Melissa C. Verde, DPM, PA

1385 W. State Rd. 434 suite 103 Longwood, FL 32750
Phone 407-332-6700 fax 407-332-6226
www.Verdepodiatry.com verdepod@gmail.com

DATE: _____ PATIENT ACCOUNT: _____

PATIENT DEMOGRAPHIC INFORMATION

FIRST NAME: _____ MI: _____ LAST NAME: _____

DOB: _____ AGE: _____ SEX: M / F RACE: _____ ETHNICITY: _____

PRIMARY LANGAUGE: _____ OTHER LANGUAGE(S): _____

SSN #: _____ MARITAL STATUS: SINGLE / MARRIED / DIVORCED / OTHER

SPOUSE: _____

PATIENT CONTACT INFORMATION

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

CELL PHONE: _____ HOME PHONE: _____

EMAIL: _____ PREFERRED CONTACT METHOD: CALL / EMAIL / TEXT

EMERGENCY CONTACT: _____ RELATIONSHIP: _____
PHONE: _____

LEGAL GUARDIAN/PRIMARY CAREGIVER: _____ RELATIONSHIP: _____
PHONE: _____ COMMENTS: _____

IF PATIENT UNDER THE AGE OF 18, I hereby consent for my child _____ to have evaluation and treatment by Dr. Melissa C. Verde and her staff.
PATIENT NAME

LEGAL GUARDIAN SIGNATURE: _____ PRINTED NAME: _____

EMPLOYMENT INFORMATION

☐ EMPLOYED ☐ UNEMPLOYED ☐ FULL-TIME STUDENT ☐ PART-TIME STUDENT ☐ DISABLED ☐ OTHER

EMPLOYER: _____ WORK PHONE: _____EXT: _____
DEPARTMENT: _____ OCCUPATION: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ ID #: _____ GROUP #: _____
POLICY HOLDER NAME: _____ HOLDER DOB: _____ RELATIONSHIP: _____

SECONDARY INSURANCE: _____ ID #: _____ GROUP #: _____
POLICY HOLDER NAME: _____ HOLDER DOB: _____ RELATIONSHIP: _____

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PATIENT NAME: _____ DOB: _____

AGE: _____ HEIGHT: _____FT _____IN WEIGHT: _____ SHOE SIZE: _____

REASON FOR TODAY'S VISIT: _____

PREVIOUS TREATMENT FOR THIS PROBLEM? (PLEASE EXPLAIN): _____

_____

ALLERGIES: YES / NO
IF YES, PLEASE SPECIFY: _____

CURRENT MEDICATIONS (INCLUDE NAME, DOSE, AND FREQUENCY): _____

_____

_____

_____

_____

_____

PREFERRED PHARMACY:

NAME: _____ LOCATION: _____ PHONE: _____
NAME: _____ LOCATION: _____ PHONE: _____

CONSENT TO E-PRESCIBING

My signature certifies that I authorize Dr. Melissa C. Verde to electronically prescribe and to access my medication history.

