DR.G'S FOOT Center

Sandra R. Gotman, D.P.M

Diplomate American Board of Podiatric Orthopedics
Diplomate American Board of Podiatric Surgery
11760 Bird Road Suite616 Miami, FL 33175
Phone: 305- 229- 9595
Fax: 305- 229 -9596

Name/Nombre:_____ Gender/Sexo: ___ M ___ F

Date of Birth/ Fecha de Nacimiento:_____ Social Security #:_____

Address/Dirección: _____ State: _____ Zip code:_____

E-mail/Correo electrónico: _____

Home Phone Number/Número de teléfono de casa: _____

Cell Phone Number/Numero de celular: _____

Work Phone Number/Número de Teléfono del Trabajo:_____

Primary Insurance Name/Seguro Medico Primario: _____

Member ID Number/ Numero de Miembro:_____

Secondary Insurance Name/ Nombre del Segundo Seguro:_____

Member ID Number/ Numero de Miembro:_____

Marital Status/ Estado Civil:

____Single/Soltero ____Married/Casado _____Divorced/Divorciado
___Widowed/ Viuda _____Partner/Compañero _____Legally Separated/Legal-Mente Separados

Ethnicity/Etnicidad: _____Hispanic or Latino _____Not Hispanic or Latino

Primary Spoken Language/ Primer Idioma: _____

Race/Raza:

_____American Indian or Alaska Native _____ Native Hawaiian or other Pacific Islander
____Black or African American _____Asian _____ White
Other:_____

Height/ Estatura: _____ **Weight/Peso:** _____

Wide/ Horma Ancha? ____Yes/ Si _____ No **Shoe size/Talla de Zapato:** _____

Employment Status: Estado de Empleo: ____Full-Time ____Part-Time ____Not Employed

Company Name/ Nombre de la Compañía:_____

Ocupation/Ocupacion:_____

Student Status/ Estado de Estudiante ____ Full-Time ____Part-Time ____Not a Student

Emergency Contact/ Contactor de Emergencies : _____

Phone Number/ Número de teléfono:_____

Relation to you/ Realcion a usted: _____

PCP/Medico Primario: _____

PCP Phone Number/ Número de teléfono del Medico Primario:_____

Please describe your foot/ankle problem (include date of injury if applicable) /Por favor describa el problema con sus pies o tobillos:

_____

_____

ALLERGIES/ALERGIAS

Please check all allergies/Por favor seleccione todas las alergias que tenga:

____ Medication/Medicinas:_____

____Foods/Comidas:_____

____ Tapes or Topical Skin Sensitivity_____

Other/ Otra:_____

What types of reactions have you experienced? Cual ha sido reacción?

_____

____No known drug allergies/ No alergias

MEDICATIONS/ MEDICINAS

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Please list all medications, dosages and reason/ Por favor liste todas las medicinas miligramosy las razón porque las está tomando:

Medications/Medicinas	Dosage/ Dosis	Reason/Razon
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

____ **NO MEDICATION/ NO TOMO MEDICINA**

Pharmacy:

Name:_____ Address:_____

Zip code:_____

Past Medical History/ Historia Medica

(Please check all conditions that you have or have had.) Seleciones las condiciones que tuvo o tiene.

□ None/Niguna
□ Anxiety/Ansiedad □ High Cholesterol/Colesterol Alto □ Allergy/Alergias
□ Heart Disease/Enfermedad del corazon □ Bleeding Difficulties/Dificultades de Sangrado
□ Seizure/Convulciones □ High Blood Pressure/Presion Alta □ Hepatitis A-B or C
□ TB/Tuberculosis □ Stroke □ HIV □ Arthritis/Atritis □Osteoporosis/Osteoporosis
□Osteoarthritis/Osteoartritis □ Asthma/Asma □Anemia □ Emphysema/Enfisema
□ Hypothyroid/ Hipotiroidismo □ Hyperthyroid/Hipertiroidismo
□Coronary Artery Disease/Enfermedad de la arteria Coronaria □Heart Attack/Ataque al Corazon
□Diabetes/ Diabetes Type/Tipo_____□Depression/Depresion
□ Cancer: Type/Tipo:_____

□ Other/Otro:_____

Past Surgical History/Historia Quirúrgica Pasado:
(Type of Surgery & Year) Tipo de Cirugía y Año

1._____ 2._____

3._____4._____

5._____6._____

Social History/Historia Social:

Do you Currently Smoke /Fuma Regularment? □ Yes/Si □ No

If Yes, How many packs per day/Si Fuma cuantos paquetes diario?_____

Have you smoked previously/Alguna vez Fumo? □ Yes/Si □ No

When did you Quit/Cuando Paro de Fumar?_____

Do you Drink alcohol/Consume Alcohol? □ Yes/Si □ No
□Socially/Social □Daily/Diario □ Rarely/Rara vez

Do you Drink Caffeine/Consume Cafeina? □ Yes/Si □ No Daily/Diario?_____

For Females:

Are you pregnant?_____ Are you Breast Feeding?_____ # of Pregnancies/Deliveries____

Family History/Historia Familiar

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Father Name/Nombre del Padre:_____

Date of Birth/Fecha de nacimiento:_____ Age/ Edad:_____

☐ Alive/Vivo ☐ Deceased/Fallecio If Deceased, at what age/Si fallecio a que edad?_____

Medical History or Cause of death/Historia medica o causa de muerte:

_____

_____

_____

Mother Name/Nombre de la Madre:_____

Date of Birth/Fecha de nacimiento:_____ Age/ Edad:_____

☐ Alive/Vivo ☐ Deceased/Fallecio If Deceased, at what age/Si fallecio a que edad?_____

Medical History or Cause of death/Historia médica o causa de muerte:

_____

_____

_____

____ I Refuse to answer this question / Yo me niego a dar esta informacion.

____ I do not have any information or knowledge/ No tengo ninguna informacion o conocimeiento.

Signature/Firma:_____ Date/Fecha:_____

I hereby authorize direct payment of surgical and medical benefits on my behalf to the provider of these services that I would otherwise be payable to me if I did not make this assignment. I understand that I am

personally responsible to the physician for charges not covered by my insurance agreement. I permit a copy of this assignment to be used in place of the original for purposes of billing.

- Por la presente autorizo el pago directo de las prestaciones médicas y quirúrgicas en mi nombre al proveedor de estos servicios que de otro modo serían pagaderos a mí si yo no hice esta asignación. Yo entiendo que soy personalmente responsable al médico para cargos no cubiertos por mi contrato de seguro. Me permito una copia de esta asignación a ser utilizada en lugar de la original para los propósitos de facturación.

The information provided by me is true to the best of my knowledge. I authorize release of any previous medical records by fax, mail or phone by either physician or hospital generated. Also, I herby authorize the doctor or his assistants to initiate the diagnosis and treatment of my condition, to use x-ray examination, or photographs as necessary.

- La información proporcionada por mí es verdadera a lo mejor de mi conocimiento. Autorizo la liberación de todos los documentos médicos anteriores por fax, correo o por teléfono, ya sea médico u hospital generado. Además, yo autorizo al médico o sus asistentes para iniciar el diagnóstico y el tratamiento de mi condición, para usar un examen de rayos x, o fotografías, según sea necesario.

I give SANDRA R GOTMAN, D.P.M. permission to obtain and release medical information to insurance companies and referring physicians. I have read the following and understand and agree to Dr. SANDRA R GOTMAN,DPM, office policy.

- Doy permiso a la doctora SANDRA R Gotman , D.P.M. o sus asistentes para obtener y divulgar información médica a los seguros las empresas y los médicos de referencia . He leído lo siguiente y entender y estar de acuerdo con el Dr. SANDRA R Gotman, DPM, la política de la oficina.

_____ _____

DATE/FECHA **PATIENT SIGNATURE/FIRMA DEL PACIENTE**

****If not patient, relationship to patient/Si no es el paciente, digal la relacion:**

___Parent/Padre: NAME/Nombre_____

___Power of attorney/Poder legal

___Legal Guardian/Tutor legal

Other/Otro:_____

Chronic Venous Insufficiency (CVI) is a serious circulatory problem in which the legs veins cannot pump enough blood back to your heart. Symptoms of (CVI) include varicose veins, skin problems, leg and ankle swelling, tight calves and legs that feel heavy, tired, restless or achy. Factors that can increase the risk of (CVI) include pregnancy, obesity, smoking, standing or sitting for long periods of time and not

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getting enough exercise. Answers to these questions will determine if you are at risk for (CVI) and if a vascular exam will help us better assess your vascular health status.

Please circle the answer.

1. Are your legs swollen, painful or warm to the touch?	Yes	No
2. Have you had a blood clot in a vein that caused inflammation, pain or irritation?	Yes	No
3. Have you had a Deep Vein Thrombosis (DVT) in the past and are experiencing pain, swelling, changes in skin color, cellulites or non-healing ulcers?	Yes	No
4. Do you have varicose veins on your legs?	Yes	No
5. Do your legs feel heavy, tired, restless or achy?	Yes	No
6. If you push on your swollen foot, ankle or leg for 10 seconds and release, does your fingerprint leave a dimple?	Yes	No
7. If your feet, ankle and legs are swollen, does the skin look stretched or shiny?	Yes	No
8. Do you have an ulcer on the inside of your ankle?	Yes	No

La Insuficiencia venosa crónica (CVI) es un grave problema circulatorio en el que las venas de la pierna no pueden bombear suficiente sangre de vuelta a su corazón. Los síntomas de la (CVI) son varices, problemas de la piel, las piernas y la hinchazón del tobillo. Lo siguiente puede aumentar el riesgo de (CVI), el embarazo, la obesidad, uso de tabaco, estar de pie o sentado durante largos periodos de tiempo y no hacer suficiente ejercicio. Las respuestas a estas preguntas determinaran si está en riesgo de (CVI) y si un examen vascular nos ayudara a evaluar su estado de salud vascular.

Por favor circule la respuesta.

1. Estan sus piernas hinchadas, dolorosas, rojas o calientes al tocar?	Si	No
2. Ha tenido un coagulo sanguíneo que le causo inflamación, dolor o irritación?	Si	No
3. Tiene usted varices en las piernas?	Si	No
4. Ha tenido usted una trombosis venosa profunda TVP y experimento dolor, hinchazón, cambios en el color de la piel, celulitis, o ulceras que no se curaron?	Si	No
5. Siente sus piernas pesadas, cansadas, dolorosas o inquietas?	Si	No
6. Si Usted presiona por 10 segundos su pie, el tobillo o la pierna que esta hinchada, deja una huella después de remover su dedo?	Si	No
7. Sus pies, tobillos o piernas están hinchadnos/aparece la piel estirada o brillante?	Si	No
8. Tiene usted un ulcera en el lado interior de su tobillo?	Si	No

Signature/Firma _____ Date/Fecha _____

Attention

Each patient is responsible for calling their insurance company to inform themselves about their coverage and benefits.

Additionally, each patient of this office is responsible for the payment of the following if the insurance does not cover it:

- Deductibles
- Any percentage that is not covered by your insurance company.

For your convenience, we accept: **Visa, MasterCard, Discover, and American Express** your co-pay will be charged at your arrival to our office.

Please remember that you have the responsibility to pay for any remaining balance after your insurance company has paid their part. If necessary, we provide payment arrangements.

We do not take personal checks.

Thank you, The Administration

Date: _____ Signature:_____

Atención

Cada paciente es responsable de llamar a su seguro médico para informarse sobre la cobertura provenida por su compañía. Adicionalmente, cada paciente de esta oficina será responsable por el pago de lo siguiente si el seguro no se lo cubre:

- Deducible
- El porcentaje que no sea cubierto por su plan de seguro medico.

Para su conveniencia nosotros aceptamos **Visa, Mastercard, Discover y American Express.** Su co-pago será cobrado al llegar a nuestra oficina. Por favor acuérdese que usted tiene la responsabilidad de cualquier balance que reste después del pago de su seguro. Si es necesario ofrecemos arreglos de pago.

No aceptamos cheques personales.

Gracias, La Administration

Fecha : _____ Firma:_____

RELEASE OF INFORMATION / DIVULGACIÓN DE INFORMACIÓN:

NAME/NOMBRE: _____ DATE OF BIRTH:_____/_____/_____

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_____ I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:
___ Autorizo la divulgación de información, incluyendo el diagnóstico, registros, el examen rendido a mí y reclama información. Esta información puede ser revelada a:

____ Spouse/ Esposo_____

____ Child(ren)/ Hijos_____

____Other/Otro:_____

____ **INFORMATION IS NOT TO BE RELEASED TO ANYONE.**
____ **INFORMACIÓN NO SEA LIBERADO A NADIE.**

THIS REALEASE OF INFORMATION WILL REMAIN EFFECT UNTIL TERMINATED BY ME IN WRITING. / Este Release de informacion permanecerá vigente hasta su vencimiento por mi por escrito .

Messages and Email

Please call/ Por favor llame: ___my home/ mi casa ___cell ___my work/mi trabajo

Number/Numero:_____ OR EMAIL:_____

If unable to reach me/ Si no me puede contactar:
_____ you may leave a detailed message/ Usted puede dejar un mensaje detallado.

Other/ Otro:_____

The best time to reach me is (day)_____ between(time)_____

Signed:_____ Date:_____

Witness:_____ Date:_____

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

During your treatment at Sandra R. Gotman DPM, our caregivers may gather information about your medical history and current health. This Notice of Privacy Practices explains how that information may be used and shared with others. It also explains your privacy rights regarding this information.

Sandra R. Gotman DPM is required by law to abide by the terms of this Notice, to make sure that information that identifies you is kept private, and to give you this Notice of our legal duties and practices with respect to medical information about you.

Uses and Disclosures of your Health Information

Sandra R. Gotman DPM may use health information to carry out treatment, payment and health care operations.

1. Treatment is the provision, coordination or management of health care. For example, we may use and disclose your information to consult with a third party or to refer you to other health care providers. We will get your written consent prior to making disclosures outside Sandra R. Gotman DPM for treatment purposes, except in emergencies.

2. Payment includes the activities necessary to obtain reimbursement for the provision of health care. For example, we may need to give your health plan information about treatment you received at Sandra R. Gotman DPM, so your health plan will pay us or reimburse you for the treatment. We will get your written consent prior to making disclosures for payment purposes.

3. Health care operations include the activities necessary for Sandra R. Gotman DPM to run its business operations. For example, we may use your information to review treatment and services and to evaluate the performance of our staff.

We may use or disclose your health information:

1. When required by federal, state, or local law.

2. To support public health activities by reporting as required or authorized by state or federal law. These reports may include the reporting of exposure to a communicable disease or risk of spreading a disease or condition.

3. To cooperate with law enforcement officials for certain law enforcement purposes as directed by a court order, warrant, criminal subpoena, or other lawful process.

4. To report abuse or neglect.

5. To support health oversight activities that are authorized by law, such as administrative or criminal investigations, inspections, licensure or disciplinary actions and other similar activities necessary for appropriate oversight of government benefit programs or functions.

6. When required by a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as required by law.

7. When necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, as consistent with applicable law and standards.

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8. For judicial or administrative proceedings, in response to a valid court order, administrative order, a grand jury subpoena, or with your written consent.

9. For research purposes, with your written authorization or as permitted by state law.

10. To business associates to perform functions on Sandra R. Gotman DPM behalf, if the business associate has signed an agreement to protect the confidentiality of the information.

We may disclose your health information to a family member, other relatives, or a close friend or any other person you identify if the information relates to that person's involvement in your health care if you consent to such a disclosure. If you are unable to agree or object to the use or disclosure, we may disclose such information as necessary if we determine that it is in your best interest.

In other situations, your written authorization will be obtained before Sandra R. Gotman DPM will use or disclose your health information to third parties outside Sandra R. Gotman DPM.

State and federal laws may be more stringent and may prohibit certain uses and disclosures identified above. When another law is more stringent than HIPAA, we will follow the more stringent requirements. For example, some state laws require additional protection for records related to mental health treatment, drug and alcohol treatment, and HIV-related information.

Patient Rights

You may request Sandra R. Gotman DPM to restrict uses and disclosures of your health information. However, Sandra R. Gotman DPM is not required to agree to the requested restriction. These requests should be made to Sandra R. Gotman DPM, Privacy Office. Requests must be made in writing. In your request, you must tell us (a) what information you want to limit; (b) whether you want to limit Sandra R. Gotman DPM use, disclosure, or both, and (c) to whom you want the limits to apply, for example, if you want to prohibit disclosures to your spouse.

You have the right to request confidential communications by alternative means or at alternative locations. For example, you may request that we communicate with you only by mail. We will accommodate all reasonable requests, but your request must specify how or where you wish to be contacted, and we may require you to provide information about how payment will be handled. You must request confidential communications in writing.

You have a right to inspect and obtain a copy of your health information that is used to make decisions about your care for as long as Sandra R. Gotman DPM maintains the information. This right does not apply to certain health information, including information compiled in reasonable anticipation of or for litigation and other information not subject to the right to access information under state law and Requests for access to health information should be made in writing to Sandra R. Gotman DPM, HIPAA. Privacy Office. If access is denied, you will be provided with a written explanation that sets forth the basis for the denial, a description of how you may review those rights and a description of how you may complain.

You have the right to request that Sandra R. Gotman DPM amend your health information if it is incorrect or incomplete. Requests for amendment of information should be made in writing to Sandra R. Gotman DPM, Privacy Office, and you must provide a reason that supports your request to have the information changed. Sandra R. Gotman DPM may deny your request for an amendment if the request is not in writing and submitted to the Privacy Office. In addition, we may deny your

request if you ask us to amend information that: (a) was not created by Sandra R. Gotman DPM unless the person or entity that created the information is no longer available to make the amendment); (b) is not part of the medical information kept by Sandra R. Gotman DPM; (c) is not part of the information you would be permitted to inspect and copy; or (d) is accurate and complete.

At your request, Sandra R. Gotman DPM, will provide you with an accounting of disclosures by Sandra R. Gotman DPM, of your health information during the six years prior to the date of your request. However, such accounting will not include disclosures made: 1) to carry out treatment, payment or health care operations; 2) directly to you or your personal representatives; 3) prior to the effective date of this notice; or 4) based on your written authorization. If you request more than one accounting within a 12-month period, Sandra R. Gotman DPM, will charge a reasonable, cost-based fee for each subsequent accounting. Requests for a request of an accounting of disclosures should be made in writing to Sandra R. Gotman DPM, Privacy Office.

To obtain a paper copy of this notice, contact Sandra R. Gotman DPM.

You may exercise your rights through a personal representative as permitted or required by applicable law. Your personal representative may be required to produce evidence of authority to act on your behalf before that person will be given access to your information or allowed to take any action for you.

If you believe your privacy rights have been violated you may complain to Sandra R. Gotman DPM. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. All complaints should be submitted in writing. You will not be penalized in any way for filing a complaint.

(Sandra R. Gotman DPM Duties)

This Notice is effective beginning January 26, 2006. However, Sandra R. Gotman DPM, reserves the right to change its privacy practices and this Notice, and to apply the changes to any health information received or maintained by Sandra R. Gotman DPM prior to the date of the changes. If the terms of this Notice are changed, a revised version will be available upon request and will be posted in a clear and prominent location. You may access the notice by visiting our website at:

Signature _____ Date_____

Complaints, Questions, and Requests

You may direct your questions about this Notice or privacy practices, requests regarding your information, or other

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CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours notice. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot.

Office appointments which are cancelled with less than 24 hours notification may be subject to a $25.00 cancellation fee. Procedure cancellations require 5-7 business day advance notice, without notification they may be subject to a $150.00 cancellation fee.

Patients who do not show up for their appointment without a call to cancel an office appointment or procedure appointment will be considered as NO SHOW. Patients who No-Show two (2) or more times in a 12 month period, may be dismissed from the practice thus they will be denied any future appointments. Patients may also be subject to a $50.00 fee for office appointment No Show and $150.00 procedure No Show fee.

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that Special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval. Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no show fees should be directed to our office manager at (305)229-9595

Please sign that you have read, understand and agree to this Cancellation and No show Policy.

_____ _____

Patient Name (Please Print) : Date of Birth:

_____ _____

Signature of Patient or Patient Representative : Date: