91 Montgomery Street, Rhinebeck, NY 12572 Office: (845) 876-8637 Fax: (845) 876-0218

	PATIENT INFORMATION										
Name (Last, First, M.I.):	Name (Last, First, M.I.):							DOB:		Age:	
Soc. Sec. #:							L				
Street Address:						City:			ST:	Zip:	
Home Phone:			Cel	Il Phone:				Work P	hone:		
Preferred Language: □ English □ Spanish				Hispanic/Lati Pacific Island	ino 🗆				□ Hispanic □ ] Native Hawaiia	Asian n/Other Pacific Island	
Communication Prefer				<b>Referre</b> □ Patie		octor 🗆 Insur	ance	Ref. Na	me:		
Email address:	Email address:										
Marital status:	Marriec	I □ Se	eparate	ed 🗆 Divo	rced I	□ Widowed					
Occupation:						Employer					
Emergency Contact:						Phone:					
Primary Care Physician						Phone:					
Date of last visit to Phy	/sician:					Preferred	Pharmacy:				
Sports/Activities:											
					-	INFORMATI					
Is this Patient under 18 □ Yes □ No	8 years of A	lge?	If yes,	, please com	plete the	Person respo	nsible for bill se	ection			
Person responsible for	bill Date	e of Birt / /	h	Address (if	fdiffere	ent):	nt): Home phone no.				
Is this person a patient	t here?	□ Yes		No If yes, i	ndicate p	patients name	:				
Primary Insurance Car	rier Name:										
Subscriber's name:	5	Subscrib	oer's S	5.S. #:	Birth (	date: /			Policy no.:	<i>Co-payment:</i> \$	
Patient's relationship t	o subscribe	er: 🗆 S	Self	Spous	e 🗆	Child	□ Other				
Secondary Insurance C	arrier Nam	e:									
Subscriber's name:	5	Subscrib	oer's S	5.S. #:	Birth (	date: /	Group no.: Policy no.:		<i>Co-payment:</i> \$		
Patient's relationship t	o subscribe	er: 🗆 S	Self	Spous	e 🗆	I Child	Other				
	CONCERNING INSURANCE										
deductibles and non participate are fully responsible for non- deductible has been	Patients who are a member of a plan with which we participate are responsible at the time of service for all co-pays, deductibles and non-covered services and materials. Patients who are members of a plan which this office does not participate are fully responsible for all procedures and materials at the time of service. Medicare patients are responsible for non-covered materials, charges applied to their deductible and 20% of the office fees once the deductible has been satisfied. Secondary insurances will be billed if provided.										
office.	e and fully	y under	stan	-		sponsibiliti	es for all ser	vices a		received in this	
Signature:				Printed	Name:				Date:		