Patient name: _____ Patient signature: _____

PRIMARY CARE PHYSICIAN: _____ LAST VISIT: _____
SPECIALIST: _____ LAST VISIT: _____
SPECIALIST: _____ LAST VISIT: _____

PAST/CURRENT MEDICAL CONDITION

- ☐ RECENT DECLINE IN HEALTH
- ☐ MIGRAINE/HEADACHES
- ☐ EYE PROBLEMS
- ☐ HEARING PROBLEMS
- ☐ ASTHMA/BRONCHITIS/COPD
- ☐ SLEEP APNEA
- ☐ OTHER BREATHING PROBLEMS
- ☐ HEART MURMUR
- ☐ HEART ATTACK
- ☐ HEART PROBLEMS
- ☐ HIGH/LOW BLOOD PRESSURE
- ☐ HIGH CHOLESTEROL
- ☐ HEPATITIS
- ☐ LIVER DISORDERS
- ☐ GASTRIC REFLUX
- ☐ STOMACH/DIGESTIVE DISORDRES
- ☐ AMPUATION
- ☐ ARTHRITIS
- ☐ BACK PROBLEMS
- ☐ GOUT
- ☐ FIBROMYALGIA
- ☐ PARALYSIS/MUSCLE WEAKNESS
- ☐ POOR BALANCE
- ☐ PREVIOUS FRACTURE
- ☐ DEMENTIA
- ☐ DEPRESSION/ANXIETY
- ☐ EPILEPSY/SEIZURES
- ☐ STROKE
- ☐ NUMBNESS OF FEET
- ☐ CANCER
- ☐ SCARRING TENDENCIES
- ☐ SKIN DISORDERS
- ☐ SLOW HEALING WOUNDS
- ☐ DIABETES
- ☐ THYROID DISEASE
- ☐ ANEMIA
- ☐ POOR CIRCULATION
- ☐ HIV
- ☐ BLOOD THINNERS
- ☐ KIDNEY DISORDERS
- ☐ AUTOIMMUNE DISORDERS
- ☐ OTHER

PLEASE EXPLAIN: _____

_____

_____

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PATIENT NAME: _____ DOB: _____

MEDICAL FAMILY HISTORY (i.e HIGH BLOOD PRESSURE, CANCER, STROKE, ETC.)

MATERNAL GRANDPARENTS: _____ PATERNAL GRANDPARENTS: _____
MOTHER: _____ FATHER: _____
SIBLINGS: _____ CHILDREN: _____
OTHER: _____

SURGICAL HISTORY (INCLUDE PROCEDURE NAME AND DATE): _____
_____
_____
_____
_____
_____
_____

COMPLICATIONS WITH ANESTHESIA? YES / NO
COMPLICATIONS WITH HEALING? YES / NO
CURRENT PREGNANCY OR CURRENTLY BREAST-FEEDING: YES / NO

IMMUNIZATION HISTORY:

RECENT FLU SHOT? YES / NO DATE OF LAST IMMUNIZATION: _____
RECENT COVID IMMUNIZATION? YES / NO DATE OF LAST IMMUNIZATION: _____
OTHER RECENT IMMUNIZATIONS: _____
_____

SOCIAL HISTORY:

ALCOHOL? YES / NO HOW OFTEN: _____
TOBACCO? YES / NO HOW OFTEN: _____
RECREATIONAL DRUG USE? YES / NO HOW OFTEN: _____
HISTORY OF DRUG ADDICTION? YES / NO
EXERCISE REGULARLY? YES / NO
IF YES, WHAT EXERCISE: _____

PATIENT PHOTO RELEASE CONSENT:

By signing below, the patient understands that images taken may be used for different purposes indicated hereunder. By consenting to the release of images, you agree you will not receive any form of compensation. You likewise understand that your name will not be included in the images. It is still possible someone may recognize you. Your refusal to consent to the release of photographs will not, in any way, affect the medical care you will receive. You may rescind your authorization to the release of photographs by writing us a request.

I authorize the use of photographs or videos for the following purposes:

- ☐ Educational purposes such as medical procedure demonstration
- ☐ Social media and online publishing sites

Patient name: _____ Patient signature: _____ Date: _____

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HIPAA Consent Form

This HIPAA Consent Form is a legally binding agreement between Dr. Melissa C. Verde, DPM and the patient named below. This Form outlines the Patient's consent to the Provider's use and disclosure of the Patient's Protected Health Information (PHI) as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Consent to Use and Disclosure of PHI
The Patient hereby consents to the Provider's use and disclosure of the Patient's PHI for the following purposes:

- Treatment: The Provider may use and disclose the Patient's PHI to provide treatment, diagnosis, or health care services to the Patient.
- Payment: The Provider may use and disclose the Patient's PHI to bill and collect payment for health care services rendered to the Patient.
- Healthcare Operations: The Provider may use and disclose the Patient's PHI for healthcare operations, such as quality assurance, quality improvement, and case management.
- Other Purposes: The Provider may use and disclose the Patient's PHI for other purposes as permitted or required by law, such as public health reporting, law enforcement, and research.

