Patient Name: ______________________________

Street Address: ______________________________

City& State: ______________________ **Zip Code:** __________

Mailing Address if Different: ______________________________

Home#: __________ **Cell#:** __________ **Work#:** __________

Social Security#: __________ **Date of Birth:** ______ **Sex: Male** ______ **Female:** ______

Married: ______ **Single:** ______ **Divorced:** ______ **Widowed:** ______ **Partner:** ______

Race (required by state law): American Indian/or Alaska Native__ White__ Black/African American__ Native Hawaiian or Pacific Islander__ Other______

Ethnicity (required by state law): American__ Hispanic or Latino__ Asian__ Other______

Email: ______________________________

Primary Care Physician: ______________________ **Phone:** __________

Referring Physician: ______________________ **Phone:** __________

Primary Insurance (IN ADDITION to a copy of the insurance card)

Insurance Name: ______________________ If necessary did you bring your referral: Yes/No/NA

Insurance Phone # for eligibility: __________ Claims address: ______________________

Primary Insured's Full Name: ______________ Date of Birth: ______ Gender: M/F SS #: __________

Primary Insured's home address: ______________________________

Secondary Insurance

Insurance Name: ______________________ If necessary did you bring your referral: Yes/No/NA

Insurance Phone # for eligibility: __________ Claims address: ______________________

Primary Insured's Full Name: ______________ Date of Birth: ______ Gender: M/F SS #: __________

Primary Insured's home address: ______________________________

Medical History

Weight: ________ Height: ________ Shoe Size: ________

Family Doctor: ______________________ Last Seen: __________

Related to: Work: Yes/ No/ Auto: Yes/ No/ Accident: Yes/ No/ Illness: Yes/ No/ Are you pregnant? Yes/ No/ Maybe

Smoking: Packs/day: _____Years: _____ Past Smoker: Packs/day _____Years: _____Employment requires you to: Sit/Stand/Walk/Not Employed

Caffeine: Quantity ________ Alcohol: None/Rarely/Moderately/Daily/Quit Recreational Drug Use: None/Rarely/Moderately/Daily/Quit

List Athletic activities: ______________________ Amount per day/week: __________

Describe the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints. ______________________________

____

____

How long have you had pain? ___ Weeks ___ Months ___ Years - On a scale of 1-10 how bad is the pain? 1 2 3 4 5 6 7 8 9 10

Minimal ... Severe

History Of : Do you have or have you ever been treated for: (circled items to indicate YES)

AIDS/HIV	Bunions	Fibromyalgia	Liver Disease	Sinus Problems
Anemia	Chest Pain	Flat Feet	Low Blood Pressure	Special Diet
Angina	Chemical Dependency	Gout	Lung Disease	Sports Related Injuries
Ankle Pain	Cancer	Headaches	Nervous Problems	Stomach Ulcers
Arthritis	Circulatory Problems	Heart Disease	Osteoporosis	Stroke
Artificial Heart Valves	Corns and Calluses	Heel Pain	Phlebitis	Swelling in Ankles/Feet
Artificial Joints	Depression	Hemophilia	Plantar Warts	Tired Feet
Asthma	Diabetes	Hepatitis	Polio	Thyroid Disorder
Athlete's Foot	Ear Problems	High Blood Pressure	Radiation Treatment	Tuberculosis
Back Problems	Eptlepsy	Ingrown Toenails	Rash	Varicose Veins
Bleeding Disorders	Eye Problems	Kidney Problems	Rheumatic Fever	Venereal Disease
Blood Clots	Fainting	Leg Cramps	Seizure Disorders	Weight Loss, unexplained

Family History

List Relationship to you of family members who have had: Foot Problems: __________ Arthritis: __________ Cancer: __________

Diabetes: ____________ Heart Problems: ____________ High Blood Pressure: ____________ Other: ______________

Past Surgical Procedures/other Hospitalization:

Surgical History & Date	Hospitalization History & Date
]	[
]	[
]	[
]	[
]	[
]	[

Have you previously had a **Blood Transfusions**: Yes/ No   Have you previously been exposed to **Hepatitis**: Yes/ No

Medications (please attach additional list if they apply)

Include prescriptions, over-the-counter medications and vitamins: ____

____

____

____

Pharmacy Name: __________________________ Location: __________________________ Phone #:__________________

Allergies

Are you allergic to any of the following: (circle what applies and note any reactions) or CIRCLE: **No Known Allergies**

Adhesive/Tape: __________ Anticoagulants: ____________ Aspirin:____________ Codeine: ______________ Demerol: __________

Iodine: _______ Local Anesthetics: _________ Novocain: __________ Penicillin: ____________ Seafood: ________ Sulfa: __________

Other: ____

Privacy Information

Can we leave messages at any of the above listed numbers? Home: Yes/No Work: Yes/No Cell: Yes/No

X Emergency Contact Name: ______________________ Relationship: ____________ Phone: ______________________________

Names of family/friends who can pick up your records and/ medical supplies: ______________________________

Names of family/friends that have parents' authorization to bring in the Minor child when guardian is absent:

____

Privacy Authorization for Use or Disclosure of Protected Health Information (PHI)
Required by the Health Insurance Portability and Accountability Act, (HIPAA) 45 C.F.R.Parts 160 and 164

I authorize Michael A, Garvin, DPM, PA to use and disclose my protected health information including my complete health record (which may include records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse). This authorization shall be in force and effect until I revoke this authorization, in writing. This medical information may be used by Michael A, Garvin, DPM, PA for medical treatment or consultation, billing or claims payment, or other purposes as I may direct. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