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Have you had any previous foot care or surgery:       IN O       Yes       If Yes, by whom:         Current Age       Height       Weight       Shoe Size         Current Age       Height       Weight       Shoe Size         PLEASE CHECK ANY OF THE FOLLOWING, WHICH YOU HAVE BEEN TREATED OR ARE BEING TREATED FOR       Osteoporosis         Anemina       Hepatitis       Osteoporosis         Anemina       Hepatitis       Osteoporosis         Anxiety Disorders       Hith Cholesterol       Polio         Arking       Hypertension (high blood pressure)       Scarife Fever         Carciac Disease       Kidney Stones       Stow to heal         Diabetes Type I       Liver Disease       Stow to heal         Diabetes Type I       Liver Disease       Thyroid Disease         Gastrointestinal Problems       Migraine Headaches       Varicose Veins         Gastrointestinal Problems       Muscular Disease       Varicose Veins         Gastroint	Plea	ase describe your foot problen	n:										
PLEASE CHECK ANY OF THE FOLLOWING, WHICH YOU HAVE BEEN TREATED OR ARE BEING TREATED FOR         Amputation       Hepatitis       Osteoprorsis         Anemia       Hemophilia (bleeder)       Phibbits (Blood Clots)         Anxiety Disorders       High Cholesterol       Phibbits (Blood Clots)         Arkintis       HIV       Respiratory Condition         Arthritis       HIV       Respiratory Condition         Arthritis       HIV       Respiratory Condition         Cancer       Kidney Stease       Stroke         Circulation Problems       Kidney Stones       Sexually Transmitted Disease         Diabetes Type I       Liver Disease       Thyroid Disease         Diabetes Type I       Liver Disease       Varicose Veins         Gastrointestinal Problems       Muscular Disease       Varicose Veins         Galaucoma       Muscular Disease       /         Gott       Nervous System Disorder       /         Other:       Emale Patients, are you Pregnant:       No       Ves         If "Yes" Due Date:       /       /         I consent and authorize release of my protected health information as required, and outlined in the Notice of Privacy Practices (HIPAA). I have read a copy of the Notice of Privacy Practices (HIPAA), and if requested, will be given a copy of such notice.         I autho	Hav	e you had any previous foot ca	re or su	rgery:	🗌 No 🗌 Yes	If Yes	, by whom	:					
□       Amputation       □       Hepatitis       □       Osteoporosis         □       Anemia       □       Hemophilia (bleeder)       □       Philebitis (Blood Clots)         □       Anxiety Disorders       □       High Cholesterol       □       Polio         □       Anthritis       □       HiV       □       Respiratory Condition         □       Asthma       □       Hypertension (high blood pressure)       □       Scarlet Fever         □       Carciator Disease       □       Kidney Oscones       □       Slow to heal         □       Diabetes Type I       □       Liver Disease       □       Tuberculosis         □       Diabetes Type I       □       Liver Disease       □       Tuberculosis         □       Diabetes Type I       □       Liver Disease       □       Tuberculosis         □       Diabetes Type I       □       Liver Disease       □       Tuberculosis         □       Gastrointestinal Problems       □       Mitral Valve Prolapse       □       □         □       Gatura       □       Nervous System Disorder       □       □         □       Other:       -       -       Consent and authorize release of my prot		Current Age		Heig	ht		We	ight	Shoe Size				
□       Amputation       □       Hepatitis       □       Osteoporsis         □       Anxiety Disorders       □       High Cholesterol       □       Philebitis (Blood Clots)         □       Anxiety Disorders       □       High Cholesterol       □       Philebitis (Blood Clots)         □       Anthritis       □       Hily       □       Respiratory Condition         □       Asthma       □       Hypertension (high blood pressure)       □       Scarlet Fever         □       Carcation Droblems       □       Kidney Disease       □       Stroke         □       Circulation Problems       □       Kidney Stones       □       Slow to heal         □       Diabetes Type I       □       Liver Disease       □       Tuberculosis         □       Diabetes Type I       □       Liver Disease       □       Tuberculosis         □       Gastrointestinal Problems       □       Mitral Valve Prolapse       □       □         □       Gaiacoma       □       Muscular Disease       □       □       □         □       Other:													
□       Anemia       □       Hemophilia (bleeder)       □       Philebits (Blood Clots)         □       Anklety Disorders       □       High Cholesterol       □       Polio         □       Anthritis       □       HIV       □       Respiratory Condition         □       Asthma       □       Hypertension (high blood pressure)       □       Sexually Transmitted Disease         □       Cardiac Disease       □       Kidney Stones       □       Sitroke         □       Carculation Problems       □       Kidney Stones       □       Sitroke         □       Diabetes Type I       □       Liver Disease       □       Tuberculosis         □       Diabetes Type II       □       Liver Disease       □       Tuberculosis         □       Gastrointestinal Problems       □       Mitral Valve Prolapse       □       Tuberculosis         □       Galacoma       □       Muscular Disease       □       /       /         □       Other:	1				, WHICH YOU HAV	E BEEN							
□       Anxiety Disorders       □       High Cholesterol       □       Polio         □       Arthritis       □       HIV       □       Respiratory Condition         □       Asthma       □       Hypertension (high blood pressure)       Scarlet Fever         □       Cardiac Disease       □       Kidney Disease       □       Stroke         □       Carcer       □       Kidney Stones       □       Stroke         □       Diabetes Type I       □       Liver Disease       □       Tubroid Disease         □       Diabetes Type II       □       Liver Disease       □       Tubroid Disease         □       Gastrointestinal Problems       □       Mitral Valve Prolapse       □       □         □       Other:       □       □       Nervous System Disorder       □       □         □       Other:       □       □       Nervous System Disorder       □       □         □       Other:       □       □       No<□ Yes		· ·						-					