Patient Rights
The Patient has the following rights under HIPAA:

- Right to Access: The Patient has the right to access and inspect their PHI.
- Right to Request Amendment: The Patient has the right to request that the Provider amend their PHI.
- Right to Receive an Accounting of Disclosures: The Patient has the right to receive an accounting of disclosures of their PHI.
- Right to Request Restrictions: The Patient has the right to request that the Provider restrict the use and disclosure of their PHI.
- Right to Revoke Consent: The Patient has the right to revoke this consent in writing at any time.

Patient Signature: _____ Date: _____

Patient Printed Name:_____

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Patient Name: _____ DOB: _____

Medical Records Release Authorization

Information to be Released:
I hereby authorize the release of my medical records as follows (check all that apply):

- ☐ Entire Medical Record
- ☐ History and Physical Exam
- ☐ Lab Reports
- ☐ X-ray/Imaging Results
- ☐ Billing Information
- ☐ Prescription/Medications
- ☐ Other (Please specify): _____

Dates of Service Requested:
Please release records for the period from: _____ to _____.

Revocation of Authorization:
I understand that I may revoke this authorization at any time by notifying the healthcare provider in writing, except to the extent that action has already been taken based on this authorization. A revocation will not affect any previous disclosures made based on this authorization.

Acknowledgments:

- I understand that I am entitled to a copy of this authorization form after signing.
- I understand that the release of my medical records may include information related to drug and alcohol abuse, mental health, HIV/AIDS status, and other sensitive information, and I consent to the release of such information as part of my records.
- I understand that this authorization is voluntary and that I am not required to sign it in order to receive treatment.

Patient signature: _____ Date: _____

Patient name: _____ Date: _____

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Financial Policy

I understand and agree that all fees are due at the time of service, unless previous arrangements have been made. I authorize Dr. Melissa C. Verde to release any medical information or records concerning diagnosis and treatment when requested for the use in determining a claim or payment to any third party such as insurance companies or governmental agencies.

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to Dr. Melissa C. Verde.

As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.

Signature (Patient/Responsible party):_____Date:_____
Relationship:_____Date:_____

- $50 fee for paperwork completed in-office, including disability, FMLA, etc.
- $50 non-sufficient funds fee will be charged for ALL RETURNED CHECKS.
- $50 missed appointment fee will be charged for missed/cancelled appointments without 24 hours' notice to us.
- A fee of 40% of the total outstanding balance will be charged for ALL DELIQUENT ACCOUNTS.

I have read and understand the above statements and accept financial responsibility for these additional tests.

Signature (Patient/Responsible party):_____Date:_____
Relationship:_____Date:_____

Melissa C. Verde, D.P.M.
1385 W. State Road 434, Suite 103
Longwood, Florida 32750

A. Patient Name: **B. Insurance Name:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If insurance doesn't pay for services or supplies below, you may have to pay.
Some insurance companies do not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect insurance may not pay for the **service or supplies** below.

C.	D. Reason Insurance May Not Pay:	E. Estimated Cost
	• Copays and deductibles • Non-covered office products • Insurance claim denials • Patient responsibilities • Durable medical equipment	

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **services or supplies** listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but insurance cannot require us to do this.

F. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **services or supplies** listed above. You may ask to be paid now, but I also want insurance billed for an official decision on payment, which is sent to me on an insurance Summary Notice. I understand that if insurance doesn't pay, I am responsible for payment, but I can appeal to my insurance by following the directions on the ISN**.** If my insurance does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **services or supplies** listed above, but do not bill my insurance. You may ask to be paid now as I am responsible for payment. I cannot appeal if my insurance is not billed.

☐ **OPTION 3.** I don't want the **services or supplies** listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if my insurance would pay.

G. Additional Information:

This notice gives our opinion, not an official insurance decision. If you have other questions on this notice or insurance billing, **call your insurance company.**
Signing below means that you have received and understand this notice. You may ask to receive a copy.

H. Signature:	I. Date: