Annual Authorization Signature Form

First Name:	Middle Name	Last Name	Generation (Sr., Jr., III)
Birth Date:	Your Age today:	Gender: □ M □ F	Social Security #
Street Address 1	Street Address 2	City State	Zip Code
Home Phone	Work Phone	Cell Phone	Email

Your Billing Information

Please bring your insurance cards, your driver's license with you and any required podiatry referral forms. Insurance copays are collected at the time of your visit. We accept cash, check, money order and credit card.

Primary Insurance	Secondary Insurance
Policy Number:	Policy Number:
Policy Holder's Name	Policy Holder's Name
Policy Holder's DOB: ___/__/___	Policy Holder's DOB: ___/__/___
Relationship:	Relationship:
Is this an HMO ☐ PPO ☐ Copay Amt $_____	Is this an HMO ☐ PPO ☐ Copay Amt $_____
ID # _____Group #_____	ID # _____Group #_____
Policyholder's Employer:	Policyholder's Employer:
Tertiary 3rd Insurance	**Workman's Compensation Injury**
Policy Number:	Claim Number:
Policy Holder's Name	Workman's Comp Insurance Name:
Policy Holder's DOB: ___/__/___	Address:
Relationship:	
Is this an HMO ☐ PPO ☐ Copay Amt $_____	Date of Injury: ___/__/___
ID # _____Group #_____	Contact Name for your claim:
Policyholder's Employer:	Contact Phone number:
I do not have health Insurance. I agree to pay for my podiatry visits and other services rendered. Yes ☐	

Billing Patient Insurance Authorization

I hereby authorize Giardina & Glubo, DPM, PA to apply for benefits on my behalf for services rendered. I request that payment from my insurance company to be made directly to Giardina & Glubo, DPM, PA. I understand that Giardina & Glubo, DPM, PA will bill insurance where applicable for all clinical services. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I permit a copy of this authorization to be used in place of the original. I consent to release medical information for conditions or diagnoses regulated by Federal statutes. I may revoke this authorization at any time, in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided, when a statement is rendered.

Yes, bill my insurance □ No, you may not bill my insurance □

Patient /Responsible Signature:

Relationship: Self □ Parent □ Guardian □ Legal Representative □

Authorization to release my medical information

I authorize the following person/people access to my medical records and/or to call on my behalf for medical, account, and/or billing questions.	
Name:	Phone:
Name:	Phone:
Name:	Phone:

Parental Authorization for a minor child (18 years old and younger)

I authorize the following designated adult(s) authorized representative to arrange for podiatric care for my child when either parent or legal guardian do not accompany the child.

Name of child's representative:

Relationship to the child:

Additional Parental Information

Mother's Name	Mother's Cell	Mother's Email	Mother's Home Phone	Mother's Work Phone
Father's Name	Father's Cell	Father's Email	Father's Home Phone	Father's Work Phone
Guardian's Name	Guardian's Cell	Guardian's Email	Guardian's Home Phone	Guardian's Work Phone

Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

Patient Name: _____ Date: _____ /_____ /_____

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information. I understand that Giardina & Glubo, DPM, PA may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Giardina & Glubo, DPM, PA has a detailed document called the '*Notice of Privacy Practices*'. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information. I understand that I have the right to read the 'Notice' before signing this agreement. If I ask, Giardina & Glubo, DPM, PA will provide me with the most current *Notice of Privacy Practices.*

My signature below indicates that I have been given the chance to review such copy of the Notice of Privacy Practices. My signature means that I agree to allow Giardina & Glubo, DPM, PA to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Giardina & Glubo, DPM, PA has taken action relying on this consent.

SIGNATURE _____ **Date: _____ /_____ /_____**
(Patient or Legal Custodian/Authorized Representative)

Relationship to Patient if signed by another party _____ **Date: _____ /_____ /_____**

The signature on file for billing and release of health care information is valid for one year. All information released is in compliance with HIPAA as stated in our Notice of Privacy Practices. You may obtain a copy of the Notice of Privacy Practices, including any revisions by contacting: Giardina & Glubo, DPM, PA at 410.242.7066 and www.ggpodiatry.com. Thank you for completing our form(s). Medicare, Medicaid and other insurance companies require us to collect this important information about you.

Authorization to Release My Medical Information

I authorize the following person/people access to my medical records and/or to call on my behalf for medical, account or billing questions.

Patient Signature: _____ Date: _____

Name: _____ Phone: _____

Authorized person's email: _____

Name: _____ Phone: _____

Authorized person's email: _____

Your Vital Signs

What is your Height: _____ Weight: _____ Blood Pressure: _____

Name of your pharmacy: _____ Phone Number _____

Pharmacy Address: _____

Bring a list of your medicines or fill in the chart below and include how many pills you take per day.

Name of Medicine ***Example: Lisinopril***	Dosage ***Example: 10 mg one time a day***

Are you allergic to the following?

Novocaine ☐ Penicillin ☐ Sulfa ☐ Adhesive ☐ Tape ☐ Iodine ☐ Latex ☐ I do not have any allergies ☐

Other: _____

Main Concern/Reason for Seeing the Podiatrist Today:

Bunions ☐ Hammertoes ☐ Plantar Fasciitis ☐ Shin Splints ☐ Ingrown Toe Nail ☐ Flat Feet ☐ Gout ☐

Other: _____

Do you Have or Ever Been Treated for the Following Medical Conditions:

Alzheimer's ☐	Arthritis ☐	Asthma ☐	Cancer ☐	Cardiovascular ☐
Deep Vein Thrombosis- DVT ☐	Diabetes ☐	Epilepsy ☐	Heart Disease ☐	Hearing Disorder ☐
Hepatitis ☐	High Blood Pressure ☐	High Cholesterol ☐	HIV/AIDS ☐	Kidney Disease ☐
Liver Disease ☐	Low Back Pain/Sciatica ☐	Lung Disease ☐	Lyme's Disease ☐	Poor Circulation ☐
Osteoporosis ☐	Peripheral Neuropathy ☐	Psychiatric Disorder ☐	Seizures ☐	Stroke ☐
Stomach Ulcer ☐	Thyroid Disease ☐	Vascular Disease ☐	Vertigo ☐	None ☐
Other Please List:				

If any other medical conditions, please explain: _____

_____

Surgical History - What surgeries have you had within the last 10 years?

Surgical Procedure	Date of Surgery

I have not had any surgeries ☐

Social History

Do you smoke?	Yes ☐	no ☐	Every day ☐ some days ☐ former smoker ☐ never ☐ Heavy smoker ☐ Light smoker ☐ How many cigarettes/day? _____	
Do you drink alcohol?	Yes ☐	no ☐	Never ☐ quit ☐ 1 -2drink/day ☐ moderate ☐ heavy ☐ How many drinks in a day/week? _____	
Do use drugs?	Yes ☐	no ☐	Never ☐ quit ☐ occasionally ☐ daily ☐	
Seasonal Flu Shot	Yes ☐	no ☐ do not know ☐	If yes, Date:	
Pneumonia Shot	Yes ☐	no ☐ do not know ☐	If yes, Date:	
Daily baby aspirin	Yes ☐	no ☐		
What is your Shoe Size				

Family History for Mother and/or Father Only

Alzheimer's ☐ Mother ☐ Father ☐	Arthritis ☐ Mother ☐ Father ☐	Cancer ☐ Mother ☐ Father ☐	Diabetes ☐ Mother ☐ Father ☐	Heart Disease ☐ Mother ☐ Father ☐	High Blood Pressure ☐ Mother ☐ Father ☐
Poor Circulation ☐ Mother ☐ Father ☐	Vascular Disease ☐ Mother ☐ Father ☐	None ☐ Other:			

Preventive Health Profile for the Diabetic Patient

Do you have diabetes or diagnosed with pre-diabetes? Yes ☐ No ☐

If yes, please answer the following questions to better understand your diabetic profile:

What was your Hemoglobin A1c blood test result? _____

Date of your A1c test_____ /_____ /_____

Patient or Legal Representative Signature:

Sign Here: _____ Date: _____

I affirm the above History Form is true to the best of my knowledge