Adirondack Foot Care
954 Route 146 SUITE 1, Clifton Park, NY 12065
Salvatore Galluzzo, D.P.M./Douglas Mason/Lori Lundberg D.P.M.

Patient: _____ S.S. #: _____ Date of Birth: _____

Address: _____ Home Phone #: ( ) _____
(Number & Street)

_____ Marital Status: _____ Sex: ☐ Male ☐ Female
(Town) (State) (Zip)

Employer: _____ Work Phone #: ( ) _____

Address: _____
(Number & Street) (Town) (State) (Zip)

Next of Kin: _____ Relationship: _____ Phone #: ( ) _____

Address: _____
(Number & Street) (Town) (State) (Zip)

Who is responsible for payment of this bill? ☐ **Patient** ☐ **Other** _____

Name of Responsible Party: _____ Relationship: _____

Address: _____ Date of Birth: _____

Insurance Carriers ☐ Medicare ☐ Medicaid ☐ MVP ☐ Empire Blue Cross ☐ Blue Shield Northeast NY / Senior Blue

☐ CDPHP ☐ Tricare ☐ GHI ☐ NYS Empire Plan ☐ Other: _____

Member #: _____ **Group #:** _____ **Name under which policy is issued:** _____
Please provide us with your insurance cards so copies can be made.

Is this a Worker's Compensation Case? ☐ Yes ☐ No Date of Accident _____

Who is your Primary Physician?: _____ **Date of Last Examination** ____/_____/____

Address_____ _____**City**_____**Zip**_____

Primary Pharmacy Name/Address_____**Phone**_____

How did you find out about our practice?: _____

What Foot Problem Brings You to Our Office: _____

_____

_____

_____

Assignment and Release: I hereby authorize my insurance benefits to be paid directly to Dr. Salvatore Galluzzo and acknowledge that **I am ultimately financially responsible for all charges and/or balances whether or not covered by insurance** and in the event of not payment I am responsible costs of recovery and/or collection. I also authorize the physician to release any information required to my insurance carrier(s).

Signed: _____ Date: _____
In the event of non-payment you may be responsible for reasonable costs of recovery & collection.

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Patient's Medical History & Chief Complaint

Patient _____ D.O.B. _____ Sex ____ Date of Treatment _____

Chief Concern: _____

_____

_____ Onset of condition / Duration: _____

Family History

	Father	Mother	Brothers / Sisters	Children
Diabetes				
High / Low Blood Pressure				
Heart Disease				
Stroke				
Cancer				
Gout				
Arthritis				
Asthma / Emphysema				
Kidney / Liver Disease				
Colitis				
Ulcers				
State of Health if Living				
Cause of Death				

Personal Social History

Do you use tobacco ?	Yes	No
Avg. # of packs / day		
Number of years		
Do you consume alcoholic beverages ?		
Yes	No	Social
Do you use drugs (recreational) ?		
Yes	No	
Do you exercise regularly ?		
Yes	No	

Personal Medical History - Have you ever had or been diagnosed with:

	Yes	No
High / Low Blood Pressure		
Heart Disease		
Heart Murmur		
Stroke		
Heart Attack		
Enlarged Heart		
Seizures		
Bleeding Disorder		
Blood Transfusion		
Anemia		
Pneumonia		
Emphysema		
Asthma		
Hay Fever		

	Yes	No
Eye Trouble		
Cataracts		
Glaucoma		
Diabetes		
Gout		
Thyroid Disease		
Kidney / Liver Disease		
Urinary Trac Infection		
Jaundice		
Gall Bladder Disease		
Ulcers		
Colitis		
Diverticulitis		
Unconsciousness		

	Yes	No
Cancer		
Skin Cancer		
Radiation Treatment		
Breast Lump		
Rheumatic Fever		
Elevated Cholesterol		
Measles		
Rubella (German Measles)		
Mumps		
Venereal Disease		
Exposure to TB		
Broken Bones		
HIV Positive		

Drug Sensitivities: _____

_____

Previous Operations (Complications?): _____

_____

Current Medications: _____

_____

Patient Signature _____ Date: _____

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954 Route 146
Clifton Park, NY 12065

Phone (518) 383 - 0302
Fax (518) 373 - 2298

ATTENTION ALL PATIENTS

Our practice has implemented the following policy which will allow you to reschedule your procedure or office visit no more than three times before we ask that you seek care elsewhere and we will notify your referring physician of such.

Although we do understand that sometimes situations arise beyond your control, if you find it necessary to change your appointment more than three times you will be asked to return to your primary care physician to seek care. We find this is necessary due to the increase in rescheduling and no-shows that have occurred. As a result we are finding it difficult to provide optimal care to all our patients.

Therefore, we adopted the following policies associated with last minute cancellations and no-shows. The following fees will be incurred.

Less than 48 hours notice of cancellation for an office visit:	$50.00
Short Notice (less than 24 hours) cancellation for an office visit:	$100.00
Less that 5 days notice of cancellation for surgery:	$ 100.00
Not showing for a scheduled office visit appointment:	$100.00
Not showing for a scheduled surgical procedure:	$ 100.00
Surcharge for non-payment of co-pay at time of service rendered:	$ 20.00
Returned check:	$ 25.00

Any of the fees above that have been placed on your account must be paid in full prior to any future appointments.

If you have any questions please see any staff member who will then direct you to the appropriate person if necessary.

We thank you for your cooperation and allowing us to participate in providing you with quality health care.

_____ _____

Signature Date

Adirondack Foot Care

Salvatore J. Galluzzo, DPM/Douglas Mason, DPM, Lori Lundberg, DPM

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Clifton Park, NY 12065
(518) 383 – 0302

Acknowledge of Receipt of Notice of Privacy Practice and Consent to Use and Disclose Information for Treatment, Payment and Operational Purposes

By signing below, I hereby acknowledge that I have been provided with a copy of this office's *Notice of Privacy Practices* and have been advised of how my health information is protected and may be used and disclosed by this office and how I may obtain access to and control of this information. In addition, by signing below I hereby consent to the use and disclosure of my health information for treatment purposes, payment activities and healthcare operations of the office.

Signature of Patient or Personal Representative

Print Name of Patient or Personal Representative

Relationship to or Legal Authority of Personal Representative

Date