DR. ELISA KAVANAGH

PODIATRIC MEDICINE
+
FOOT SURGERY

New Patient Information (Please Print)

Name _____ Sex ☐ Male ☐ Female Date of Birth ____/____/____
First Middle Last

Home Address _____ City _____ State _____ Zip _____

Email Address _____ SSN _____

Home Phone _____ Work Phone _____ Cell Phone _____

Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Divorced Occupation _____ Employer _____

Emergency Contact _____ Relationship _____ Phone _____

Primary Care Physician Name and Phone Number _____

Preferred Pharmacy Name, Address, & Phone Number _____

Primary Language _____ Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other

Race : ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Multi-Racial
☐ Native Hawaiian or Pacific Islander ☐ White ☐ Some other Race ☐ Other _____

How did you find out about our practice? ☐ Physician ☐ Internet ☐ Family Member/Friend ☐ Other _____

(If patient is a child or dependent adult, please give name of responsible party for finances and billing)

Responsible Party _____ Date of Birth _____/_____/_____

Address _____

Phone Number _____ Relationship to Patient _____

Insurance Information

☐ Check here if NO health insurance

Primary Carrier _____ Group # _____ ID No. _____

Policy Holder (if other than patient) _____ Date of Birth _____/_____/_____

Employer of policy holder (if other than patient) _____

Secondary Carrier _____ Group # _____ ID No. _____

Secondary Carrier Policy Holder (if other than patient) _____ Date of Birth _____/_____/_____

Is this a compensation or work-related case? ☐ Yes ☐ No Date of Accident _____/_____/_____

Are you interested in Laser Treatment for Toenail Fungus? ☐ Yes ☐ No

I hereby give the above named doctor permission to administer the necessary treatment in order to diagnose and treat my present foot condition, after it has been explained to me.

Signature _____ Date _____/_____/_____

Relationship _____

440 MAMARONECK AVE, SUITE 502, HARRISON, NY 10528
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Past Medical History (Please Print)

Date _____ Name _____ DOB _____

Age _____ Height _____ Weight _____ Shoe Size _____

Reason for Visit _____

How long has this bothered you? _____ ☐ days ☐ weeks ☐ months ☐ years

Any prior imaging? ☐ Yes ☐ No ☐ x-ray ☐ MRI ☐ CT scan

Medications
Include prescriptions, over the counter medications and vitamins

_____
_____
_____
_____
_____

Allergies/Reaction

Adhesive Tape_____ Latex _____
Anticoagulant _____ Food _____
Aspirin _____ Novocain _____
Codeine _____ Penicillin _____
Demerol _____ Sulfa _____
Local Anesthetics _____ Iodine _____
Other _____

Smoking History Tobacco User ☐ Yes ☐ No

☐ Current Every Day ☐ Current Some Day ☐ Heavy Smoker
☐ Light Tobacco Smoker ☐ Former Smoker ☐ Never Smoker
☐ Smoker Current Status Unknown ☐ Unknown If Ever Smoked

Past Medical History *(Place a check mark to indicate if you have had any of the following)*

☐ Anxiety ☐ Heart Disease ☐ Rheumatic Fever
☐ Arthritis ☐ Hepatitis ☐ Seizures/Epilepsy
☐ Asthma ☐ High Cholesterol ☐ Sickle Cell Disease
☐ Bleeding Disorder ☐ HIV/AIDS ☐ Skin problems
☐ Circulation Problems ☐ Hypertension (High B/P) ☐ Stomach Ulcer
☐ Diabetes ☐ Kidney Disease ☐ Stroke
☐ Depression ☐ Liver Disease ☐ Thyroid Disease
☐ Gout ☐ Nervousness ☐ Other_____

Hospitalizations _____

Past Surgical History:

Surgery	Date	Surgery	Date
_____	_____	_____	_____
_____	_____	_____	_____

Social History

Alcohol Use ☐ Non-Drinker ☐ Occasional ☐ Social ☐ Moderate ☐ Heavy
Drug Use Yes _____ No _____ Exercise Habits ☐ Never ☐ < 3X Week ☐ >3X Week

Family History (Please list the family member parent, grandparent, brother, sister)

_____

_____

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FINANCIAL POLICIES

Thank you for choosing Dr. Elisa Kavanagh as your foot care provider. We are committed to providing you with quality and affordable health care. Please read the following office payment policy and feel free to ask us any questions that you may have. Once you accept this policy, kindly sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some - and perhaps all - of the services you receive may be not covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Insurance Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

6. Referrals. It is the patient's responsibility to ensure the office receives required referrals prior to your appointment. Failure to do so may result in your appointment being cancelled or rescheduled and you will be responsible for any charges incurred.

7. Nonpayment. Invoices are sent out every 30 days. Your prompt payment will assist us in keeping the cost of healthcare down. If your account is over 90 days past due, you will receive a letter requesting immediate payment. Partial payments will not be accepted unless otherwise approved by our Billing Department. Please be aware that if a balance remains unpaid, we may refer your account to small claims court and you may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative podiatric care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. Cancellation Policy. Our office requires at least 24 hours notice for all appointment cancellations. We reserve the right to charge a $25.00 Missed Appointment Fee for patients that do not give sufficient cancellation notice.

9. Requests for Medical Records. If a patient requests a copy of their medical records, there is a fee of $0.76 per page plus the cost of shipping and handling.

10. Benefits. Insurance carriers state all benefits quoted are not a guarantee of payment. As a courtesy, we try to contact your insurance carrier to verify your benefits and see if pre-certification is required. However, this is not a guarantee of payment. Therefore, we recommend you contact your insurance carrier prior to any service provided. Benefit codes are available upon request.

11. Laboratory/Pathology/Radiology. When testing is required, it is the patients responsibility to notify our office which company is contracted with their insurance carrier. We are not responsible for any charges incurred due to testing at a non-participating location.

12. Returned Checks. There is a fee of $30.00 for all returned checks.

Assignment and Release: I hereby authorize my insurance benefits to be paid directly to the physician. I am legally responsible for any amount which is not paid by my insurance even if my physician is participating with my insurance company. I also authorize the physician to release any information required to process the claim. I understand that accounts are considered past due if no payment is received within 30 days of billing. If payment is not made within that time for services rendered, I agree to pay any and all necessary cost of collections, including but not limited to attorney's fee of 35% on the balance outstanding, court cost and service of process fees.

My signature below is my acceptance of this agreement.

_____	_____	_____
Signature of patient or responsible party	DOB	Date

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Acknowledgement of Receipt of Notice of Privacy Practice

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have reviewed, read and understand the Notice of Privacy Practices document containing a more complete description of the uses and disclosures of my health information. I understand that Elisa Kavanagh, DPM has the right to change their Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below for a current copy of the Notice of Privacy Practice.

Patient Name: _____ Date:_____

Signature: _____ Relationship to patient: _____

Do we have your permission to?

Leave a voicemail? ☐ YES ☐ NO

Confirm appointments? ☐ YES ☐ NO

Speak with household members concerning your podiatry care? ☐ YES ☐ NO

Name/relationship: _____

Name/relationship: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, however, acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgments

☐ Other: _____

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