PODIATRIC HOUSE CALLS
Comprehensive Foot Care in Your Home

MARC BRUCKNER, DPM

PO Box 358
Livingston, NJ 07039
973-535-6505

www.podiatrichousecalls.com

New Patients:

Podiatric House Calls welcomes new patients. After you have scheduled an appointment with Dr. Bruckner on the phone, please complete the following forms before your first visit. If you have any difficulty completing the forms, please call for assistance.

Please complete and sign the *Patient Information and Insurance Authorization Form, Privacy Practices Acknowledgement Form, and Patient Medical History Form*.

Also, please include a photocopy of your health insurance cards or have them available at the time of your house call visit.

Please return the forms by mail to:
Dr. Marc Bruckner
P.O. Box 358
Livingston, NJ 07039

Or, you may scan the completed forms back into your computer and **e-mail** the signed forms to: doctor@podiatrichousecalls.com

If you have any questions, please call 973-535-6505.

Very truly yours,

Marc Bruckner, D.P.M.

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PATIENT INFORMATION AND INSURANCE AUTHORIZATION FORM

Name:_____ **ID/Social Sec.#:**_____-_____-_____
Last First Middle

Address:_____
Number Street City State Zip Code

Telephone:_____ **Age:**_____ **Date of Birth:**_____ **Sex:** M F
Marital Status: S M W D

Referred by: _____
In case of emergency who should be notified? _____
Name Relation Telephone

Family Physician:_____ **City:** _____ **Phone:**_____ **Last visit Date:** ____

Primary Insurance Name: _____ **ID#**_____

Secondary Insurance Name: _____ **ID#**_____

"NOTICE OF PRIVACY PRACTICES" ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have been offered and/or provided with a copy of Dr. Bruckner's NOTICE OF PRIVACY PRACTICES. My signature on this form below affirms this acknowledgement.

ASSIGNMENT AND RELEASE STATEMENT FOR INSURANCE POLICIES LISTED ON THIS FORM:

I, the beneficiary, request that payment of authorized Primary, and/or Medicare, and secondary insurance benefits be made either to me or on my behalf to Dr. Marc Bruckner for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related service. I understand that I am financially responsible for all charges whether or not paid by insurance, including all deductible payments, co-payments, and non-covered services as required of the insured by the insurer. Dr. Bruckner has explained to me that the only insurance he participates with is Traditional Medicare. Dr. Bruckner does not participate with any other insurance companies including PPO, HMO or Medicare Advantage plans. For patients who have traditional Medicare, Dr. Bruckner has agreed to accept the charge determination of the Medicare carrier as the full charge. However, I, the beneficiary, remain responsible for the deductible, coinsurance, and non-covered services, including any amounts not covered by my insurance company, as allowed by law. Coinsurance and the deductible are based upon the charge determination of the Medicare Carrier. I further acknowledge that any insurance benefits, when received by and paid to Dr. Marc D. Bruckner will be credited to my account, in accordance with the above assignment. I authorize my primary and secondary insurance carriers, if any, to pay and hereby assign directly to Dr. Bruckner all benefits, if any, otherwise payable to me, for his medical and surgical services. I agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered, or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents. I will be bound by this signature as though the undersigned had personally signed the particular claim. This authorization is in effect until I choose to revoke it. I also authorize treatment to be rendered by Dr. Marc Bruckner.

Insurance Assignment Authorization Signature and HIPAA Acknowledgment Signature:

PLEASE SIGN HERE X _____ **DATE: X**_____

Marc D. Bruckner, D.P.M. Podiatric House Calls PO Box 358 Livingston, NJ 07039 (973) 535-6505

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED, DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires that all medical records and other individually identifiable health information used or disclosed by us in any form are kept confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. As required by HIPAA, we may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations. Treatment means providing, sharing, coordinating, or managing health care information and related services by one or more health care providers or technicians who are taking care of you. Payment means using and disclosing your medical information for payment purposes. Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service.

We may also create and distribute de-indentified health information by removing all references to individually identifiable information. We may contact you via mail or telephone to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Doctor:

1. The right to request restrictions on certain uses and disclosures of protected health information to family members, other relatives, friends, or any other person identified by you. We are not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
2. The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
3. The right to receive, inspect, and copy your protected health information. You may be charged a nominal fee for copies as is allowed by New Jersey State laws.
4. The right to amend your protected health information.
5. The right to receive an accounting of disclosures of protected health information.
6. The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.
This notice is in effect as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. The current Notice of Privacy Practices will be held by the doctor at all times at the office or with the doctor during a house call visit. You may request a written copy of a revised Notice of Privacy Practices from the doctor's office.

If you have any questions or feel that your privacy rights have been violated, you have the right to submit a written complaint with our office or with the U.S. Department of Health & Human services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate in any way if you choose to file a complaint.

----------PLEASE SIGN AND DATE BELOW----------

"NOTICE OF PRIVACY PRACTICES" ACKNOWLEDGEMENT FORM

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information.
I acknowledge that I have been provided with a copy of Dr. Bruckner's Notice of Privacy Practices Form.

Please Sign Your Name Here: X _____ DATE: X_____

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PATIENT MEDICAL HISTORY FORM

Patient Name: _____ Social Security #:_____

PAST MEDICAL HISTORY:
Please list all Medical Problems you have now, or have been treated for in the past:
-
-
-
-
-
-
-
-
-
-
-

ALLERGIES:
Please list any Allergies or Reactions to any medicine, antibiotic, anesthesia, etc.:
-
-
-
-
-

MEDICATION LIST:
Please list all of the Prescription and Over-The-Counter Medication that you take:
-
-
-
-
-
-
-
-

Foot Problems:
Briefly describe what nail, foot, ankle, or leg problems you are having today:
-
-
-
-

Please Sign Your Name Here: X _____ Date: X_____