□       Arthritis       □       Hiv       □       Respiratory Condition         □       Asthma       □       Hypertension (high blood pressure)       □       Scarulal Fever         □       Cardiac Disease       □       Keloid Former       □       Sexually Transmitted Disease         □       Carculation Problems       □       Kidney Stones       □       Stroke         □       Diabetes Type I       □       Liver Disease       □       Tuberculosis         □       Diabetes Type II       □       Liver Disease       □       Varicose Veins         □       Gastrointestinal Problems       Mitral Valve Prolapse       □       Varicose Veins         □       Gastrointestinal Problems       □       Mitral Valve Prolapse       □         □       Other:				-									
Asthma       Hypertension (high blood pressure)       Scarlet Fever         Cardiac Disease       Keloid Former       Scarlet Fever         Cardiac Disease       Kidney Disease       Stroke         Circulation Problems       Kidney Disease       Stow to heal         Diabetes Type I       Liver Disease       Tuberculosis         Epilepsy       Migraine Headaches       Varicose Veins         Gastrointestinal Problems       Mitral Valve Prolapse       Varicose Veins         Gaucoma       Muscular Disease       Varicose Veins         Glaucoma       Muscular Disease       Varicose Veins         Gout       Nervous System Disorder       Varicose Veins         Value       Nervous System Disorder       Varicose Veins         Other:       Varicose of my protected health information as required, and outlined in the Notice of Privacy Practices (HIPAA). I have read a copy of the Notice of Privacy Practices (HIPAA). I have read a copy of the Notice of Privacy Practices (HIPAA). I have read a copy of bud musch acopy of such notice.         I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits for services funished to me, or my child.         I request that payment of authorized Medicare benefits be made on my behalf to Rhinebeck Podiatry Services for services for is agents, and private insurances to determine these benefits or the benefits payels for related services.         I		-		_	esterol								
Cardiac Disease       Keloid Former       Sexually Transmitted Disease         Carcer       Kidney Disease       Stroke         Circulation Problems       Kidney Stones       Slow to heal         Diabetes Type I       Liver Disease       Thyroid Disease         Bibetes Type II       Lyren Disease       Tuberculosis         Gastrointestinal Problems       Mitral Valve Prolapse       Tuberculosis         Gastrointestinal Problems       Mitral Valve Prolapse       Varicose Veins         Gout       Nervous System Disorder       Varicose Veins         Other:       AutHORIZING AND RELEASE       Varicose Veins         Female Patients, are you Pregnant:       No       Yes       If "Yes" Due Date:       /         Varicose Varico					sion (high blood								
Cancer       Kidney Disease       Stroke         Circulation Problems       Kidney Stones       Slow to heal         Diabetes Type I       Liver Disease       Thyroid Disease         Diabetes Type II       Lyme Disease       Tuberculosis         Gaucoma       Mitral Valve Prolapse       Varicose Veins         Gaucoma       Mitral Valve Prolapse       Varicose Veins         Gout       Nervous System Disorder       Varicose Veins         Other:       Varicose Veins       Varicose Veins         Female Patients, are you Pregnant:       No       Yes         Varicose Veins       Varicose Veins       Varicose Veins         Varicose Veins       Varicose Veins       Varicose Veins         Gout       Nervous System Disorder       Varicose Veins         Other:       Varicose Veins       Varicose Veins         Female Patients, are you Pregnant:       No       Yes       Yes" Due Date:       /         Varicose Veins       Varicose Veins       Varicose Veins       Varicose Veins       Varicose Veins         Varicose Veins       Varicose Veins       Varicose Veins       Varicose Veins       Varicose Veins         Varicose Veins       Varicose Veins       Varicose Veins       Varicose Veins       Varicose Veins						pressu							
□       Circulation Problems       □       Kidney Stones       □       Slow to heal         □       Diabetes Type I       □       Liver Disease       □       Thyroid Disease         □       Diabetes Type II       □       Liver Disease       □       Tuberculosis         □       Gastrointestinal Problems       □       Mitral Valve Prolapse       □       Varicose Veins         □       Gaut       □       Nuscular Disease       □       Varicose Veins         □       Glaucoma       □       Muscular Disease       □       Varicose Veins         □       Gout       □       Nervous System Disorder       □       □         □       Other:									ISTITULEU DISEASE				
□       Diabetes Type I       □       Liver Disease       □       Thyroid Disease         □       Diabetes Type II       □       Lyme Disease       □       Tuberculosis         □       Epilepsy       □       Mitrail Valve Prolapse       □       □         □       Glaucoma       □       Muscular Disease       □       □       □         □       Other:       □       ■       ■       ■       ■       ■         Female Patients, are you Pregnant:       □       No       Yes       If "Yes" Due Date:       /       /         AUTHORIZING AND RELEASE         AUTHORIZING AND RELEASE         •         Interview Pregnant:       □       □       /       /         AUTHORIZING AND RELEASE         •         •         •       I consent and authorize release of my protected health information as required, and outlined in the Notice of Privacy Practices (HIPAA). I have read a copy of the Notice of Privacy Practices (HIPAA). I have read a copy of the Notice of Privacy Practices (HIPAA). and if requested, will be given a copy of such notice.       •       I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits for services rendered to me, orm y child. <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>													
□       Diabetes Type II       □       Lyme Disease       □       Tuberculosis         □       Epplepsy       □       Migraine Headaches       □       Varicose Veins         □       Gastrointestinal Problems       □       Mitral Valve Prolapse       □       Varicose Veins         □       Galacoma       □       Muscular Disease       □       □       Other:         Female Patients, are you Pregnant:       □       No       Yes       If "Yes" Due Date:       /       /         AUTHORIZING AND RELEASE         •       I consent and authorize release of my protected health information as required, and outlined in the Notice of Privacy Practices (HIPAA). I have read a copy of the Notice of Privacy Practices (HIPAA), and if requested, will be given a copy of such notice.       •       I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits for services rendered to me, or my child.       •       I request that payment of authorized Medicare benefits be made on my behalf to Rhinebeck Podiatry Services for services furnished to me by the provider.       •       I authorize and Medicaid Services, its agents, and private insurances to determine these benefits or the benefits payable for related services.       •       I certify that the above information is correct and I consent to diagnostic procedures including but not limited to X-ray, medical care, and treatment as deemed necessary by Rhinebeck Podiatry Services.       •									266				
