Welcome to Taub Podiatry

The office of Jessica Taub, DPM & Joseph Taub, DPM
3515 SE Willoughby Blvd, Stuart, FL (772) 283-3800 Fax: (772) 283-7046

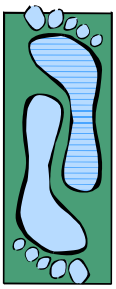
Thank your for choosing our office for your foot and ankle care. We strive to provide you with efficient and courteous attention at each of your visits. We respect your time and make every effort to see you at your appointed time. It is our hope that the following information will answer any questions that you may have about our office, if you have any questions, please feel free to ask.

Office Hours: Hours are by appointment. Appointments are available Monday through Thursday. Urgent appointments are available. We do not have an answering service. Voicemail is provided for your convenience; you may leave a message for a return call. If you have an after-hours emergency, please call 911 or go to the nearest emergency room.

Co-pays, Deductibles, and Billing: All co-pays and deductibles are due at the time of service. We also accept major credit cards.

Office Procedures: Our office utilizes government certified electronic medical record software. Most of our charting is done in the exam room. The appointment time you are given allows for 15 minutes of charting before you see the doctor. **Please limit your initial visit to one primary complaint to receive the most efficient and comprehensive care.**

We look forward to getting to know you and helping you improve and maintain your health



Jessica Taub, DPM & Joe Taub, DPM

Please have your insurance cards available and complete these forms in their entirety.

Patient Information

Patient Name: _____ Preferred Name: _____

Gender: [] Male [] Female Date of Birth: _____/_____/_____

Address: _____

_____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

How would you like to receive appointment reminders? [ ] phone [ ] text [ ] email

How did you hear about us? _____ Occupation: _____

Email Address: _____

Primary Care Physician: _____ Date Last Seen: _____/_____/_____

Language: _____ Race: [] Amer.Indian [] Asian [] Black/Afr-Am [] White Ethnicity: [] Hispanic/Latino [] Other Marital Status: [] Single [] Married [] Divorced [] Widowed {} Other

Pharmacy: _____

Contact Information

In case of emergency who should we contact?

Name: _____Relationship:_____

Work #:_____Home #: _____Cell #: _____

Address: _____

Guarantor information (SKIP THIS SECTION IF NOT APPLICABLE)

Who is responsible for this account? [ ] Same as patient

Name:_____Relationship:_____

DOB:_____

Address:_____

Employer:_____

Work#:_____Home#:_____Cell#:_____

Insurance Information

Please present your insurance cards to the front desk.

Signature: _____ Date: _____

Medication Allergies:_____

Medications: (Please print names, mg, and directions from your medicine bottles or attach list):

_____

_____

Family History Do/Did either of your parents and/or immediate family have any of the following?

[ ] Blood Clot [ ] Cancer [ ] Diabetes [ ]Heart Disease

[ ] High blood pressure [ ] Rheumatoid arthritis [ ]Stroke [ ] Thyroid disease [ ] Other:

_____

Patient Medical History

Do you have or have you ever been treated for any of the following conditions?

[ ] Anxiety
[ ] Arthritis
[ ] Asthma
[ ] Atrial fibrillation
[ ] Back Problem
[ ] Bipolar disorder
[ ] Blood Clot
[ ] COPD
[ ] Cancer _____
[ ] Cardiac pacemaker
[ ] Cholesterol High
[ ] Chronic liver disease NOS
[ ] Chronic neck pain
[ ] Depression
[ ] Diabetes
[ ] Fibromyalgia
[ ] GERD
[ ] Gout
[ ] HIV/AIDS
[ ] Headache
[ ] Heart disease
[ ] Hepatitis
[ ] High blood pressure
[ ] Kidney Disease
[ ] MS-Multiple Sclerosis
[ ] Neuropathy
[ ] Osteoporosis
[ ] Parkinson's disease
[ ] Post-traumatic Stress disorder
[ ] Psoriasis NOS
[ ] Raynaud's Disease
[ ] Rheumatoid Arthritis
[ ] Schizophrenia
[ ] Seizure disorder
[ ] Sleep Apnea
[ ] Stroke
[ ] Thyroid disease
[ ] Ulcer
[ ] Other:_____

