haro** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefit payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable MEDIGAP benefits, be made either to me or my behalf to **Haro Podiatry Center** for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to leases to the Centers for Medicare and Medicaid Services. My MEDIGAP insurer and their agents any information needed to determine these benefits or benefits for related services.

_____ _____

Signature of Beneficiary, Guardian or Personal Representative **Date**

_____ _____

Print Name of Beneficiary, Guardian or Personal Representative **Date**

PLEASE CONTINUE TO THE NEXT PAGE

This is the most important part of this paper work.

List ***any allergies*** you have

_____

_____

List ***any health*** condition(s)

_____

_____

List ***any medications*** you are presently taking

_____

_____

_____

In the last few months has there been a recent change in **(circle all that applies)**

Weight
Work
Activity
Shoe Gear
Flooring at work or home

If yes, please explain _____

Please tell us what your specific foot condition is _____

_____

Relating to your specific complaint(s), what would you like to accomplish **during your first visit?**

_____

_____

Relating to your specific complaints, what would you like to be able to accomplish **in the near future** that you may not be able to currently do? **(Please include intermediate and long term goals)**

_____

_____

I certify that all information I have provided is true and correct to the best of my knowledge

_____
Patient Name (PLEASE PRINT)

_____ _____
Signature **Date**

PLEASE CONTINUE TO THE NEXT PAGE

E-PRESCRIBING CONSENT FORM

E-Prescribing is defined by a Physician's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an E-Prescribe program.

These include:

Formulary and benefit transactions – gives the prescriber information about which drugs are covered by the drug benefit plan.

Medication history transactions – provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

I authorize Haro Podiatry Center to view my external prescription history via electronic prescribing services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies and pharmacy benefit managers may be viewable by my provider and staff at Haro Podiatry Center and it may include prescriptions back in time for several years, and may include prescriptions to treat HIV, substance abuse and psychiatric conditions, if applicable. I understand that my prescription history will become part of my Haro Podiatry Center medical record.

Understanding all of the above, I hereby provide informed consent to Haro Podiatry Center to enroll me in the ePrescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

This consent will remain enforce until revoked or changed.

_____

Patient Name (PLEASE PRINT)

_____ _____

Signature **Date**

PLEASE CONTINUE TO THE NEXT PAGE

PATIENT HIPAA ACKNOWLEDGEMENT
AND DESIGNATION DISCLOSURE FORM

I. Acknowledgement of Practice's *Notice of Privacy Practices*:
By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understands the Notice of Privacy Practices (NPP) and agree to its terms.

_____	_____	_____	_____
Name of Patient	**Date of Birth**	**Signature of Patient/Parent/Guardian**	**Date**

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:
I agree that the practice may disclose certain pieces of my health information to a Personal Representative of my choosing, since such person is involved with my healthcare or payment relating to my healthcare. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement in my healthcare or payment relating to my healthcare.

Print Name: _____ **DOB or other identifier:** _____

Print Name: _____ **DOB or other identifier:** _____

III. Request to receive Confidential Communication by Alternative Means:
As provided by Privacy Rule Section 164.522 (b), I hereby request that the Practice make all communications to me as I have listed below:

Home telephone number:
__ Ok to leave message with detailed information or __ Leave message with call back number only

Work telephone number:
__ Ok to leave message with detailed information or __ Leave message with call back number only

Cell telephone number:
__ Ok to leave message with detailed information or __ Leave message with call back number only

Fax telephone number:
__ Ok to fax at number listed here: _____

Email:
__ Ok to email address Practice has on file

Text Message:
__ Ok to send txt message & remind you of your appointment

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1. The above authorizations are voluntary and I may refuse to their terms without affecting any of my rights to receive healthcare at the Practice.
2. These authorizations may be revoked at any time by notifying the Practice in writing at the Practice's mailing address marked to the attention of "HIPPA Compliance Officer."
3. The revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.
4. If you request it, a copy of the information described in this form can be obtained at the front desk.
5. This form was completely filled in before I signed it and I acknowledge that all of my questions were answered to my satisfaction and that I fully understand this authorization form.
6. This authorization is valid as of the date I have signed below and shall remain valid until changed or revoked.

_____	_____	_____
Name of Patient (PRINTED)	**Signature of Patient**	**Date**

PLEASE CONTINUE TO THE NEXT PAGE