101 Dixie Drive
Oakdale, PA 15071
PHONE # 412-787-8380
FAX # 412-787-1099

1170 NILES CORTLAND RD
NILES, OH 44446
PHONE # 330-544-4141
FAX # 330-544-4134

Jeffrey T. Molinaro, DPM, FACFAS

DATE____________________

LAST NAME____________________ FIRST NAME____________________ M.I.________

SS #(REQUIRED)____________________ DOB____________________ AGE__________ SEX: M_____ F_____

HOME PHONE #____________________ CELL PHONE #____________________

STREET ADDRESS____________________

CITY, STATE, ZIP____________________

SINGLE_____ MARRIED_____ DIVORCED_____ WIDOWED_____ SEPARATED_____ MINOR_____ OTHER_____

EMAIL ADDRESS____________________

PATIENT EMPLOYER/SCHOOL____________________

EMPLOYER/SCHOOL ADDRESS____________________

EMPLOYER/SCHOOL PHONE #____________________

OCCUPATION____________________

EMERGENCY CONTACT____________________ CONTACT PHONE #____________________

RELATIONSHIP TO PATIENT____________________

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?____________________

SPOUSE/PARENT/GUARDIAN NAME____________________ RELATIONSHIP ____________________

DOB____________________ SS #(REQUIRED)____________________ PHONE #____________________

ADDRESS____________________

EMPLOYER____________________ EMPLOYER PHONE #____________________

EMPLOYER ADDRESS____________________

PRIMARY INSURANCE____________________ POLICY HOLDER NAME____________________

POLICY HOLDER DOB____________________ POLICY HOLDER SS #(REQUIRED)____________________

RELATIONSHIP TO PATIENT____________________ POLICY HOLDER PHONE #____________________

POLICY HOLDER ADDRESS____________________

POLICY HOLDER EMPLOYER____________________ EMPLOYER PHONE #____________________

EMPLOYER ADDRESS____________________

SECONDARY INSURANCE____________________ POLICY HOLDER NAME____________________

POLICY HOLDER DOB____________________ POLICY HOLDER SS #(REQUIRED)____________________

RELATIONSHIP TO PATIENT____________________ POLICY HOLDER PHONE #____________________

POLICY HOLDER ADDRESS____________________

POLICY HOLDER EMPLOYER____________________ EMPLOYER PHONE #____________________

EMPLOYER ADDRESS____________________

WHAT IS THE CHIEF COMPLAINT FOR WHICH YOU CAME TO BE TREATED FOR? **RIGHT OR LEFT OR BOTH**	HAVE YOU EVER BEEN TO A PODIATRIST BEFORE? CIRCLE YES / NO IF YES: NAME AND LAST VISIT	IS THERE ANY PERSONAL OR FAMILY HISTORY OF DIABETES? YES / NO IF YOURSELF: PILL OR INSULIN IF FAMILY MEMBER RELATIONSHIPTO YOU?

ANKLE PAIN	YES	NO
ATHLETE'S FOOT	YES	NO
BUNIONS	YES	NO
CORNS/CALLUSES	YES	NO
FLAT FEET	YES	NO
FOOT OR LEG CRAMPS	YES	NO
HEEL PAIN	YES	NO
INGROWN TOENAILS	YES	NO
PLANTAR WARTS	YES	NO
TIRED FEET	YES	NO
SWELLING IN ANKLES/ FEET	YES	NO
CRAMPS OR NUMBNESS	YES	NO

FAMILY PHYSICIAN: PHONE #:

PHARMACY: PHONE #:

ALLERGIES:

- ADHESIVE TAPE
- LOCAL ANESTHETICS
- ANTICOAGULANT THERAPY
- NOVOCAINE
- ASPIRIN
- PENICILLIN
- CODEINE
- SEAFOODS
- DEMEROL
- SULFA
- IODINE
- NO KNOWN ALLERGIES
- OTHER
- ______________________

MEDICATIONS/DOSAGE:

FAMILY HISTORY:

CANCER/HEART DISEASE/DIABETES/ARTHRITIS	RELATIONSHIP TO PATIENT

101 Dixie Drive
Oakdale, PA 15071
PHONE # 412-787-8380
FAX # 412-787-1099

1170 NILES CORTLAND RD
NILES, OH 44446
PHONE # 330-544-4141
FAX # 330-544-4134

JEFFREY T. MOLINARO, DPM, FACFAS

MEDICAL HISTORY:

- ALLERGIES ANESTHETICS
- AIDS/HIV
- ANEMIA
- ARTHRITIS
- ARTIFICIAL HEART VALVES
- ARTIFICIAL JOINTS
- ASTHMA
- BACK PROBLEMS
- BLEEDING DISORDER
- CANCER
- CIRCULATORY PROBLEMS
- DEPRESSION
- EPILEPSY
- FAINTING
- GOUT
- DIABETES PILL OR INSULIN
- HEADACHES
- HEART DISEASE
- HEMOPHILIA
- HEPATITIS A B C
- JAUNDICE
- HIGH BLOOD PRESSURE
- KIDNEY PROBLEMS
- LIVER DISEASE
- LOW BLOOD PRESSURE
- MRSA OR STAPH INFECTION
- NEUROPATHY
- RADIATION TREATMENT
- RESPIRATORY DISEASE
- RHEUMATIC FEVER
- STROKE
- TUBERCULOSIS
- THYROID
- ULCERS
- VARICOSE VEINS
- UNEXPLAINED WEIGHT LOSS

SOCIAL HABITS:		
DO YOU SMOKE? PACKS PER DAY? # DATE QUIT:	YES	NO
DO YOU DRINK? HOW OFTEN? PLEASE CIRCLE SOCIAL OR EVERYDAY	YES	NO

PAST MAJOR SURGICAL HISTORY:

HEIGHT:	WEIGHT:

TREATMENT CONSENT:

I HEREBY CONSENT AND GIVE MY PERMISSION TO THE DOCTOR (AND THE DOCTOR'S ASSISTANTS OR DESIGNATED REPLACEMENT) TO ADMINISTER AND PERFORM SUCH PROCEDURES UPON ME AS THE DOCTOR DEEMS NECESSARY.

DATE:

SIGNATURE OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

RELATIONSHIP TO PATIENT:

PLEASE PRINT NAME OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

JEFFREY T. MOLINARO, DPM, FACFAS

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage and assign directly to **Dr. Jeffrey T. Molinaro** all insurance benefits, if any, for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Please sign if you have health insurance

DATE:

SIGNATURE OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

I have received a copy of the Notice of Privacy Practices from Jeffrey T. Molinaro, DPM, FACFAS.

DATE:

SIGNATURE OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

101 Dixie Drive
Oakdale, PA 15071
PHONE # 412-787-8380
FAX # 412-787-1099

1170 NILES CORTLAND RD
NILES, OH 44446
PHONE # 330-544-4141
FAX # 330-544-4134

Jeffrey T. Molinaro DPM, FACFAS

Authorization to Release Medical Information to Individuals/Family Members

In accordance with federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPAA), in order for your physician or staff of the Practice to discuss your condition or finances with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

________ I do not authorize the Practice to release any or all information concerning my medical care or finances to any individual except as set forth above.

________ I authorize the Practice to verbally release any or all information concerning my medical care or finances to the following individuals:

Name: ____________________________ Phone # ______________________________

Relationship to Patient ____________________________________

Name: ____________________________ Phone # ______________________________

Relationship to Patient ____________________________________

Name: ____________________________ Phone # ______________________________

Relationship to Patient ____________________________________

Patient Signature X______________________________ Date____________

Witness Signature X______________________________ Date ______________

Dr. Jeffrey T. Molinaro, DPM, FACFAS

101 Dixie Dr
Oakdale, Pa 15071
412-787-8380

1170 Niles Cortland Rd
Niles, Oh 44446
330-544-4141

TREATMENT AUTHORIZATION

I,________________________, acknowledge and accept any and **ALL** financial responsibility for any treatment received in this office in the event my insurance does not allow or denies payment. This includes nail care, orthotics, injections, surgery, post op visits, follow up visits and any other treatment performed by Dr. Jeffrey T. Molinaro whether in the office or at an outpatient facility.

I understand that I am also responsible for all co-payments, deductibles and any denied treatment as explained above.

______________________________ __________

patient signature date

______________________________ __________

witness date

Jeffrey T. Molinaro, DPM, FACFAS
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.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require you authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information

Appointment reminders. Your health information may be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and service that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

1. The right to request restrictions on the use and disclosure of your protected health information
2. The right to receive confidential communications concerning your medical condition and treatment
3. The right to inspect and copy your protected health information
4. The right to amend or submit corrections to your protected health information
5. The right to receive an accounting of how and to whom your protected health information has been disclosed
6. The right to receive a printed copy of this notice

Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice or privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

Permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your record by contacting the privacy secretary.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Associates in Foot and Ankle Care, Inc.
1170 Niles Cortland Road
Niles, Ohio 44446
ATTN: Privacy Secretary

or

Jeffrey T. Molinaro, DPM, FACFAS
101 Dixie Drive
Oakdale, PA 15071
ATTN: Privacy Secretary

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person

The name and address of the person you can contact for further information concerning our privacy practices is:

Privacy Secretary
Associates in Foot and Ankle Care, Inc.
1170 Niles Cortland Road
Niles, Ohio 44446
(330) 544-4141

or

Privacy Secretary
Jeffrey T. Molinaro, DPM, FACFAS
101 Dixie Drive
Oakdale, PA 15071
(412) 787-8380

Effective Date

This notice is effective on or after June 1, 2011.