# GOTHAM FOOTCARE, P.C.

501 5th Ave Suite 506 233 Broadway Suite 1775
New York, NY 10017 New York, NY 10007
Office: (212) 921-7900 Fax: (212) 921-7908

## PATIENT INFORMATION AND HISTORY

**PATIENT INFORMATION**

NAME:_______________________________________________ GENDER: ☐ M ☐ F ☐ Other ☐ Prefer Not to Respond
DOB:____________ AGE:____ SSN:__________________________
MARITAL STATUS: ☐ Married ☐ Single ☐ Divorced ☐ Widowed
PHONE (H):___________________________ (W):____________________________ CELL:____________________________
EMAIL: ____________________________________________________________
ADDRESS:___________________________ CITY:__________________________ ST:___________ ZIP:_______________
EMPLOYER:_________________________ OCCUPATION:______________________________________________________
EMERGENCY CONTACT: __________________________ PHONE:____________________ RELATIONSHIP:____________
PRIMARY PHYSICIAN: ____________________________ PHONE:____________________________
PHARMACY: _____________________________________ PHONE: ____________________________

**INSURANCE**

PRIMARY INSURANCE: _____________________________________________ POLICY #:___________________________
RELATIONSHIP TO PATIENT: ☐ Self ☐ Spouse ☐ Parent
SECONDARY INSURANCE: __________________________________________ POLICY #:___________________________

**REASON FOR VISIT**

PRIMARY REASON (Body part & description): _______________________________________________________________
HOW DID YOU HEAR ABOUT US? ☐ Yelp ☐ Gotham Website ☐ Google ☐ Zocdoc ☐ Other:______________________
DATE PROBLEM STARTED: ________________________
WORK-RELATED? ☐ Yes ☐ No CAR ACCIDENT? ☐ Yes ☐ No
CHIEF COMPLAINT: _____________________________________________________________________________________
CONCERN LOCATION: ☐ Right Foot ☐ Left Foot ☐ Both Feet
TRAUMA HISTORY? ☐ Yes ☐ No
PAIN (1-10): ____ TYPE: ☐ Burning ☐ Throbbing ☐ Sharp ☐ Dull ☐ Other:_________________________________________
TREATMENT ATTEMPTS? ☐ Yes ☐ No DETAILS: ____________________________________________________________

**MEDICAL CONDITIONS**: ☐
None__________________________________________________________________________
CURRENT MEDICATIONS: ☐ Yes ☐ No If yes, list:
____________________________________________________________
ALLERGIES: ☐ None ☐ Penicillin ☐ Codeine ☐ Novocaine ☐ Aspirin ☐ Tape ☐ Iodine ☐ Other:____________________
SURGERIES (Dates):______________________________________________________________________________________

**FAMILY HISTORY (Relation to you):**

☐Arthritis ☐Diabetes ☐High Blood Pressure
☐Birth Defects ☐Foot Problems ☐Stroke
☐Cancer ☐Heart Attack ☐None
☐Other__________________________________________________

**Signature of Patient/Guardian:** ________________________________________ **Date:** ____________________

**SOCIAL HISTORY**

OCCUPATION: __________ CURRENTLY WORKING? ☐ Yes ☐ No ☐ Student

DRINK ALCOHOL? ☐ Yes ☐ No If yes, how much? __________

SMOKE? ☐ Yes ☐ No If yes, how much? __________ YEARS: __________ If quit, when? __________

USE DRUGS? ☐ Yes ☐ No If yes, type: __________

PREGNANT? ☐ Yes ☐ No

## REVIEW OF SYSTEMS

Do you have any problems with, or have you noticed any change in the following areas? If yes, please check that apply to you.

| | | | | |
|---|---|---|---|---|
| ___Abdominal Pain | ___Breast Masses | ___Enlarged Lymph Nodes | ___Irregular Heart Beats | ___Skin Ulcers |
| ___Anemia | ___Chest Pain | ___Excessive Hunger | ___ Malaise | ___Sleep Disturbances |
| ___Arthritis | ___Constipation | ___Excessive Thirst | ___Menstrual Problems | ___Sprain |
| ___Atrophy | ___Cough | ___Fever | ___Numbness | ___Stiffness |
| ___Anemia | ___Depression | ___Fracture | ___Palpitations | ___Urinary Hesitancy |
| ___Asthma | ___Dermatitis | ___Hallucinations | ___Pregnancies | ___Weakness |
| ___Balance Problems | ___Diabetes | ___High Blood Pressure | ___Seizures | ___Weight Loss |
| ___Bleeding Tendency | ___Diarrhea | ___Incontinence | ___Shortness of Breath | ___None |
| ___Bloody Sputum | ___Double Vision | ___Incoordination | ___Skin Rashes | |

If YES to any of the above, please explain: ____________________________________________

If there is anything pertinent in your health that was not mentioned above, please explain: ______________________

## COMMITMENT TO CONFIDENTIALITY

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.

At Gotham Footcare, P.C., we are committed to protecting your protected health information (PHI). We maintain confidentiality through employee training, secure procedures, and a strict privacy policy. PHI access is limited to staff who need it for their job. We comply with federal and state privacy laws, including during telemedicine consultations, where existing confidentiality protections apply.

### Consent

By signing this notice, you ("Patient," including parents, guardians, or authorized representatives) consent to receive medical services from *Gotham Footcare, P.C.* You authorize the Practice and its representatives to discuss, disclose, and record your PHI for the purposes of treatment, payment, and healthcare operations. This may involve sharing PHI with healthcare providers, insurers, and third parties involved in your care or reimbursement.

### Telemedicine

Telemedicine consultations involve communication through audio, video, or electronic means. Your PHI may be shared with other healthcare professionals, and examinations or recordings may take place. While telemedicine offers the benefit of remote specialist access, occasional technical issues or privacy risks may occur. If preferred, in-person consultations remain an option.

**Signature of Patient/Guardian:** ________________________________________ **Date:** ____________________

## Use and Disclosure of PHI

We may use and disclose your PHI for:

- **Treatment**: Sharing PHI with physicians, hospitals, pharmacies, and other healthcare providers involved in your care.
- **Payment**: Using PHI to bill health insurers or other responsible organizations for services provided.
- **Healthcare Operations**: Internal activities such as performance reviews, audits, and research (with identifying information removed).
- **Legal Requirements**: PHI may be disclosed as required by law for public health, abuse reporting, or legal proceedings.

## Business Associates

We may share PHI with third-party contractors (Business Associates) who provide services like billing, legal assistance, or medical records processing. These parties are required to protect your privacy under federal law.

## ASSIGNMENT OF BENEFITS AND ERISA AUTHORIZATION

By signing below, you assign your health insurance benefits and rights to *Gotham Footcare, P.C.* and its representatives, authorizing them to:

- File claims, appeals, and grievances.
- Discuss and disclose PHI with third parties, including health plans.
- Pursue legal actions and manage healthcare expenses under ERISA.

This authorization may be revoked in writing, and a photocopy is as valid as the original. You are responsible for keeping your insurance information accurate.

You also authorize your health plan to send these documents to *Gotham Footcare, P.C.*:

- Summary Plan Description (SPD)
- 5500 Form (Annual Report)
- Certified PPACA Grandfathered Plan Certificate

**Your Rights:**

- Access and amend your PHI.
- Restrict certain uses or disclosures.
- File a complaint if your privacy rights are violated by contacting our Privacy Officer or the U.S. Department of Health and Human Services. We will not retaliate against you for filing a complaint.

**Contact Us:**

*Gotham Footcare, P.C.*
501 5th Ave, Suite 506, New York, NY 10017
Privacy Officer: Evelyn Kawalko
Phone: 212-921-7900 X 5
Email: evelyn@gothamfootcare.com

**Signature of Patient/Guardian:** ________________________________________**Date:** ____________________

## CANCELLATION/ NO-SHOW POLICY

To ensure quality care and availability, Gotham Footcare has a cancellation policy for appointments canceled with less than 48 business hours' notice. **A "No-show," "No call," or missed appointment without proper 48-hour notice may result in a $75.00 fee**, which is not covered by insurance. You must notify us at least 48 business hours in advance to avoid the fee, and you can leave a message with our answering service. Arriving 15+ minutes late may result in rescheduling and a possible fee. Repeated missed appointments may end your physician/patient relationship. Reminder calls are a courtesy, but the policy applies regardless. You will be provided with a copy of this policy.

## UNENCRYPTED EMAIL POLICY

By providing your email address, you agree to receive unencrypted emails from *Gotham Footcare, P.C.* These emails may include appointment reminders, billing information, and other non-sensitive communications. Please note that unencrypted emails are not secure, and there is a risk that your information may be accessed by unauthorized individuals. If you prefer not to receive communication via unencrypted email, please inform our office to arrange an alternative method.

## INSTRUCTIONS FOR INSURANCE CHECKS SENT TO PATIENT

You may receive checks from your insurance for services by *Gotham Footcare, P.C.* You must endorse and forward these checks, along with the Explanation of Benefits (EOB), to our office. Failure to do so may make you liable for the full balance, plus interest and legal fees.

Steps:

1. Endorse the check and write "Payable to Gotham Footcare" and "For Deposit Only."
2. Mail the check and documents to:
   **Gotham Footcare, P.C.**
   501 5th Ave, Suite 506
   New York, NY 10017

## FINANCIAL AGREEMENT

I understand that I am responsible for paying deductibles, copayments, or coinsurance. Gotham Footcare, P.C. (the "Practice") will not waive these payments unless specific hardship requirements are met. The Practice collects all amounts owed by the Patient and acknowledges that the Practice is out-of-network, meaning the Physician does not have a managed care contract with the Patient's health plan. The Patient will be responsible for any remaining balances, commonly referred to as a "balance bill," after all health plan and patient payments have been made. **ESTIMATED RATES FOR OUT-OF-NETWORK SERVICES** are available upon request, although these estimates do not account for unforeseen medical circumstances. The Patient is responsible for all coinsurance, copayments, deductibles, balance bills, and non-covered services within 30 days of a written request. Failure to pay within 30 days will result in a 3% monthly interest charge. The Patient is also responsible for obtaining any necessary pre-authorizations or referrals from their insurer. If financial hardship is a concern, the Patient may request a copy of the Practice's Financial Hardship Policy.

I, ___________________ (Patient/ Guardian), acknowledge that I have received the Practice's Financial Agreement, Financial Hardship Policy, and Consent Agreement at the start of my treatment or services. I understand that I am responsible for paying all deductibles, copayments, or coinsurance. Gotham Footcare, P.C. (the "Practice") will not waive these payments unless specific hardship requirements are met. By signing below, I voluntarily consent to and agree to the terms and conditions outlined by the Practice.

**Signature of Patient/Guardian:** ________________________________________**Date:** ____________________