Adnan Shariff, DPM
Joshua Roberts, DPM
Podiatric Physician and Surgeon
www.FloridaFootSpecialist.com

235 NE 19th Dr.
Okeechobee, Fl. 34972
(863) 357-1166
Fax: (863) 357-0424

1008 W. Sagamore Ave.
Clewiston, Fl 33440
(863) 983-2188

1900 Nebraska Ave. Ste. 2
Fort Pierce, Fl. 34950
(772) 595-6065

2632 W. Indiantown Rd.
Jupiter, Fl 33458
(561) 340-3132

Dear Patient:

Effective immediately there will be a charge of $25 for a no show appointment. We request that you call 24 hours prior to your scheduled appointment to cancel or reschedule. The office confirms all appointments, so please make sure that we have your correct day telephone numbers. Thank you.

Patient signature: ________________________________

Date: ________________________________

FLORIDA FOOT SPECIALIST
Dr. Adnan Shariff and Dr. Joshua Roberts

Patient: ________________________________ Date: ________________
(Full name)
Street: ______________________ City: __________ State: ________ Zip: ____________
Date of Birth: ____________ Age: ______ Social Security #: ______________________ Sex __M __F
Single ___ Married___ Widowed___ Divorced___
Phone: __________________ Work: ______________ Cellular: ________________
E-mail address ____
Occupation: __________________ Spouse's Full Name: ____________________
Employer: ______________________________ Work Phone: (____)________________
Your Pharmacy: __________________ Town: ____________ Phone #: ____________
Emergency Contact - Name: ______________________ Phone: (____) ____________

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Insurance Company ______________________ Policy ID: ________________
Name of Insured: ________________________ Group #: ________________
Soc. Sec.: __________________ D.O.B of Insured: ____/____/____ Relationship: __________
Secondary Ins. Co.: ______________________ Policy ID: ________________
Name of Insured: ________________________ Group #: ________________
Referred by: ________________ Date of Last Physicial: __________ By Whom: __________
Primary care or Family Doctor. __________________ Address: ________________

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What is your foot problem(s): ____

Shoe Size: ________ Weight: ______ Height _______

Do you smoke? ___Y___N How many packs per day______ For how many years______. Drink alcohol __Y__N How much per week ____________ Do you use a cane, walker or wheelchair? ________________ Wear eyeglasses? ___Y___N

Illnesses: (Circle those which apply):
Poor Circulation   Heart Disease   Liver Disease   Diabetes   Arthritis   Anemia   Kidney Problem   Hepatitis   Lung Disease   Back Problems   Bleeding Disorders   Asthma   Gout
High Blood Pressure   Rheumatic Fever   Stroke   Back Pain   Neck Pain   Numbness in Feet
Hearing problems
Other ____
____

Allergies to Medications: (Circle those which apply):
Penicillin   Aspirin   Codeine   Adhesive Tape   Iodine
Sulfa   Sea Food   Local Anesthetic   Other: ____________________

Medication: (Prescription and non-prescription) ______________________________
____
____
____

Prior Surgery: ____

I hereby give my permission to Dr. Adnan Shariff, DPM or Dr. Joshua Roberts to perform diagnostic, therapeutic services.

____
Patient signature   Date

FINANCIAL POLICY FOR FLORIDA FOOT SPECIALIST.

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

INSURANCE: We participate in most insurance plans. 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. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

MEDICARE: We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. However; that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any copayments, which are usually 20% of the allowed amount for an item or service.

COPAYMENTS AND DEDUCTIBLES: All co-payments and deductible 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.

SELF PAY: Payment in full is due at the time of service if you do not have health insurance.

NON-COVERED SERVICES: Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payment of these services.

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan which mandates us that when you visit a specialist such as ours, you must have a referral from your primary care physician prior to seeking specialty care. Therefore, you are financially responsible for the services received, unless your referral is presented at the time of this visit. If you do not have a referral from your primary care physician at the time of a visit, you will be financially responsible for all services received due in full upon completion of the visit. Full credit will be given if a referral is presented to our office within 48 hours of this visit. You will also be given the option to reschedule your appointment.

PATIENT BILLING: You will be sent up to three notices for your financial responsibility (co-insurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After the third and last notice, your account may be forwarded to collections. Please let the billing office know if you have any difficulties resolving your bill. Payment arrangements can be made on a case by case basis. We accept the following payment methods: Cash, Check or VISA/MasterCard. An additional $25.00 will be added to your statement if the check is returned for insufficient funds. In the event that your insurance company should happen to send payment to you, the patient, we expect that you would forward it to our office to be applied to your balance.

I have read the above policy regarding my *financial responsibility* to Dr. Adnan Shariff, DPM for medical services provided. I agree to pay Dr. Adnan Shariff, DPM any balance unpaid by my insurance carrier for myself or the below named person.

Assignment of Benefits
I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to **Dr. Adnan Shariff, DPM** all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

PRINT Patient Name: ______________________ Signature: ______________________

FINANCIALLY RESPONSIBLE PARTY:

PRINT Name: ______________________ Signature: ______________________

Relationship to Patient: ______________________ Date: ______________________

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 understand 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 with my healthcare or payment relating to my health care.

Print Name:________________ **Last four digits of SSN or other identifier:**__________

Print Name:________________ **Last four digits of SSN or other identifier:**__________

Print Name:________________ **Last four digits of SSN or other identifier:**__________

III. Request to Receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

Home Telephone Number:

____

____ OK to leave message with detailed information

____ Leave message with call back numbers only

Written Communication Address:

____

____ OK to mail to address listed above

____ E-mail me at:________________

Work Telephone Number:

____

____ OK to leave message with detailed information

____ Leave message with call back numbers only

Fax Communication:

____

____ OK to Fax at the number listed above

____ E-mail me at:________________

Other:________________________________

IV. The following person(s) <u>are not authorized</u> to receive my Patient Health Information (PHI):

Print Name:________________ **Print Name:**________________

Print Name:________________ **Print Name:**________________

V. The HIPAA Privacy rule requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI. I understand that this accounting will not reflect disclosures that are made in the course of the Practice's ordinary health care activities related to providing patient treatment, obtaining payment for its services or its internal operations. Also, the Practice does not have to account for disclosures for which I have executed an Authorization permitting disclosures of my PHI.

Date of disclosure request	Disclosed to whom: address/fax	Description of disclosure	Purpose of disclosure	Dates of Service of disclosure	Person completing request	Date completed

1. The above authorizations are voluntary and I may refuse to agree 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 Practices mailing address marked to the attention of "HIPAA Compliance Officer."

3. The revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.

4. I may see and copy the information described in this form, if I ask for it, and I will get a copy of this form after I sign it.

5. This form was completely filled in before I signed it and I acknowledge that all of my questions were answered to my satisfaction, that I fully understand this authorization form, and have received an executed copy.

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

Referral Questionnaire

***Please Answer Every Question

Name________________________________

Date of Birth______________________

Address______________________________

Phone Number_______________________

Email ID______________________________

1) How did you hear about us?

a) News Paper **b)** Clipper Magazine **c)** yellow Pages **D)** Radio **e)** Internet

f) Doctor Office____

g) Friend or Relative____

h) Other_______________________________________