# MICHAEL A GARVIN D.P.M. P.A.

Patient Name: _____

Address: _____

City & State: _____

Mailing Address: _____

Home #: _____ Work #: _____ Cell #: _____

Contract By: Phone call: ____ E-Mail: ___ Mail: ___ Speak with: Spouse: ___ Family: ___ Voice mail: ___

Social Security #: _____ Date of Birth: _____ Sex: F_____ M_____

Married: _____ Single: _____ Divorced: _____ Widowed: _____

Race: White/Caucasian ___ American Indian/Alaska Native ___ Black/African American ___ Native Hawaiian/Pacific Islander ___ Asian ___

Ethnicity: Hispanic/Latino ___ Non-Hispanic/Latino ___

E-Mail: _____

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

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

## Medical History

Weight: _____ Height: _____ Shoe size: _____ Smoking: Heavy ___ Light ___ Former ___ Never ___

Related to: Work: Yes___ No ___ Auto: Yes ___ No ___ Accident: Yes ___ No ___ Illness: Yes___ No ___

Are you pregnant? Y ___ N ___ Maybe ___

Caffeine quantity: _____ Coffee/Tea/Soda (Circle one)

Alcohol: None/Rarely/Moderately/Daily/Quit (circle one)

Recreational Drug Use: None/Rarely/Moderately/Daily/Quit (Circle one)

List athletic activities: _____ Amount per day/week: _____

Describe the reason for your visit today: _____

_____

How long have you had pain? Weeks ___ Months ___ Years ___

## 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 | Epilepsy | 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

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. _____ (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._____ (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._____ (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: _____ 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
Phone: 772-335-7171
Fax: 772-335-2119

# 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**

# 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:_____