Dr. Steven Stummer

The Purestep Podiatry Group

220 Fort Salonga Road (25A) Northport, NY 11768
1800 Walt Whitman Rd. Melville, NY 11747
2631 Merrick Rd., #300 Bellmore, NY 11710

Phone: 516.449.1841 • Fax: 631.754.2909 • drstummer@northportwellnesscenter.com

PRACTICE: _____ **TODAY'S DATE:** _____

Name: _____ DOB: _____ Chart Number: _____
Sex: □ M □ F Marital Status □ Single □ Married □ Widowed □ Divorced SS#: _____
Address: _____ City: _____ State: _____ Zip: _____
Home #: _____ Cell #: _____ Other #: _____
Employer: _____ Phone: _____
Employer Address: _____ City: _____ State: _____ Zip: _____

Primary Insurance: _____ Are you the insured? □ Yes □ No
Insured Information
Subscriber Name: _____ *Relationship to insured* □ Spouse □ Child □ Self □ Other
Phone #: _____ Sex □ Male □ Female DOB: _____
Address: _____
Policy ID: _____ Group: _____ Employer: _____

Secondary Insurance: _____ Are you the insured? □ Yes □ No
Insured Information
Subscriber Name: _____ *Relationship to insured* □ Spouse □ Child □ Self □ Other
Phone #: _____ Sex □ Male □ Female DOB: _____
Address: _____
Policy ID: _____ Group: _____ Employer: _____

How did you find out about our practice? □ Physician □ Internet □ Telephone book □ Family member □ Friend
□ Other: _____
What is the reason for your visit today?: _____
_____ Result of accident or work injury? □ No □ Yes
How long has this bothered you? 1 2 3 4 5 6 7 □ Days □ Weeks □ Months □ Years
What treatments have you tried & have they been effective: _____
_____
On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain? _____ /10
The pain quality is: □ burning □ constant □ dull □ sharp □ shooting □ throbbing □ tingling other: _____

PLEASE READ AND SIGN
The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information above.

Patient Signature: _____ **Date:** _____

History and Physical

Name: _____ DOB: _____ Chart Number: _____

Medical History: □ Alcoholism □ Blood disorders □ Circulation problems □ Musculoskelatal □ Breathing issues
□ Liver □ Sleep apnea □ Gout □ Allergies □ Heart disease □ Asthma
□ Heart murmer □ Stomach/bowel □ Depression □ Anxiety disorder □ Mental illness □ Kidney disease
□ Blood clot □ High cholesterol □ High Blood Pressure □ Cancer □ Hepatitis
□ Neuropathy (specify) _____ □ Thyroid disease (specify) _____
□ Diabetes (type1, type 2) □ Arthritis (specify) _____ □ Other (specify) _____
□ HIV □ CVA □ Skin disorders □ Stroke
Are you pregnant? □ Yes □ No Are you nursing? □ Yes □ No

Surgical History □ None □ Appendectomy □ C-Section □ Angioplasty □ Cataracts □ Cholecystectomy
Have you ever had surgical procedures on foot/ankle or anywhere else on your body? □ Yes □ No
If yes, please describe: _____
Do you have any artificial joints? □ Yes (where? _____) □ No
Do you have an artificial heart valve? □ Yes □ No

Social History
Do you smoke? □ Yes □ No If yes, how many packs per day ? □ 1 □ 2□ 3 □ 4 □ 5 For how long? _____
Do you drink alcohol? □ Yes, everyday (5-7 days/week) □ Yes, occasionally/socially □ No/Rarely
Substance abuse: □ Yes, I have current substance abuse problem. Please specify: _____
□ Yes, I had past substance abuse problem. Please specify: _____
□ No, I have never had a substance abuse problem
What is your occupation _____ Does it involve mostly □ Standing or □ Sitting
Do you exercise regularly? □ No, I do not exercise regularly □ Yes, I do the following exercise: _____
_____

Family History Is there any family history (blood relative) of: (Please indicate family member)

□ Alzheimer's	_____	□ Depression	_____
□ Arthritis	_____	□ Diabetes	_____
□ Bleeding disorders	_____	□ Emphysema	_____
□ Blood clot	_____	□ Heart disease	_____
□ Cancer	_____	□ High Blood Pressure	_____
□ Cataracts	_____	□ Neurological	_____
□ Circulation problems	_____	□ Strokes	_____
□ Other (specify)	_____		

Review of Systems (please check the box if you currently have any of these symptoms or check "NONE")

