New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I _____, understand that as part of my health care, John Ariza, DPM originates and maintains paper and/or electronic records describing my name, address, phone number, health history, symptoms, examination test result, diagnoses, treatment, and any plans for future care or treatment, I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for assessing quality and review of records
- A way of contacting me concerning my care, my appointment or marketing information regarding Dr. Ariza's office

I understand that I will be provided upon request with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing these consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that John Ariza, DPM is not required to agree to the restrictions requested, I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that John Ariza, DPM reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should John Ariza, DPM change their notice, they will send a copy of any revised notice to the address I've provided whether U.S. mail or , if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for this permitted uses, including disclosures via fax.

I understand and accept the terms of this consent,

Patient Signature _____ Date: _____

JOHN ARIZA, D.P.M.
BOARD CERTIFIED A.B.P.S.

75 PRINGLE WAY, SUITE 302
RENO, NEVADA 89502
TELEPHONE 775-355-1001 FAX 775-355-8216

ASSIGNMENT: I HEREBY ASSIGN AND REQUEST PAYMENT OF MY MEDICAL BENEFITS TO GO TO JOHN ARIZA, D.P.M. FOR SERVICES, BY HIM THAT ARE BILLED TO MY INSURANCE COMPANY.

X _____

SIGNED: PATIENT (OR PARENT IF MINOR) DATE

ASSIGNMENT: I HEREBY AUTHORIZE JOHN ARIZA, D.P.M. TO FURNISH INFORMATION, AS NEEDED, TO MY INSURANCE CARRIERS AND/OR TO MY PHYSICIANS, CONCERNING MY CARE AND TREATMENT.

X _____

SIGNED: PATIENT (OR PARENT IF MINOR) DATE

John Ariza, DPM
General Podiatry and Foot Surgery

NAME _____ ADDRESS _____

CITY _____ ST. _____ ZIP _____ PHONE(H) _____ CELL _____

SOCIAL SECURITY# _____ DRIVERS LIC.# _____ DATE OF BIRTH _____

EMPLOYER NAME _____

WHAT IS YOUR FOOT PROBLEM? _____

HAVE YOU SEEN A PODIATRIST IN THE PAST? IF YES NAME: _____

WHO IS YOUR PRIMARY CARE PHYSICIAN? _____

CURRENT MEDICATIONS _____

ALLERGIES TO MEDICATIONS _____

PAST SURGERIES OR HOSPITALIZATIONS _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

SHOE SIZE _____

PLEASE CIRCLE THOSE THAT APPLY TO YOU CURRENTLY OR IN THE PAST:

HEART: HEART ATTACK HEARTMURMER CHEST PAIN HEART CONDITION HIGH BLOOD PRESSURE

LUNGS: ASTHMA EMPHYSEMA **SMOKER?** YES/NO PACKS PER DAY _____ HOW MANY YEARS? _____

LIVER: HEPATITIS JAUNDICE **NEUROLOGICAL:** HEADACHES SEIZURES FAINTING STROKES

GENERAL: DIABETES GOUT ARTHRITIS POOR CIRCULATION HIV TAKING BLOOD THINNERS

Other medical problems or diseases _____

INSURANCE AND BILLING INFORMATION

WE WILL NEED A COPY OF YOUR INSURANCE CARD(S) IF WE ARE BILLING FOR YOU.
IF YOU ARE PAYING BY CASH OR CHECK, PAYMENT IS DUE AT THE TIME OF SERVICE.

In the interest of all concerned, we have established a financial policy to avoid any misunderstandings.

1. Please feel free to ask up front what the doctor's services will cost.
2. We accept cash, personal checks and credit cards. Each patient is responsible for his or her charges.
3. As a service to you we will bill your insurance company, however, the Doctor's fees are your responsibility and not the insurance companies.
4. All co-pays, deductibles, and non-covered services are due at the time of service.
5. Payment plans will be made if needed.

I have read this form and agree to follow the financial policy of this office. Dr. Ariza has my permission to examine, diagnose and administer treatment for my foot problem. I authorize Dr. Ariza's office to furnish my insurance company with all information needed to process my claim.

SIGNATURE: _____ DATE: _____

Medication List