PAUL J. KALIN, D.P.M., F.A.C.F.S.
PODIATRIST
Medical and Surgical Treatment of Foot and Ankle

Welcome to our office

Thank You For Choosing Our Office:
In order to serve you properly, we will need the following information. (Please Print)
All information will be strictly confidential.

Your Name: _____
Last First Middle

Physical/Local Address: _____
Street

Mailing Address: _____
City State Zip

E-mail Address: _____ Social Security # _____

Date of Birth: _____ Age: _____ Home Phone: _____ Cell Phone: _____

Sex: _____ Shoe Size: _____ Weight: _____ Marital Status: _____

Employed By: _____ Bus. Phone: _____

Business Address: _____

Responsible Party: (if other than patient) _____ Relation to Patient: _____

Employer of Responsible Party: _____ Phone: _____

Whom may we thank for referring you? _____

Have you ever seen a Podiatrist before? _____ If yes, name: _____

Who to notify in case of emergency: Name: _____ Phone No.: _____

Relation to Patient: _____

Family Physician: _____ Last Seen: _____

***MEDICARE:** (for Medicare patients only)*

I certify that the information given by me in applying for payment under the Title XVII of the Social Security Act is correct. I authorize all medical records to be released to the Social Security Administration or its intermediaries or carriers and request that payment of authorized benefits be made on my behalf and I assign the benefits payable for physician service to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment for me.

Date: _____ Signature: _____

ASSIGNMENT OF BENEFITS:

I hereby request that my insurance company pay any / all benefits due and payable under the terms of my contract to Paul J. Kalin, D.P.M., F.A.C.F.S. I hereby authorize Paul J. Kalin, D.P.M., F.A.C.F.S. to release such information as may be necessary for the completion of any insurance claim. Any parent or guardian who brings in a minor for treatment is and hereby agrees to be financially responsible for paying the minor's account in full. In the event that an account is referred to an outside collection agency and/or small claims suit, the responsible party will be subject to paying any/all fees associated with the collection processes. I hereby authorize Paul J. Kalin, D.P.M., F.A.C.F.S. to obtain a credit history for such collection purposes.

Date: _____ Signature: _____

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

_____
Date Signature of Patient or Legal Guardian

Patient _____ Date _____

Check (✓) any of the following you have or have had a problem with.

___ Anemia	___ Cancer	___ Hard of Hearing	___ Neuropathy
___ Arthritis	___ Circulatory Problems	___ Heart Problems	___ Rheumatic Fever
___ Asthma	___ Diabetes	___ High Blood Pressure	___ Stroke
___ Bleeding Tendency	___ Epilepsy	___ Liver or Kidney Problems	___ Thyroid
___ Blood Clot (Phlebitis)	___ Gout	___ Mitral Valve Prolapse	___ Ulcer (Stomach)

Please indicate which foot problems you now have or have had in the past.

___ Ankle Pain	___ Corns and Calluses	___ Plantar Fasciitis	___ Plantar Warts
___ Athlete's Foot	___ Cramps or Numbness in Feet or Legs	___ Heel Pain	___ Swelling in Ankles or Feet
___ Bunions	___ Flat Feet	___ Ingrown Toenails	___ Tired Feet

What is your chief foot or ankle complaint? _____

_____

_____

This condition/s has existed for: _____

Previous injuries _____

Previous hospitalizations _____

Previous surgery _____

Are you pregnant, or is there any possibility of being pregnant? YES NO

Are you being treated for any conditions by a physician now? YES NO

Are you taking any medication now? YES NO

If yes, the name of the medication/s. _____

_____

Are you allergic or sensitive to local or general anesthetics, medications, tape, etc.? YES NO

If yes, their name/s. _____

_____

FAMILY HISTORY

Mother: If living, any medical problems? _____

If deceased, cause of death. _____

Father: If living, any medical problems? _____

If deceased, cause of death. _____

Brothers: How many? _____ Any medical problems? _____

Sisters: How many? _____ Any medical problems? _____

SOCIAL HISTORY

Smoking Packs _____ How long? _____ Drinking _____

Sports and Exercise _____

PAUL J. KALIN, DPM
1013A MAR WALT DRIVE
FORT WALTON BEACH, FL 32547
(850) 863-1238

NOTICE OF PRIVACY PRACTICES

Effective Date: 4-14-03

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

Each time you visit a physician, hospital, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination, and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. Your record represents Protected Health Information.

We are *committed* to treating and using Protected Health Information about you responsibly. This Notice describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your Protected Health Information. This Notice applies to all Protected Health Information, as defined by federal regulations, that is generated by our office.

THE FOLLOWING CATEGORIES DESCRIBE EXAMPLES OF THE WAY WE USE AND DISCLOSE HEALTH INFORMATION

For Treatment: We may use your health information to provide you with medical treatment or services. We may disclose medical information about you to other health professionals who contribute to your care (such as doctors, nurses, technicians, or other personnel who are involved in taking care of you).

For Payment: We may use and disclose medical information about your treatment and services to bill and collect payment from you, your insurance company, or a third party payer. For example, we may need to give your insurance company information about your treatment so they will pay us for the treatment. We may also tell your health plan about treatment you are going to receive to determine whether your plan will cover it.

For Healthcare Operations (Business Associates): There are some services provided in our office through contracts with business associates. Examples include transcription of your dictated health information, a copy service making copies of your health records, and off-site storage of medical records. When services such as these are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do. To protect your health information, however, we require the business associates to appropriately safeguard your information.

For Research: We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research.

Communication with Family or Friend: We may release medical information about you to a friend or family member who is involved in your medical care or who helps pay for your care.

We may also use and disclose medical information to/for the following:

* to remind you that you have an appointment
* to assess your satisfaction with our services
* Food and Drug Administration
* Organ and Tissue Donation Organizations
* Health Oversight Agencies
* Funeral Directors, Coroners, Medical Directors
* to notify or assist in notifying a disaster relief entity so that your family can be notified about your health status
* Public Health Authorities
* Workers Compensation Agents
* Legal Authorities
* Military Command Authorities
* National Security & Intelligence Agencies
* Proactive Services for the President
* for law enforcement purposes as required by law or in response to subpoena

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of this office, you have the right to:

Inspect and Copy: You have the right to view your Protected Health Information, obtain a copy of the information, or both. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. We are allowed to charge you for these copies.

Amend: If you feel that medical information is incorrect or incomplete, you may ask us to amend (not change) the information. We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.

An Accounting of Disclosures: You have the right to request a list of certain disclosures we make of your medical information for purposes other than treatment, payment, or healthcare operations.

Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you. We are not required to agree to your request. If we do agree to the requested restriction, it will be honored with the exception of permitted disclosures, including emergency treatment, public health authority, Food & Drug Administration, work-related injury, and OSHA compliance.

Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location (for example, at work, or by U.S. Mail). We will grant this request only if it is submitted in writing. We reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response.

A Paper Copy of This Notice: You may ask us to give you a copy of this Notice.

If you have any questions about this Notice, please contact our Privacy Officer at (850) 863-1238

We reserve the right to change this notice and to make the new provisions effective for all Protected Health Information we maintain from the first date of your health record. The current notice will be posted and include this effective date.

If you believe your privacy rights have been violated, you may file a complaint by contacting the Privacy Officer in our office at 1013 Mar Walt Drive, Suite A, Fort Walton Beach, FL 32547. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You may revoke your permission to use or disclose medical information about you, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Acknowledgment of Receipt of Notice of Privacy Practices, Office of Paul Kalin, D.P.M., P.A.

By signing this document, I acknowledge that I have read a copy of this office's Notice of Privacy Practices.

_____	_____	_____
PRINT Name	Signature	Date

Office Use Only:
Date Acknowledgment received _____ by _____
OR reason Acknowledgment was not obtained _____

Source: ECHA

DR. PAUL J. KALIN'S FINANCIAL POLICY

We are committed to providing you with the best possible podiatric care. If you have medical insurance, we would like to help you receive your maximum allowable benefits. In order to achieve the goals, we need your assistance and your understanding of our policy.

Payments for office services are due at the time services are rendered, unless payment arrangements have been approved in advance by the office secretary. We do accept cash, checks, Master Card and Visa. If services are not covered in full by your insurance company, you will receive a statement for the balance. Prompt payment will be greatly appreciated. Please provide our office with all your insurance information, so that claims can be expedited immediately.

Your insurance policy is a contract between you, your employer, and the insurance company. Our office does not know what type of policy you have purchased and we are not party to that contract. READ YOUR POLICY!!
Know what it covers and what it does not cover. Keep their phone number available so that you may call with questions.

We must emphasize, that as medical care providers our relationship is with you and not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may effect timely payment of your account. If such problems arise, we encourage you to contact us promptly for assistance in the management of your account.

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I understand that my policy may not allow benefits for non-covered services. I realize that I will be responsible for the payment of all non-covered services and deductibles. I give permission to release my medical data to my insurance company for the review or payment of all claims. I also give permission for my insurance company to review my medical records during a chart review at this particular office. I understand if my account becomes delinquent, I may be responsible for outside agency collection fees.

Any patient payment made by Credit Card which results in a refund, will be subject to a 2% charge of total refund amount. Effective 7/1/2007

_____ _____

Signature Date