□       Epilepsy       □       Migraine Headaches       □       Varicose Veins         □       Gastrointestinal Problems       □       Mitral Valve Prolapse       □         □       Glaucoma       □       Muscular Disease       □       □         □       Other:       □       Nervous System Disorder       □       □         □       Other:       □       Varicose Veins       /         AUTHORIZING AND RELEASE         • </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>													
Gastrointestinal Problems       Mitral Valve Prolapse         Glaucoma       Muscular Disease         Gout       Nervous System Disorder         Other:       Premale Patients, are you Pregnant:       No         Yes       If "Yes" Due Date:       /         AUTHORIZING AND RELEASE       AUTHORIZING AND RELEASE         • I consent and authorize release of my protected health information as required, and outlined in the Notice of Privacy Practices (HIPAA). I have read a copy of the Notice of Privacy Practices (HIPAA), and if requested, will be given a copy of such notice.         • I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits for services rendered to me, or my child.         • I request that payment of authorized Medicare benefits be made on my behalf to Rhinebeck Podiatry Services for services furnished to me by the provider.         • I authorize and Medicaid Services, its agents, and private insurances to determine these benefits or the benefits payable for related services.         • I authorize and Medicaid Services.         • I certify that the above information is correct and I consent to diagnostic procedures including but not limited to X-ray, medical care, and treatment as deemed necessary by Rhinebeck Podiatry Services.         • I authorize Rhinebeck Podiatry Services to take medical photographs for charting and educational purposes.         IUNDERSTAND THAT LAM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE									15				
□       Glaucoma       □       Muscular Disease         □       Gout       □       Nervous System Disorder         □       Other:				-				varieose ven	15				
□       Gout       □       Nervous System Disorder         □       Other:         Female Patients, are you Pregnant:       □       No       Yes       If "Yes" Due Date:       /          AUTHORIZING AND RELEASE         •       I consent and authorize release of my protected health information as required, and outlined in the Notice of Privacy Practices (HIPAA). I have read a copy of the Notice of Privacy Practices (HIPAA), and if requested, will be given a copy of such notice.         •       I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits for services rendered to me, or my child.         •       I request that payment of authorized Medicare benefits be made on my behalf to Rhinebeck Podiatry Services for services furnished to me by the provider.         •       I authorize and Medicaid Services, its agents, and private insurances to determine these benefits or the benefits payable for related services.         •       I certify that the above information is correct and I consent to diagnostic procedures including but not limited to X-ray, medical care, and treatment as deemed necessary by Rhinebeck Podiatry Services.         •       I authorize Rhinebeck Podiatry Services to take medical photographs for charting and educational purposes.         IUNDERSTAND THATTIAM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE         Patient Signature:       Date:													
□       Other:         Female Patients, are you Pregnant:       □ No □ Yes       If "Yes" Due Date:       / /         AUTHORIZING AND RELEASE          •       I consent and authorize release of my protected health information as required, and outlined in the Notice of Privacy Practices (HIPAA). I have read a copy of the Notice of Privacy Practices (HIPAA), and if requested, will be given a copy of such notice.         •       I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits for services rendered to me, or my child.         •       I request that payment of authorized Medicare benefits be made on my behalf to Rhinebeck Podiatry Services for services furnished to me by the provider.         •       I authorize and Medicaid Services, its agents, and private insurances to determine these benefits or the benefits payable for related services.         •       I certify that the above information is correct and I consent to diagnostic procedures including but not limited to X-ray, medical care, and treatment as deemed necessary by Rhinebeck Podiatry Services.         •       I authorize Rhinebeck Podiatry Services to take medical photographs for charting and educational purposes.         UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE         Patient Signature:       Date:													
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		<ul> <li>of Privacy Practices (HIPAA). I have read a copy of the Notice of Privacy Practices (HIPAA), and if requested, will be given a copy of such notice.</li> <li>I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits for services rendered to me, or my child.</li> <li>I request that payment of authorized Medicare benefits be made on my behalf to Rhinebeck Podiatry Services for services furnished to me by the provider.</li> <li>I authorize any holder of medical information about me to release it as necessary to the Centers for Medicare and Medicaid Services, its agents, and private insurances to determine these benefits or the benefits payable for related services.</li> <li>I certify that the above information is correct and I consent to diagnostic procedures including but not limited to X-ray, medical care, and treatment as deemed necessary by Rhinebeck Podiatry Services.</li> <li>I authorize Rhinebeck Podiatry Services to take medical photographs for charting and educational purposes.</li> </ul>											
Parent/Guardian: Date:	Pat	ient Signature:					Date:						
	Par	ent/Guardian:					Date:						