Social History

Do you smoke? [ ] No; Quit Date: _____ [ ] Yes; Cigarette [ ] Cigar [ ] Pipe [ ] How many years?/Amount: _____

Do you drink alcohol? [ ] No [ ] Yes If yes, what type? Beer [ ] Wine [ ] Hard Liquor [ ]

Frequency: Socially [ ] Occasionally [ ] Light [ ] Heavy3+drinks/day [ ]

Do you use "recreational" drugs?: [ ] No [ ] Yes Type and Frequency: _____

Surgical History Please list all major surgeries.

_____

_____

Patient/Guardian Signature: _____ Date: _____

Patient Name Printed: _____Height:_____ Weight:_____

Please Tell Us About Your Foot/Ankle Problem

Name: _____

What is your complaint? _____

_____

Where is your pain/problem located? [ ] Toe [ ] Heel [ ] Ankle [ ] Ball of foot [ ] Arch [ ] Left [ ] Right [ ] Both

Other: _____

How long have you had this complaint/condition? _____

_____

Did the problem result from a specific injury? [ ] No [ ] Yes Please describe: _____

_____

Please rate your pain on a scale of 1-10 (10 being the most painful):

At rest: 1 2 3 4 5 6 7 8 9 10 At its worst: 1 2 3 4 5 6 7 8 9 10

Is the pain: [ ] Constant [ ] Occasional [ ] Sharp [ ] Dull [ ] Aching [ ] Stabbing [ ] Throbbing [ ] Radiating/Traveling Other:

_____

What symptoms are you experiencing?

[ ] Locking [ ] Numbness [ ] Giving Away [ ] Popping [ ] Tingling [ ] Burning [ ] Grinding [ ] Swelling [ ] Bruising

Other: _____

Does anything make your symptoms feel better? _____ Does anything make your symptoms feel worse? _____

Have you seen another physician for this problem? _____ Doctor's Name: _____

What treatments have you tried? [ ] Nothing [ ] Physical therapy [ ] injections [ ] Bracing [ ] Icing [ ] Compression

[ ] Medications [ ] Shoe change [ ] Arch support [ ] Massage [ ] Other_____

Have you had any of the following tests/studies for this condition/complaint? [ ] Xrays [ ] Blood test [ ] MRI [ ] CT scan

If so, where were the tests performed? _____

Signature: _____ Date: _____

Thank you for completing these forms. We appreciate your efforts in filling them out completely.

Please sign the HIPAA form and ePrescribing consent as these are a federal requirement to protect all disclosure of your health information.

If you would like a copy of the "Notice of Privacy Practices" please let us know, there is a copy in our lobby for you to review.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT,
CONSENT TO PHOTOGRAPH, VIDEO AND/OR OBTAIN DIGITAL IMAGES,
And CONSENT TO SEND PRESCRIPTIONS ELECTRONICALLY

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been given an opportunity to read the Notice of Privacy Practices, which is kept in the patient lobby and contains a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that Taub Podiatry will retain ownership rights to these photographs, videotapes, digital, or other images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in the policy of Dr. Taub. Images that identify me will be released and/or used outside the institution only upon written authorization from me or my legal representative.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I give permission to Taub Podiatry to contact me by phone and it is ok to leave detailed message related to my medical condition.

I authorize Taub Podiatry to discuss my medical history with the following people:

[ ] spouse
[ ] children: _____
[ ] other: _____

I agree that Taub Podiatry may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payers for treatment purposes and consent to the use of electronic prescribing as federally mandated.

_____

Responsible Party's Signature Date

Taub Podiatry Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

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

· Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check.

· Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.

· We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/coinsurance/deductible.

· If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.

· All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

· You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

· For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.

· There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.

· Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.

· There is a service fee of $35.00 for all returned checks. Your insurance company does not cover this fee.

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party Date: _____