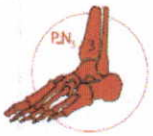


Welcome!! Percy L. Nelson D.P.M., P.A.

PATIENT REGISTRATION FORM

Patient Name: _____ Social Security Number: _____-_____-____
Date of Birth: _____/_____/_____ Sex: M / F (Circle one) Married/Single/Divorced/Widow
Address:_____
(Street) (City/State/Zip) _____
Home Phone: (_____) _____-_____
E-mail Address: _____
Would you be interested in having communications sent to you via your e-mail address?
(examples: appointment reminders, administrative updates and health bulletins) Yes No
Employer Name: _____
Employer Phone Number: (_____) _____
Primary Care Physician: _____ Copay Amount
$_____

How did you hear about our Practice?

_____

_____

Person responsible for bill or parent (Complete only if different from patient)
Guarantor Name: _____
Social Security Number: ____ - ____ - ____
Relationship to Patient: (please check): ( ) self, ( ) spouse, or ( ) parent Date of Birth:
_____/_____/_____
Address: _____
Employer Name: _____
Employer Phone Number: (___) _____

_____

Who to call for an emergency:
Name: _____
Address:_____
Home Phone: (__) _____ - _____ Work Phone: (___) _____-_____
Relationship: _____

_____

FIRST INSURANCE INFORMATION
Plan Name: _____ I.D. Number:_____
Address: _____
Group Number:_____
Policy Holder: _____ Effective Date: _____
Policy Holder's Social Security Number: _____ - _____ - _____
Policy Holder's Date of Birth: _____/_____/_____ Sex: M / F

SECOND INSURANCE INFORMATION

Plan Name: _____ I.D. Number: _____

Address: _____ Group Number: _____

Policy Holder: _____ Effective Date: _____

Policy Holder's Social Security Number: _____ - _____ - _____

Policy Holder's Date of Birth: _____/_____/_____ Sex: M / F

IS YOUR VISIT DUE TO A JOB RELATED INJURY OR AUTOMOBILE ACCIDENT? Y_____ N_____

IF YES, PLEASE NOTIFY THE RECEPTIONIST

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Percy Nelson D.P.M., P.A. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

I acknowledge that any unpaid balances or balances not paid by my insurance company are my responsibility.

I acknowledge that if these balances are not paid in a timely manner they may be forwarded to a collections agency.

I acknowledge that there is a no call/ no show policy in place if my appointment is missed.

I acknowledge that I must call and cancel my appointment at least 24 hours before the time of my appointment.

Signature: _____

Date: _____

"Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims of medical malpractice. YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALEPRACTICE INSURANCE. This permitted under Florida law subject to certain conditions Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law" 458,320(5)(g),F.S

Dr. Percy Nelson, D.P.M., P.A.

PODIATRY SURGERY AND MEDICINE

Adult and Pediatric Foot and Ankle Surgery,
Wound Care and Diabetic Foot Limb Salvage, and
Reconstruction Surgery

2630 NE 203rd Street, Suite 102
Aventura, FL 33180

Ph: (305) 466-9498
Fax: (305) 466-9698

nelson3@drnelsondpm.com
www.drnelsondpm.com

Date _____

Name _____
Date of birth _____ Age _____
General health _____

Are you currently or have you ever been treated for

Yes	No	Condition	Explain
☐	☐	Asthma	
☐	☐	Bleeding disorders	
☐	☐	Blood Pressure	
☐	☐	COPD	
☐	☐	Diabetes	
☐	☐	Ear/sinus	
☐	☐	Fainting	
☐	☐	Gastro-intestinal problems	
☐	☐	Heart disease	
☐	☐	Kidney disease	
☐	☐	Learning disorders	
☐	☐	Menstrual problems	
☐	☐	Musculo-skeletal	
☐	☐	Psychological/psychiatric	
☐	☐	Seizures	
☐	☐	Sickle cell disease	
☐	☐	Sleep disorders	
☐	☐	Stroke	
☐	☐	Surgery	
☐	☐	Thyroid disease	
☐	☐	Serious injury	
☐	☐	Other	

List all medications you are currently taking, include over-the-counter drugs and herbal supplements

Medication	Dosage	Reason

Allergies

Signature _____

www.FreePrintableMedicalForms.com

PERCY LEE NELSON, DPM, PA

NOTICE OF PRIVACY PRACTICES

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. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Overview

The law requires us to keep your protected health information ("PHI") private in accordance with this Notice of Privacy Practices ("Notice"), as long as this Notice remains in effect. We are also required to provide you with a paper copy of this Notice, which contains our privacy practices, our legal duties, and your rights concerning your PHI. From time to time, we may revise our privacy practices and the terms of our Notice at any time, as permitted or required by applicable law. Such revisions to our privacy practices and our Notice may be retroactive. Our Notice will be updated and made available to our patients prior to any significant revisions of our privacy practices and policies.

This Notice contains the privacy practices for [types of organizations] listed below, with the [types of facilities] sites they maintain for delivery of health care products and services. Each of these organizations participates in an organized health care arrangement and may use and disclose your PHI among themselves as they shall deem appropriate for your treatment, payment or health care operations.

Our Privacy Practices

Use and Disclosure. We may use or disclose your PHI for treatment, payment, or health care operations. For your convenience, we have provided the following examples of such potential uses or disclosures:

> *Treatment.* Your PHI may be used by or disclosed to any physicians or other health care providers involved with the medical services provided to you.
>
> *Payment.* Your PHI may be used or disclosed in order to collect payment for the medical services provided to you.
>
> *Health Care Operations.* Your PHI may be used or disclosed as part of our internal health care operations. Such health care operations may include, among other things, quality of care audits of our staff and affiliates, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Authorizations. We will not use or disclose your medical information for any reason except those described in this Notice, unless you provide us with a written authorization to do so. We may request such an authorization to use or disclose your PHI for any purpose, but you are not required to give us such authorization as a condition of your treatment. You may revoke any written authorization from you by you in writing at any time, but such revocation will not affect any prior authorized uses or disclosures. We may contact you to provide appointment about treatment alternatives or health-related benefits and service that may be of interest to you

Patient Access. We will provide you with access to your PHI, as described below in the Individual Rights section of this Notice. With your permission, or in some emergencies, we may disclose your PHI to your family members, friends, or other people to aid in your treatment or the collection of payment. A disclosure of your PHI may also be made if we determine it is reasonably necessary or in your best interests for such purposes as allowing a person acting on your behalf to receive filled prescriptions, medical supplies, X rays, etc.

Locating Responsible Parties. Your PHI may be disclosed in order to locate, identify or notify a family member, your personal representative, or other person responsible for your care. If we determine in our reasonable professional judgment that you are capable of doing so, you will be given the opportunity to consent to or to prohibit or restrict the extent or recipients of such disclosure. If we determine that you are unable to provide such consent, we will limit the PHI disclosed to the minimum necessary.

Continuing Care. Based upon your PHI, we may provide you with appointment reminders or information concerning health issues, benefits and services, or treatment alternatives that we believe may be of interest to you.

Disasters. We may use or disclose your PHI to any public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Required by Law. We may use or disclose your medical information when we are required to do so by law. For example, your PHI may be released when required by privacy laws, workers' compensation or similar laws, public

health laws, court or administrative orders, subpoenas, certain discovery requests, or other laws, regulations or legal processes. Under certain circumstances, we may make limited disclosures of PHI directly to law enforcement officials or correctional institutions regarding an inmate, lawful detainee, suspect, fugitive, material witness, missing person, or a victim or suspected victim of abuse, neglect, domestic violence or other crimes. We may disclose your PHI to the extent reasonably necessary to avert a serious threat to your health or safety or the health or safety of others. We may disclose your PHI when necessary to assist law enforcement officials to capture a third party who has admitted to a crime against you or who has escaped from lawful custody.

Deceased Persons. After your death, we may disclose your PHI to a coroner, medical examiner, funeral director, or organ procurement organization in limited circumstances.

Your Individual Rights

Access and Copies. In most cases, you have the right to review or to purchase copies of your PHI by requesting access or copies in writing to our Privacy Officer. Please contact our Privacy Officer regarding our copying fees.

Disclosure Accounting. You have the right to receive an accounting of the instances, if any, in which your PHI was disclosed for purposes other than those described in the following sections above: Use and Disclosures, Facility Directories, Patient Access, and Locating Responsible Parties. For each 12-month period, you have the right to receive one free copy of an accounting certain details surrounding such disclosures that occurred after April 13, 2003. If you request a disclosure accounting more than once in a 12-month period, we will charge you a reasonable, cost-based fee for each additional request. Please contact our Privacy Officer regarding these fees.

Additional Restrictions. You have the right to request that we place additional restrictions on our use or disclosure of your PHI, but we are not required to honor such a request. We will be bound by such restrictions only if we agree to do so in writing signed by our Privacy Officer.

Alternate Communications. You have the right to request that we communicate with you about your PHI by alternative means or in alternative locations. We will accommodate any reasonable request if it specifies in writing the alternative means or location, and provides a satisfactory explanation of how future payments will be handled.

Amendments to PHI. You have the right to request that we amend your PHI. Any such request must be in writing and contain a detailed explanation for the requested amendment. Under certain circumstances, we may deny your request but will provide you a written explanation of the denial. You have the right to send us a statement of disagreement to which we may prepare a rebuttal, a copy of which will be provided to you at no cost. Please contact our Privacy Officer with any further questions about amending your medical record.

Complaints

If you believe we have violated your privacy rights, you may complain to us or to the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with us by notifying our Privacy Officer. We support your right to protect the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Us

Clora Adkins (Office Manager)
21110 Biscayne Blvd # 201
Aventura, FL 33180
305-466-9498

PERCY LEE NELSON, DPM, PA

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned Patient or legally authorized representative ("Agent") of the Patient acknowledges that he or she personally received a copy of the **Percy Lee Nelson DPM PA's** Notice of Privacy Policies on the date indicated below.

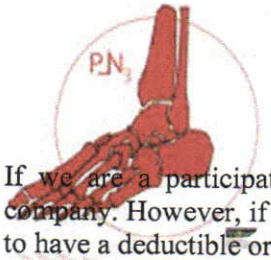
Signature: _____ Date: _____

Patient: _____

Information about Agent (attach appropriate documentation):

Agent: _____

Title: _____



Dr. Percy Nelson DPM., P.A

EASY PAY CONSENT **FORM**

If we are a participating provider for your health insurance, we will file insurance claims to your company. However, if a service performed by the doctor is denied, not a covered service or you are found to have a deductible or co-insurance amount, you will be responsible for paying the balance with the Easy Pay Form. **You have the option of filling out the Easy Pay Form, paying cash for the visit, providing a blank check made out to Dr. Percy Nelson or being referred to another Podiatrist**. The validity of the credit card will be checked prior to services being rendered.

What is the Easy Pay Form? Why is it necessary?
Occasionally you will have deductibles & co-insurance obligations unbeknownst to us that have been set by your insurance company, leaving a balance on your bill. We will always warn you if we feel a service may not be covered, however, ultimately the insurance contract is between you & your insurance company.

Your insurance will mail you a notice of your balance. If we receive notice from your insurance company that there is a balance on your account your payment will be processed with the Easy Pay Form. **Dr. Percy Nelson DPM PA does not mail invoices or bills to patients for balances**. This allows us to obtain quick payment so that we may concentrate on providing you with quality medical care and not be occupied with sending outstanding balances to collection agencies.

Please complete the square below to authorize future payment for any balance at which will be an out of pocket expense, as determined by your insurance company only. Your information will be kept in a PCI compliant system. Once entered in the system, all numbers are encrypted and only the last 4 numbers as visible to us.

I authorize Dr. Percy Nelson DPM PA to keep my signature on file and to charge my credit card for the patient responsibility portion of any balances incurred by me. I understand that I am entitled to a refund should my insurance company later decide to pay for the service initially denied.

I understand that this EASY PAY system will only be implemented in the following cases:
- If a deductible has been applied by my insurance company.
- If I am not covered by my insurance for the services rendered.
- If I fail to cancel 24 hours prior to a follow-up appointment or surgery I will be charged a $20.00 no-show fee.

PATIENT NAME_____ DATE OF BIRTH_____

In the boxes provided please enter the last 4 digits of the credit card you agree to keep on file. Please present card for verification.

___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Expiration Date:_____ **Type**: Visa MasterCard American Express Discover

Billing Address:_____

Name on Card:_____ **Cardholder's Signature:**_____**Date:**_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the named health care provider to release the information or records specified to upon request in person or by mail to the address specified at the time of the request.

Provider: (name and address)	Patient: SS#: DOB:

RECORDS AUTHORIZED TO BE RELEASED:

- ☐ Admission history and physical
- ☐ Discharge summary
- ☐ Complete hospital chart
- ☐ Office notes
- ☐ Outpatient records
- ☐ Psychiatric and other mental health records
- ☐ Lab reports
- ☐ Radiological images
- ☐ Consultation notes or reports
- ☐ Complaints or grievances filed, with responses or dispositions
- ☐ Records relating to drug or alcohol abuse (must specify the extent or nature of the records to be released)
- ☐ Medication administration logs, dietary logs, staff contact or service logs, and other records that may not be part of my individual medical record, but which contain information relating to me (These records should be redacted to protect information pertaining to other patients.)
- ☐ Other (specify):___

Extent or nature of records to be released: ___
(example, specific hospitalization or visit)

This information will be used for the purpose of :

- ☐ Investigating an allegation of abuse
- ☐ Providing advocacy services
- ☐ Other activities at the request of the individual
- ☐ Verifying my eligibility for services offered by the
- ☐ Legal representation

This authorization will expire one year from the date of the signature below. I understand that I can revoke this authorization at any time by writing to the health care provider or to the , but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

I also understand that:

- I am not required to sign this authorization and that my health care or payment for care will not be affected by my refusal.
- Federal privacy regulations will no longer apply to the information disclosed, and that may redisclose the information.
- I am entitled to receive a copy of this authorization.
- A copy of this authorization may be utilized with the same effectiveness as an original.

_____
Patient or Representative Date

_____
Name of Representative (print)

_____
Relationship to Patient