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		MEDICATIONS (Including Vitamins and Dosages)													
		Name					sage				Name			Dos	age
1.								7.							
2.								8.							
3.								9.							
4.								10							
5.								11							
6.								12							
					ME	DICA	TION /	ALLER	GIES/R	EACTIONS					
			Descript	ion							De	scription			
1.								5.							
2.								6.							
3.								7.							
4.						DED		8							
						PER	SONA	1	IAL HIS	1				[	
Alcoł	nol:	🗌 No 🗌 Ye	s If "Y	es" Amount	t Per We	eek:		Ca	Caffeine: 🗌 No 🗌 Yes If "Yes" Cups per		r day:				
Toba	cco:	Never a Smo	oker: 🗌	Former	Smokei	r: 🗌	Yea	rs qu	t:						
		🗌 Current e	very day	smoker	Packs	s per	day:			How mar	ny years:				
		Current o	occasiona	al smoker	Packs	s per	day:			How mar	ny years:				
Activi	ties:							Exer	cise:						
										ITALIZATIO					
		Docor	rintion	ŀ	REVIO	05 50		CIES U	RHUSP	TTALIZATIO		tion			to
1.		Desci	ription			_	Date	,	5.		Descript				ate /
2.									5. 6.					/	/
3.						_	/ / / /		7.					/	/
4.							· · · / /		8.					,	/
	Reviewed and final completion by:								Date:		/ /				
	MEDICAL SUPPLIES														
	I acknowledge that this office distributes miscellaneous medical "over-the-counter" type supplies and physician dispensed														
medic	medications that are not covered by insurances but are available for purchase on a cash pay basis. I further acknowledge that this														
office	will r	not bill the priv	vate insu	irance com	npanies	for t	hese p	burch	ased ite	ms.					
Date:		/ /	Si	ignature:											

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Patients Name:			DOB:			
Other Name:						
Street Address:	City:			ST:	Zip:	
Phone:		SS#				

#### I authorize Rhinebeck Podiatry Services to RELEASE my protected health information (PHI) to:

Name:	Name:	
Address:	Address:	
Phone #	Phone #	

#### I authorize Rhinebeck Podiatry Services to <u>RECEIVE</u> my protected health information (PHI) from:

Name:	Name:	
Address:	Address:	
Phone #	Phone #	

- I release the entities listed above their agents and employees from any liability in connection with the use or disclose of the protected health information.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the receipt and no longer protected by the Privacy Rule.
- I have a right to inspect the health information to be released and may refuse to sign this authorization.
- THE INFORMATION AUTHORIZED FOR THE USE OF DISCLOSURE MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILLIS, GONORRHEA OR THE HUMAN IMMUNNODEFICIENY VIRUS, ALSO KNOWN AS IMMUNE DEFICIENCY SYNDROME (AIDS).

With this knowledge, I give my authorization to the release of all information in my medical records, including any information concerning my identity, and release RHINEBECK PODIATRY SERVICES, affiliates, agents and employees from any liability in connection with the release of the information contained therein.

Patient Signature/Legal Representative

Date

## Practice of Podiatric Medicine and Surgery 91 Montgomery Street, Rhinebeck, NY 12572 Office: (845) 876-8637 Fax: (845) 876-0218

I authorize Rhinebeck Podiatry Services to VERBALLY discuss the following medical and billing information about me (check all that apply):

Scheduling/appointment information
Medical information including my symptoms, diagnosis, medications and treatment plans
Lab/test results
Billing and payment information
Other:

## Rhinebeck Podiatry Services has my permission to discuss the above information with:

Name	Phone	Relationship

I hereby authorize Rhinebeck Podiatry Services for any provider having treated me or my dependent, to release to government agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

Signed:

Date: