COMPLETE FAMILY FOOT CARE CENTER

340 Lumber Street, Suite B
Littlestown, Pennsylvania 17340

Part A: Patient Information

Patient Name: _____

Address: _____

City, State, Zip: _____

Home Phone: (____) _____ Work Phone: (_____) _____

Cell Phone: _____ E-Mail Address: _____

Sex: M F Birth date: _____ Age: _____

Patient SS# _____ Marital Status: S M W D

Patient Employer Name: _____

Address: _____

City, State Zip: _____

Phone: _____ Patient Occupation: _____

Emergency Contact Name: _____

Phone: (____) _____ Relationship to patient: _____

Patient Referred by: _____ Phone: (___) _____

Primary Doctor Name: _____ Phone: (___) _____

Address: _____

If Patient is a Minor, Name of Responsible Party: _____

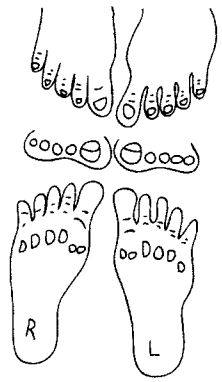
SS#: _____ Relationship: _____

Part B: Insurance Information

Primary Insurance Company	Secondary Insurance Company
Name: _____	Name: _____
Policyholder's Name: _____	Policyholder's Name: _____
Relationship to Patient: _____	Relationship to Patient: _____
Policy #: _____	Policy #: _____
Group/Claim #: _____	Group/Claim #: _____
Policyholder Sex: F M Birth date: _____	Policyholder Sex: F M Birth date: _____

Part C: What brought you in to see the doctor?

On the diagram below please mark the place(s) where you are experiencing pain in your feet.



Regarding the place(s) you marked, describe the pain you experience, for instance mild, moderate, severe, throbbing, burning, etc.:

_____

_____

_____

If Injury, date of Injury: _____

Auto Accident: yes no Work Related: yes no

First Date of Symptoms: _____

Allergies: _____

Are you pregnant? yes no

Part D: Lifetime Insurance Authorization to Release Information

I hereby authorize this physician/clinic to release any information, for insurance purposes, required in the course of my examination or treatment, which shall include HIV, Communicable disease or drug abuse information.

SIGNED: (Patient or Parent, if minor): _____ Date: _____

Part E: Authorization to Pay

I hereby authorize payment directly to the business office of this physician/clinic for the surgical and/or medical benefits, if any, otherwise payable to me for services. I understand that I am financially responsible for the charges not covered by my insurance.

SIGNED: (Patient or Parent, if minor): _____ Date: _____

Part F: Authorizations

_ Yes ___ No	I HEREBY AUTHORIZE RELEASE OF INFORMATION AND/OR MEDICAL RECORDS OF MYSELF, TO ANY TREATING PHYSICIAN, OR INSURANCE COMPANY
___ Yes ___ No	The information authorized for release may include information which may be considered a communicable or venereal disease, including, hepatitis, syphilis, gonorrhea, HIV or AIDS.
___ Yes ___ No	I voluntarily request Dr. Todd J. Goldberg, DPM, as my physician, and such associates, technical assistants and other health care providers as they deem necessary, to treat my condition.
___ Yes ___ No	I understand I am responsible for obtaining all appropriate referrals.
___ Yes ___ No	I also understand that when ordering orthotics, a payment of 50% is due at the time of casting, unless prior written authorization from your insurance company is obtained. The balance is due upon receipt of orthotics.

SIGNED: (Patient or Parent, if minor): _____ Date: _____

COMPLETE FAMILY FOOT CARE CENTER

340 Lumber Street, Suite B
Littlestown, Pennsylvania 17340

Assignment: Medicare Signature on File

I request that payment of authorized Medicare benefits be made on my behalf to Dr. Todd J. Goldberg, DPM, for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

I request payment of authorized Medicare benefits be made to this provider and also authorize any holder of medical information about me to release to the below named Medicare insurer any information needed to determine benefits payable for services from this provider.

I understand my signature below requests that payment be made and authorizes release of medical information necessary to pay the claim. My signature authorizes releasing of the information to the insurer or agency, electronically, or by mail. In Medicare assigned cases, this office agrees to accept the "charge determination" of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the "charge determination" of the Medicare carrier.

Patient's Name (please print)

X _____

Patient's Signature

X _____

Patient's Medicare Number

_____

Name of Medicare Insurer

_____

Medicare Policy Number

_____

Date _____

Provider Information

Complete Family Foot Care Center

Dr. Todd J. Goldberg, DPM

340 Lumber Street, Suite B

Littlestown, PA 17340

COMPLETE FAMILY FOOT CARE CENTER

340 Lumber Street, Suite B
Littlestown, Pennsylvania 17340

Todd J. Goldberg, DPM
(717) 359-5300
fax: (717) 359-0775

ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature

Medical History

Allergies: _____ List Meds: _____

_____ _____

_____ _____

Circle all that apply:

Anemia	Glaucoma	Poor circulation	Vascular grafts
Alzheimer's	Gout	Psychiatric disorder	Joint implants
Arthritis	Heart condition	Rheumatic fever	Replacement heart valves/nitro valve
Asthma	High blood pressure	Stomach ulcer	
Bleeding disorders	Kidney disorders	Thyroid problems	Under active chemotherapy
Cancer	Liver disease	Tuberculosis	
Diabetes oral insulin	Lung disease	None of these	Pacemaker
Epilepsy	Osteoporosis	Other: _____	AIDS/HIV
Back Problems	Blood Clots	Broken Bones	Calf Pain
Foot or leg cramps	Swelling in Ankles, Feet		

Past Surgical Procedures:

Surgery	Date	w/complications
_____	_____	_____
_____	_____	_____

Have you previously had physical therapy? When? Where? For what condition? _____

_____

_____

Social History:

Smoking: Packs/day _____ Years _____ Past Smoker: Packs/day _____ Years _____

Caffeine: Quantity _____ Alcohol: None Rarely Moderately Daily Quit

Recreational Drug Use: None Moderately Daily Quit

Type of exercise/sports: _____

Height:_____ Weight: _____ Shoe size___ Width_____

List Relationship to you of family members who have had:

Diabetes: _____ Foot Problems: _____

Arthritis: _____ Heart Problems: _____

Stroke: _____ Cancer: _____

Previous Podiatry Visit:

Name of Podiatrist: _____ Date of Visit:_____

Nature of Visit: _____

Is there anything you wish to tell your physician privately? ❑ Yes ❑ No

Patient Signature _____ Date _____

Witness Date _____ Date _____

SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding the attached Notice of Privacy Practices

The attached Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to the attached Notice of Privacy Practices for the person or persons whom you may contact.

COMPLETE FAMILY FOOT CARE CENTER

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect **April 14, 2003**, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain, including medical information we created or received before we made the changes.

You may request a copy of our notice (or any subsequent revised notice) at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Protected Health Information

We will use and disclose your protected health information about you for treatment, payment, and health care operations.

Following are examples of the types of uses and disclosures of your protected health care information that may occur. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as: making a

determination of eligibility or coverage for insurance benefits, reviewing services provided to you for protected health necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities.

For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you by telephone or mail to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact us to request that these materials not be sent to you.

Uses and Disclosures Based On Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your authorization, unless otherwise permitted or required by law as described below.

You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without your written authorization, we will not disclose your health care information except as described in this notice.

Others Involved in Your Health Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

Marketing: We may use your protected health information to contact you with information about treatment alternatives that may be of interest to you. We may disclose your protected health information to a business associate to assist us in these activities. Unless the information is provided to you by a general newsletter or in person or is for products or services of nominal value, you may opt out of receiving further such information by telling us using the contact information listed at the end of this notice.

Research; Death; Organ Donation: We may use or disclose your protected health information for research purposes in limited circumstances. We may disclose the protected health information of a deceased person to a coroner, protected health examiner, funeral director or organ procurement organization for certain purposes.

Public Health and Safety: We may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or

safety of others. We may disclose your protected health information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations; to track products; to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Required by Law: We may use or disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws. We may disclose your protected health information when authorized by workers' compensation or similar laws.

Process and Proceedings: We may disclose your protected health information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your protected health information to law enforcement officials.

Law Enforcement: We may disclose limited information to a law enforcement official concerning the protected health information of a suspect, fugitive, material witness, crime victim or missing person. We may disclose the protected health information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

Patient Rights

Access: You have the right to look at or get copies of your protected health information, with limited exceptions. You must make a request in writing to the contact person listed herein to obtain access to your protected health information. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you $0.10 for each page, $30.00 per hour for staff time to locate and copy your protected health information, and postage if you want the copies mailed to you. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

COMPLETE FAMILY FOOT CARE CENTER

340 Lumber Street, Suite B • Littlestown, PA 17340

Diabetes is a serious metabolic disease that usually affects your feet. The disease affects the way your body uses blood sugar and how it produces insulin. Today, medicine has advanced significantly in treating and preventing the dangerous effects of abnormal blood sugar conditions like hyperglycemia, ketoacidotic coma, infections, and premature death. This is both good and bad news. The good news is that people with diabetes are living longer, healthier lives. The bad news is that diabetes still causes secondary, indirect complications that affect the feet, eyes and kidneys. Diabetic foot disease is primarily caused by two complications of the disease called neuropathy and atherosclerosis (poor circulation).

Neuropathy is nerve damage of the foot causing numbness and a loss of sensation. This loss of sensation makes it difficult for a patient to distinguish between hot and cold or to realize when the foot has been cut or bruised. In a way, your feet become "unprotected" because of neuropathy. Ulcers, cuts, scrapes, burns, and other trauma to your feet can go unnoticed until it is too late to avoid serious problems like infection and gangrene.

Atherosclerosis causes a diabetic to have poor circulation, which adversely affects the legs and feet. Additionally, white blood cells which fight infection do not perform effectively when blood sugar levels are higher than normal. This can seriously compound any foot problems because the body's defenses may be unable to prevent the development of celluliti (infection of the skin), abscesses (infection of the soft tissue under the skin), or osteomyelitis (infection in the bone). This can result in foot ulcers that may not heal, gangrene, and even amputations. IT IS IMPORTANT TO REMEMBER THAT THESE ARE DIRECT COMPLICATIONS OF THE DISEASE!

While statistics show that early, conservative, preventative management of diabetic foot disease can effectively reduce or delay these bad results, there is no cure for diabetes and bad results may be unavoidable, even with the best of care. Unfortunately, this is the nature of the disease.

A daily foot care instruction sheet will be given to you by our office and you should follow these instructions and any specific instructions given to you at the time of your examination. It is VERY important that you keep your blood sugar under control. It is YOUR RESPONSIBILITY to see you internist or family doctor for the management of your diabetes. If you fail to do so, it will adversely affect our treatment of your feet.

We wish you the best of health and will work very hard to keep your feet in the best condition your disease will allow.

Sincerely,

Todd J. Goldberg, DPM

I have read and understand this letter and I agree to have my diabetic foot care by Dr. Todd J. Goldberg including: trimming of corns, calluses, nails; care of ulcers and other care as needed.

Patient's Signature _____ Date _____