Granite State Podiatry Associates, PA

424 Hanover St., Manchester, NH 03104 Phone (603) 668-3509 Fax (603) 641-8442

New Patient Registration Forms

It is important to Fully, Accurately and Legibly Complete every section of this packet.

Patient Demographics

Last Name	First Name	Middle Initial	Gender (Circle One) Male Female

Date of Birth	Social Security Number	Primary Phone Number	Secondary Phone Number

E-Mail Address

Address	City	State	Zip Code

Does Patient Reside in a Skilled Nursing Facility or Hospice? If yes, please provide facility name and address.

Does Patient have an Advanced Care Plan, Living Will or Surrogate Decision Maker? If yes, please provide details.

Ethnicity (Cultural Background)	**Primary Language**	**Race** (Genetic Background)
Please circle one:	Please fill in:	Please circle one:
Hispanic/Latino		Alaska Native American-Indian
Not Hispanic/Latino		Asian Black/African American
Decline		Native Hawaiian White Decline

Primary Care Physician	Practice Name/ Telephone Number	Date last seen in office:

Emergency Contact Person	Relationship	Telephone Number

How did you hear about the practice? (circle one)

Internet/Google_____ **Friend/Family**_____ **Doctor Referral (who?)**_____

Insurance Company_____ **Facebook**_____ **Other**_____

Responsible Party (If different from Patient)

Last Name	First Name	Middle Initial	Gender (Circle One) Male Female

Date of Birth	Social Security Number	Primary Phone Number	Secondary Phone Number

Address	City	State	Zip Code

Relationship to Patient

Podiatric Medical History

Describe the foot/ankle issues you wish to be seen for and any relevant history:

Height	Weight	Shoe Size

Patient Medical History

Medication - Please list all Prescriptions, Over the Counter Medications and Supplements

☐ No Medications

Pharmacy	**Phone Number**	**Address**

Allergies - Please Circle and/or List All Allergies:

Penicillin	Codeine	Novocain	Adhesive Tape	Seafood	Other:
Sulfa	Aspirin	Demerol	Local Anesthetics	Iodine	

☐ **No Known Allergies**

Social History - Please Check All That Apply:

☐ **Use of Alcohol:**	☐ **Use of Tobacco:**	☐ **Use of Recreational Drugs:**
If yes, how much/often:	If yes, pack/day:	If yes, type/frequency:
If former user, quit date:	If former user, quit date:	If former user, quit date:

Surgical History - Please list all your past surgeries:

Past Medical History - Please circle all that apply to you or someone in your immediate family

S=Self M=Mother F=Father

Arthritis	S M F	Diabetes	S M F	PVD	S M F
Angina/ Chest Pain	S M F	DVT/Blood Clots	S M F	Psychiatric Care	S M F
Asthma	S M F	GERD	S M F	Radiation Treatment	S M F
Back Problems	S M F	G.I. or Stomach Issues	S M F	Renal Disease	S M F
Blood/Bleeding Issues	S M F	Gout	S M F	Stroke	S M F
Cancer	S M F	High Blood Pressure	S M F	Swelling in Ankles	S M F
Cardiac Issues/Heart Disease	S M F	HIV / AIDS	S M F	Ulcers	S M F
Chemical Dependency	S M F	Liver Issues	S M F	Varicose Veins	S M F
COPD	S M F	Neuropathy	S M F		

Other:

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, and that I have read (or had the opportunity to read if I so choose) and understand the Notice of Privacy Practices and agree to its terms.
Attestation: I do hereby attest that this information is true, accurate, and complete to the best of my knowledge. I understand that any falsification, omission, or concealment of any material fact may subject me to all fees for services and/or liability. I also understand that I am to notify Granite State Podiatry Associates, PA immediately of any changes to the above information and annually upon the office's request.