Cardiovascular	□ leg pain when walking	□ fever	□ chest pain/pressure	□ leg swelling	□ cold hands/feet	
	□ Fainting	□ palpitations	□ vascular disease	□ valve problems	□ NONE	
Genitourinary	□ blood in urine	□ hesitancy	□ incontinence	□ increased urgency		
	□ decreased frequency	□ excessive urination	□ kidney disease	□ kidney stones	□ None	
Gastrointestinal	□ abdominal pain	□ heartburn	□ blood in stool	□ vomiting	□ ulcers	□ constipation
	□ diarrhea	□ trouble swallowing	□ decrease appetite	□ increase appetite	□ NONE	
Integumentary	□ athletes foot	□ nail abnormalities	□ keloids	□ itchiness	□ dry, scaly skin	□ NONE
Hematologic	□ lower leg ulcers	□ sickle cell disease	□ anemia	□ blood thinners	□ clotting disorders	□ NONE
Neurological	□ tingling	□ weakness	□ seizures	□ numbness	□ headaches	
	□ tremors	□ paralysis	□ NONE			
Musculoskelatal	□ back pain	□ joint swelling	□ muscle weakness	□ muscle pain	□ neck pain	
	□ sciatica	□ joint stiffness	□ joint pain	□ joint instability	□ arthritis	□ NONE
Respiratory	□ chest pain	□ wheezing	□ COPD	□ coughing	□ snoring	
	□ shortness of breath		□ emphysema	□ NONE		

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Patient Signature: _____ **Date:** _____

Practice: **Today's Date:**

Name: _____ DOB: _____ Chart Number: _____

Race: _____ ☐ Prefer not to answer ☐ I do not know

(white, American, Indian, Asian, Black or African, Native Hawaiian, Hispanic, etc.)

Ethnicity: _____ ☐ Prefer not to answer ☐ I do not know

Preferred Language : _____ ☐ Prefer not to answer ☐ I do not know

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address: _____ City, State, Zip: _____

Primary Care Physician: _____ Phone: _____ Date last seen: _____

Address: _____ City, State, Zip: _____

Referring Physician: _____ Phone: _____ Date last seen: _____

Address: _____ City, State, Zip: _____

Privacy Information Preferences

Do you want to be exempt from public reporting? ☐ Yes ☐ No Can we send mail to the address on file? ☐ Yes ☐ No

Can we call the phone number on file? ☐ Yes ☐ No Can we leave voice mail on machine? ☐ Yes ☐ No

Will you allow us to send Internet based (e-mail) delivery of reminders and newsletters? ☐ Yes ☐ No

If yes, please provide your e-mail address: _____

Who can we leave messages with? ☐ Wife ☐ Husband ☐ Daughter ☐ Son ☐ Other: _____

Name (s): _____

Smoking Status

☐ Current Every Day Smoker ☐ Never Smoker

☐ Current Some Day Smoker ☐ I decline to answer

☐ Former Smoker

Vital Signs

Blood Pressure: _____/ _____

Height: _____ Weight: _____

Current Medications

☐ No Known Medications ☐ I take the following medications

Name:_____ Dose: _____

Name:_____ Dose: _____

Name:_____ Dose: _____

Name:_____ Dose: _____

Name:_____ Dose: _____

Name:_____ Dose: _____

Name:_____ Dose: _____

Name:_____ Dose: _____

Use the back of this form if more room in needed

Allergies

☐ No Known Allergies ☐ No known Drug Allergies

Name:_____ Reaction: _____

Name:_____ Reaction: _____

Name:_____ Reaction: _____

Name:_____ Reaction: _____

Name:_____ Reaction: _____

Name:_____ Reaction: _____

Name:_____ Reaction: _____

Name:_____ Reaction: _____

PLEASE READ AND SIGN

The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. (Assignment of Benefits): I authorize payment of medical benefits to the practice named above. (Release of information authorize the release of any medical information necessary to process this claim. (HIPAA Privacy Practices Notice. (Medication History): I authorize the Doctor's office to retrieve my medication history.

Patient Signature: _____ **Date:** _____

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

Effective April 14, 2003

The privacy of your medical information is important to us. You may be aware that U.S. Government regulators established a privacy rule ("HIPPA") governing protected health information. This notice tells you about how it may by used, and about certain rights that you have.

If you have any questions regarding privacy matters at our office, please feel free to contact us at either of the above numbers.

Use and disclosure of protected information

Federal law provides that we may use your medical information (protected health information) for treatment of you, without further specific notice to you, or written authorization by you. (Example: if we refer you to a specialist, we may provide laboratory or test data to that specialist (subject to more stringent New York laws, such as restriction on disclosure of information concerning HIV/AIDS).

Federal law provides that we may use your medical information to obtain payment for our services without further specific notice to you, or written authorization by you. (Example: under your health plan, we are required to provide them with a diagnosis and procedure (description) code for services rendered at time of visit).

Federal law provides that we may use your medical information for health care operations without further specific notice to you, or written authorization by you (example: our accountants may see your name, date of treatment and procedure codes during audits of our books). WE may also use your information for financial services, quality assurance, rick reduction and claim management purposes with our medical professional liability insurer.

We may use of disclose your medical information, without further notice to you, or specific authorization by you where:

1. Required by law
2. Required for public health purposes
3. Required by law to report child abuse
4. Where required by a health oversight agency for oversight activities authorized by law, such as the Department of Health, Office of Professional Discipline or Office of Professional Medical Conduct
5. Required by law in judicial or administrative proceedings
6. Required for law enforcement purposes by a law official
7. Required by a coroner or medical examiner
8. Permitted by law to a funeral
9. Permitted by law for organ donation purposes
10. Permitted by law and required by military authorities if you are a member of the armed forces of the United States

New York State law provides additional protections for information regarding HIV/AIDS. We will continue to follow New York State law with respect to such information.

We may contact you by mail or phone, at your residence, to remind you of appointments or to provide information about treatment alternatives. Unless you instruct us otherwise, we may leave a message for you on any answering device or with any person who answers the phone at your residence.

You can make reasonable requests, in writing, for us to use alternative methods of communication with you in confidential manner. Space for this is provided below.

Other uses or disclosure of your medical information will be mad only with your written authorization. You have the right to revoke any written authorization that you give.

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Rights that you have

You have the right to request restrictions on certain of the uses of disclosures described above. Except as stated below, we are not required to agree to such restrictions.

You have the right to inspect and obtain copies of your medical information (a reasonable fee might be charged).

You have the right to request amendments to your medical information . Such request must be in writing, and must state the reason for the requested amendment. We will notify you as to whether we agree or disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.

You have the right to request an accounting of any disclosure we make of your medical information, except for: disclosures we make to you, or to carry out treatment, payment of health care operations, or as requested by your written authorization, or for emergency of notification purposes or national security or intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law, or/for disclosures made before April 14, 2003.

If you have received this notice electronically, you have the right to obtain a paper copy from our office.

Obligations that we have

We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices.

We are required to abide by the terms of this notice as long as it is current in effect.

We reserve the right to revise this notice, and to make a new notice effective for all protected health information we maintain. Any revised notice will be posted in our office, and copies will be available there.

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ASSIGNMENT OF BENEFITS

Patient Name: _____

I irrevocably assign to Dr. Steven Stummer, DPM all my rights and benefits under any insurance contracts for payment for services rendered to me. I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claims by Dr. Stummer to be released and give authorization to file insurance claims on my behalf for services rendered to me. I irrevocably direct that all such payments go directly to Dr. Stummer. I irrevocably authorize such doctor to act in my behalf and report any suspected violations or improper claims practices to the proper regulatory authorities.

This assignment of benefits has been explained to my full satisfaction, and I understand its nature and effect.

Patient's Signature: _____ **Date:** _____

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PRACTICE FINANCIAL POLICY

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financially policy. If you have any questions about the policy, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either yourself of your health coverage carrier, full payment is due at the time of service. For your convenience, we accept VISA, MASTER CARD, AMERICAN EXPRESS, DINERS CLUB, and DISCOVER.

YOUR INSURANCE

We have made prior arrangements with many insurers and other health plans to accept assignment of benefits. We will bill those plans for whom we have an agreement and will only require you pay the authorized co-payment at the time of service.

If you have insurance coverage with a plan that we do not have a prop agreement, we will prepare and send the claim for you on an unassigned basis. This mean your insurer will send the payment directly to you. The charges for your care and treatment are due at the time of service.

In the event your health plan determines a service to be “not covered”, you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

Orthotics and medical supplies: Due to the rising costs of materials and supples we cannot accept assignment on any custom molded foot orthotics and office supplies. You may either leave a 50% deposit on orthotics the date of casting or pay in full. Our office will be more than happy to furnish your insurance company with the necessary information to help process your claim.