NOTICE OF PRIVACY ACT
I have read a copy of Michael A, Garvin, DPM, PA. Notice of Patient Privacy Practices. X______________________________ (Signature)

ASSIGNMENT AND RELEASE
I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Michael A, Garvin, DPM, PA. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of my benefits. I authorize the use of this signature on all insurance claim submissions X______________________________ (Signature)

MEDICARE AND INSURANCE AUTHORIZATON
I request that payment of authorized Medicare or insurance benefits be made to me on my behalf to Michael A, Garvin, DPM, PA. for any service furnished to me by that physician. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agent's; the information needed to determine these benefits or the benefits payable for any related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductibles, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare Carrier. X______________________________ (Signature)

Consent

I certify that the above and attached information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary to the diagnosis and/or treatment of me or my child's condition. As a representative of myself or as a guardian, I give authorization for the above listed patient to receive medical and/or surgical care and treatment from Michael A, Garvin, DPM, PA.

Print Patient's Name: ____

Representative's Signature: X______________________________________ Date: ______________

Our Financial Policy

We are committed to provide you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy , or your responsibilities.

- All patients must complete our Patient Information Form **BEFORE** being seen by the doctor.
- Full payment/co-pays are due at the time of service.

MINOR PATIENTS

- All minor patients must be accompanied by his/her parent or legal guardian and are responsible for payment at the time of service.

INSURANCE

- If you have insurance, we will help you receive maximum benefit payments.
- Insurance is a contract between you and your carriers. We are not a party to this contract in most cases. We will infirm you if we are contracted provider with your plan and handle those claims accordingly. We file claims, as a courtesy, but you will be responsible for any portions not paid.
- Please verify with your insurance provider that our office is contracted with them.

MISSED APPOINTMENTS

- Unless you cancel your appointment with the office at least 24 hours in advance, it is our policy to charge for repeated missed appointments at the rate of $35.00, which is not covered by your insurance.
- Repeated missed appointment may result in a discharge from the practice.

RETURNED CHECKS

- All checks returned not honored by your bank will be subject to a $30.00 handling fee. This fee plus the amount of the check and bank charges must be paid in CASH within 7 days.

THANK YOU FOR UNDERSTANDING OUR POLICY

Signature:____ **Date:**__________

MICHAEL A. GARVIN, D.P.M., P.A.

MICHAEL A. GARVIN, D.P.M., F.A.C.F.S.
BOARD CERTIFIED
DIPLOMATE AMERICAN BOARD OF PODIATRIC SURGERY

E-Prescribing PBM Consent Form

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care.

Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an e-Prescribe program.

These include:

- **Formulary and benefit transactions**—Gives the prescriber information about which drugs are covered by the drug events.
- **Medication history transactions**—Provides the physician with information about medications the patient is already taking prescribed by any provider, to minimize the number of adverse drug events.

By signing this consent form you are agreeing that **Michael A. Garvin** can request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for treatment purposes.

Print Patient Name: ____

Date of Birth: ____/ ____/ _____

Signature of Patient: (or representative) ________________________________

Date: _____/ ____/ ______

Relationship if other than patient: ___________________________________

Michael A. Garvin, DPM, PA
1791 SE Port St. Lucie Blvd
Port Saint Lucie, FL 34952
(772) 335-7171
(772) 335-2119 FAX

Medical Records Release Form

Patient Name: ______________________________ **Date of Birth:** ____________

Person Requesting records and relationship: ______________________________

Home Phone: ____________________ **Daytime Phone:** ______________________

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

HIV/AIDS: I DO ___ DO NOT ___ consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. **Initial:** __________ **Date:** ____________________

Limitations on the information you may release subject to this Release Form are as follows:

____

____

Release my protected health information to the following person(s)/entity:

Name: ____

Street: ____

City: ______________________ **State:** ____________ **Zip:** ____________

I do _____ do NOT _____ give permission for these records to be faxed to the above entity.

The reasons or purposes for this release of information are as follows:

____

____

____ ____________________

Patient Signature [or parent, guardian or legal representative] **Date**

Do I Need a Test for PAD?

Peripheral Arterial Disease (PAD) is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain, or kidneys, become narrowed or clogged. It affects over 8 million Americans, most over the age of 50. It may result in leg discomfort with walking, poor healing of leg sores/ulcers, difficult to control blood pressure, or symptoms of stroke. People with PAD are at significantly increased risk for stroke and heart attack. Answers to these questions will determine if you are at risk for PAD and if a vascular exam will help us better assess your vascular health status.

Name:______________________________ Date:__________

Circle "Yes" or "No":

				Test for PAD
1.	Do you have foot, calf, buttock, hip or thigh discomfort (aching, fatigue, tingling, cramping or pain) when you walk which is relieved by rest?	Yes	No	☐
2.	Do you experience any pain at rest in your lower leg(s) or feet?	Yes	No	☐
3.	Do you experience foot or toe pain that often disturbs your sleep?	Yes	No	☐
4.	Are your toes or feet pale, discolored, or bluish?	Yes	No	☐
5.	Do you have skin wounds or ulcers on your feet or toes that are slow to heal (8-12 weeks)?	Yes	No	☐
6.	Has your doctor ever told you that you have diminished or absent pedal (foot) pulses?	Yes	No	☐
7.	Have you suffered a severe injury to the leg(s) or feet?	Yes	No	☐
8.	Do you have an infection of the leg(s) or feet that may be gangrenous (black skin tissue)?	Yes	No	☐

Patient Signature:______________________________

Physician Signature:______________________________ Date :________________

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