Print Name of Patient or Legal Authorized Representative	**Signature**	**Relationship to Patient**	**Date**

For Office Use Only

Granite State Podiatry Associates, PA (herein after collectively referred to as "GSP")
Authorization from Patient or Legal Representative

1. **Consent to Treat:** The undersigned consents to any initial or follow-up evaluations, examinations, x-rays, laboratory procedures, other tests, medications, medical treatment, surgery, physical therapy, home instructions, orthotics, other durable medical equipment, photographing and/or videotaping and/or other services rendered to the patient by GSP and its providers. The undersign agrees that it is their responsibility to contact and/or schedule with GSP for any follow up visits, other services, prescriptions and items ordered for the patient. The undersigned also understands that GSP's providers exercise their care with reasonable skill and diligence, but make no guarantee as to the results or cure that will be attained.
2. **Consent to ePrescribe:** I consent to be enrolled in GSP's ePrescribing Program. This program gives the Provider the ability to electronically send accurate, error-free and understandable prescriptions directly to a pharmacy, as well as to access information on the medications I am already taking so as to minimize adverse drug events.
3. **Assignment of Benefits:** I hereby irrevocable assign, transfer and convey to GSP and any practitioners providing care and treatment to me, any and all benefits and all interest and rights (including causes of action, the right to enforce payment and the right to appeal and adverse benefits determination) to which I am entitled under an employee benefit plan sponsored by my employer, all insurance policies, benefits, any third-party reimbursement, or prepaid health care plan for services rendered or products received from GSP.
4. **Authorization to Release Information:** I consent and authorize GSP and its agents to release my health information for the purpose of payment, treatment, and healthcare operations to any of the following: insurance company and its affiliates, any practitioner, support staff or facility involved in my plan of care or transfer of care. In addition I understand that the potential uses and disclosures of my Health Information are detailed in the Privacy notice. The HIPAA Notice of Privacy Practice are available online at www.GraniteStatePodiatry.com Individual copies are also available in the office and posted in the lobby. I have read/had the opportunity to read my HIPAA rights which include GSP's fees for records.
5. **Designation of Authorized Representative:** I designate and appoint GSP (and its agents) as my authorized representative and authorize it to act on my behalf to 1) request and receive a copy of the summary plan description, 2) pursue a benefit claim, 3) appeal an adverse benefit determination, and/or 4) file a legal/equitable action to recover benefits from my employee benefit plan, insurance policy, and any third-party reimbursement or prepaid health care plan. I understand and agree that my authorized representative shall have full authority to act, and receive notices, on my behalf with respect to an initial determination of the claim for health benefits relating to treatment and health care services received by me at GSP, any requests for documents relating to the claim and appeal of an adverse determination of the claim.
6. **Financial Agreement:** I hereby promise to pay for all products received or services rendered to me to the extent I am legally responsible for such payment. According to the language of the physician's insurance contract, I understand that I am responsible for all health insurance co-payments, deductibles, coinsurances, over the counter (OTC) convenience items and noncovered services (NCS) and any other amounts that apply at the time of service or at the preoperative appointment. Regardless of the assignment of benefits, should the insurance misrepresent their coverage or delay payment of a claim greater than 60 days, as the designated responsible party, I am responsible for all monies owed to GSP. I also understand that the insurance policy is a contract between me and the insurance company; therefore the policy holder should contact the insurance carrier first when there are questions regarding explanation of benefits.
7. **Past Due Balances and Collections:** The undersigned hereby understands that any balance being unpaid beyond 60 days from the date of service will receive a 1% interest fee, to be compounded every month there forward. A balance remaining unpaid beyond 90 days may be turned over to a collection agency. The patient will be responsible for all legal expenses and collection fees in addition to the balance of the account.
8. **Referrals:** The undersigned hereby understands that it is the sole responsibility of the patient to obtain a referral if one is required by the insurance company. Said referral is to be presented on or before the date of service. If no referral is presented and the insurance claim is therein denied, it is the responsibility of the patient to pay for the services rendered.
9. **No-Show/Cancellations:** Missed/Cancelled Appointments: A minimum of 48 hours notice is required to cancel or change an appointment. Failure to give proper notice will result in a fee ranging from $25.00 to $200.00, based on the services scheduled to be rendered. A late arrival of more than ten minutes will be considered a missed appointment. An accumulation of three or more missed appointments may result in dismissal from the practice, based on the practitioner's discretion.

The undersigned certifies that he/she has read and understands the foregoing statements 1-8, and is either the patient, or is duly authorized by the patient as the patient's general agent to execute the above and accepts its terms. This document shall remain in force until a written revocation by me is delivered to GSP.

Print Name of Patient Or Legal Authorized Representative	Signature	Relationship to Patient	Date

Revised 2/28/2017