Dr. Jordana Szpiro
Dr. Maria Bolla
264 Beacon St 2nd Floor
Boston, MA 02116
Tel: 617-262-2266
Fax: 844-766-1806

Boston Common PODIATRY Skin & Wellness
Official Podiatrist for the Boston Ballet

www.bostoncommonpodiatry.com

First Name _____ Last Name _____ Date _____

Email _____

Mailing Address _____

City_____ State _____ Zip _____ Marital Status _____

Phone _____ Date of Birth _____ Occupation/Student _____

Height _____ Weight _____ Shoe Size _____

Whom may we thank for referring you? _____

Primary Care Physician _____

Physician's Address _____

Physician Phone Number _____ Date last seen _____

Pharmacy _____ Address _____ Phone _____

**Primary Reason for Visit** _____
_____
Duration of Condition _____
What helps/makes it worse? _____
_____
Is it limiting your desire activity level? _____
Secondary problem (if there is one) _____

Please list any allergies _____
List all medications you take _____
Tobacco Use _____ Alcohol Use _____ Recreational Drug Use _____

**Medical History**

_____
_____
If you have cancer, please list type and treatment _____
_____
What surgeries have you had? _____

Hospitalizations other than for surgery _____
Trauma/Accidents _____

Dr. Jordana Szpiro
Dr. Maria Bolla
264 Beacon St 2nd Floor
Boston, MA 02116
Tel: 617-262-2266
Fax: 844-766-1806

Boston Common PODIATRY Skin & Wellness
Official Podiatrist for the Boston Ballet

www.bostoncommonpodiatry.com

**Family History**
Diabetes _____ Stroke _____ Cancer _____ Arthritis _____ Heart Attack _____

**Insurance Information**
Subscribers Name _____ Subscribers D.O.B. _____
Patient's Relation to the Subscriber _____ HMO _____
Primary Insurance _____
Policy Number _____ Group Number _____
Secondary Insurance _____ Policy Number _____
**Employer** _____
**Emergency Contact**
First Name _____ Last Name _____
Relationship to Patient _____ Phone Number _____

## Consent for Treatment and Acknowledgement of Policies

_____ I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff ofany and all updates to the information listed above. • I also give permission for photographs of my feet to be taken that are to be kept as part of my medical record only. They will not be published as part of medical research or disbursed in any way without my permission. I also give permission to use electronic systems to view, electronically prescribe and verify some or all of my medications.

## Office Policy Regarding Insurance

To preserve the best possible relationship with you, our patient, and to prevent any misunderstanding, we hope thefollowing explanation of our office policy regarding insurance and payment for services is helpful.

1.) We expect and appreciate payment for office visits at the time of service. We will accept cash, check, MasterCard,Visa, or debit cards.

2.) For any insurance plan that requires authorization from a primary care physician, (e.g. HMO, PPO, etc.), it is your responsibility, (as patient or guardian), to be sure that this office receives all necessary referrals or authorizations PRIOR to treatment. If the insurance carrier denies any charges due to lack of referral authorization, you, (the patient),are responsible for all charges incurred.

3.) If any type of supplies are dispensed during the course of treatment, (e.g. arch supports, accommodative pads, creams, surgical shoes, etc.), payment is due at the time of service. We cannot bill you or the insurance company forthese supplies.

4.) I have read, and understand and agree to the above office policies and understand that I am financially responsiblefor any balance due on my account.

5.) I hearby give permission to the Boston Common Podiatry to administer treatment and to perform such procedures asmay be deemed necessary in the diagnosis and/or treatment of my foot condition and authorize disclosure of medical information to assist in processing my insurance claim and to communicate with treating physicians. Furthermore, I assign all payment

Dr. Jordana Szpiro
Dr. Maria Bolla
264 Beacon St 2nd Floor
Boston, MA 02116
Tel: 617-262-2266
Fax: 844-766-1806
www.bostoncommonpodiatry.com

of medical benefits provided by my insurance company policy for medical/surgical care to Boston Common Podiatry.

_____ _____

Signature Date

## Patient HIPPA Acknowledgement and Designation

**Acknowledgement of Practice's Notice of Privacy Practices:**

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understands the Notice of Privacy Practices (NPP)
and agree to its terms. The NPP can be found at the following link:
https://bostoncommonpodiatry.com/images/hippa.pdf

_____ _____

Signature Date

**Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:**

I agree that the practice may disclose certain pieces of my health information to a Personal Representative of my choosing, since such person is involved with my healthcare or payment relating to my healthcare. In that case, thePhysician Practice will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my healthcare.
Name _____ Relationship to patient _____

The above authorizations are voluntary, and I may refuse to their terms without affecting any of my rights to receivehealthcare at the Practice.
These authorizations may be revoked at any time by notifying the Practice in writing at the Practice's mailing address markedto the attention of "HIPAA Compliance Officer."
The revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.
If you request it, a copy of the information described in this form can be obtained at the front desk.
This form was completely filled in before I signed it and I acknowledge that all of my questions were answered to mysatisfaction and that I fully understand this authorization form.
This authorization is valid as of the date I have signed below and shall remain valid until changed or revoked.

_____ _____

Signature Date