Charlton L. Adler, DPMPA

1380 NE Miaml Gardens Dr.-Suite 235
North Miami Beach. FL 33179

21150 Biscayme Blvd. -Suite 106
Aventura. FL 33180

Registration Form

Today's Date: _____

Patient information

Patient's Last Name	First	Middle	☐ Mr ☐ Mrs. ☐ Sr. ☐ Dr. ☐ Miss. ☐ Jr.

Date of Birth	Age	Last 4 digits of SS # 000-00- _____	☐ Single ☐ Mairried ☐ Male ☐ Female ☐ Div Divorced ☐ Divorced

Street Address	City	State	Zip code
Seasonal Address	City	State Zip code	Dates at seasonal
Home Phone ( ) -	Work Phone ( )	Cell ( )	
Preferred method of contact: ☐ Home ☐ Work ☐ Cell	Preferred method for appointment reminders ☐ Home ☐ Work ☐ Cell ☐ Text (up to 2 massages per appoinment)		
Email Address:	I authorized email contact ☐ Yes ☐ Yes		
Employed ☐ Yes ☐ No	If yes, Employer:	Occupation:	
Primary Care Physician: _____	Physician phone number: _____		

Emergency Contact

Name:_____ Relationship: _____ Phone: _____

Demographic (FOR GOVERNMENTAL STATISCTICAL ANALYSIS)

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Native American ☐ Black or African American ☐ White ☐ Hispanic ☐ Other Pacific Islander ☐ Other Race ☐ I decline to report

Ethnicity: ☐ HIspanic ☐ Non-Hispanic ☐ I decline to report Language: _____

Insurance Information

Are you aware of your insurance benefits? ☐ Yes ☐ No

Primary Insurance :	Policy#:	Group #:
Insured name:	Employer:	
Date of birth:	Age:	Last 4 digits of SS#: 000-00- _____
Insurance type: ☐ PPO ☐ EPO ☐ HMO ☐ POS ☐ Self-Pay ☐ Medicare ☐ Workers Comp. ☐ Other: _____		

Secondary Insurance :	Policy#:	Group #:
Insured name:	Employer:	
Date of birth:	Age:	Last 4 digits of SS#: 000-00- _____
Insurance type: ☐ PPO ☐ EPO ☐ HMO ☐ POS ☐ Self -Pay ☐ Medicare ☐ Workers Comp. ☐ Other: _____		

Guarantor Information

Last name:	First name: Middle:	
Address:		
Phone: Home ( )	Work ( ) -	Cell ( ) -
Date of birth:	Age:	Last 4 digits SS#: 000-00- _____
Employed: ☐ Yes ☐ No If yes, Employer: _____	Occupation: _____	

Charlton L. Adler, DPM PA

Patient name: _____ Date of birth: _____

Podiatric History

Chief foot or ankie complaint: _____

_____

_____

When did symptoms first appear or accident occur (date)? _____

Please describe your pain / discomfort: ☐Burning ☐Numbness ☐Sharp Other: _____

What makes your pain / discomfort better? _____

What makes your pain / discomfort worse? _____

Has this condition been previously treated? ☐Yes ☐No
If yes. how and when? _____

Height: _____ **Weight:** _____ **Shoe size:** _____

Surgical History

Have you had surgery ANYWHERE on your body? ☐ Yes ☐ No *If yes.pleaselist the type of sutgery and date*

Surgery	Date	Surgery	Date
1)		6)	
2)		7)	
3)		8)	
4)		9)	
5)		10)	

Social History

Do you currently use tobacco? ☐ Yes ☐ No
Have you used tobacco in the past? ☐ Yes ☐ No
If yes to either question, how many packs per day? _____
For how long?

Do you drink alcohoi? ☐ Yes ☐ No

Do you use recreational drugs? ☐ Yes ☐ No

Do you exercise on a regular basis? ☐ Yes ☐ No

Do you drink caffeine (coffee, soda,tea, etc...)? ☐ Yes ☐ No

Are you pregnant?

☐ Yes ☐ No

If yes, What is your expected Due date? _____

Are you nursing? ☐ Yes ☐ No

Are you allergic or have you ever reacted to any of the following? *Please checkyes of no for each item*

Aspirin	☐ Yes ☐ No	reaction: _____	Lidocaine	☐ Yes ☐ No	reaction: _____
Band Aids / Tape	☐ Yes ☐ No	reaction: _____	Novocaine	☐ Yes ☐ No	reaction: _____
Codeine	☐ Yes ☐ No	reaction: _____	Penicillin	☐ Yes ☐ No	reaction: _____
Generel Anesthesia	☐ Yes ☐ No	reaction: _____	Radiographic contrast/Dye	☐ Yes ☐ No	reaction: _____
Iodine	☐ Yes ☐ No	reaction: _____	Sedative	☐ Yes ☐ No	reaction: _____
Letex	☐ Yes ☐ No	reaction: _____	Sulfa Drugs	☐ Yes ☐ No	reaction: _____

Other not listed: _____

Charlton L. Adler, DPM PA

Patient name: _____ Date of birth : _____

Are you being treated or have you been treated for any of the following ? *Please check yes or no for each item*					
Alcoholism	☐Yes	☐No	High Blood Pressure	☐Yes	☐No
Anemia	☐Yes	☐No	HIV / AIDS	☐Yes	☐No
Arthritis if yes, type: _____	☐Yes	☐No	Jaundice	☐Yes	☐No
Atriai Fibrillation	☐Yes	☐No	Kidney Disease	☐Yes	☐No
Bronchitis / Emphysema / COPD	☐Yes	☐No	Mitral Valve Prolapse	☐Yes	☐No
Cancer if yes, type: _____	☐Yes	☐No	Multiple Sclerosis	☐Yes	☐No
Choiesterol / Triglycerides	☐Yes	☐No	Parkinson's disease	☐Yes	☐No
Depression	☐Yes	☐No	Psychiatric illness	☐Yes	☐No
Diabetes if yes, # of years: _____ Last blood sugar # / AIC _____ / _____	☐Yes	☐No	Rheumatic Fever	☐Yes	☐No
			Seizures		
			Stroke	☐Yes	☐No
Drug Abuse	☐Yes	☐No	Stomach Ulcers	☐Yes	☐No
Epilepsy	☐Yes	☐No	Thrombophlebitis (Blood Clot)	☐Yes	☐No
Fibromyalgia	☐Yes	☐No	Thyroid Disease	☐Yes	☐No
Gout	☐Yes	☐No	Tuberculosis	☐Yes	☐No
Heart Attack	☐Yes	☐No	Tumor	☐Yes	☐No
Hepatitis	☐Yes	☐No	Other:		

Family History- *Please orno for each item.* If yes please the family member who has been treated for the following:						
Bleeding disorders	☐Yes	☐No		Kidney Disease	☐ Yes	☐ No	_____
Cancer	☐Yes	☐No	_____	Mental Illness	☐ Yes	☐ No	_____
Diabetes	☐Yes	☐No	_____	Arthritis	☐ Yes	☐ No	_____
Heart Disease	☐Yes	☐No	_____	Stroke	☐ Yes	☐ No	_____
High Blood Pressure	☐Yes	☐No	_____	Other:	_____		

Pharmacy information

Pharmacy Name: _____ Phone Number: _____

Address: _____

Do you take medications on a daily basis, including pills, injectables, or herbs ? ☐Yes ☐No ☐See attaches list

Medication name	Dosage	Medication name	Dosage

_____ _____

Patient Signature Date

Charlton L. Adler, DPM PA

Patient name: _____ Date of birth: _____

Referred to office by - Please use one

☐ Doctor _____ ☐ Insurance plan _____ ☐ Family _____

☐ Friend _____ ☐ Other _____

Cardiovascular: ☐ Calf pain with exercise / while sleeping ☐ Chest pain / heart attack ☐ Congestive heart failure ☐ Heart failure ☐ Paipitations ☐ none of the above

Constitutional Symptoms: ☐ Fever ☐ Chilis ☐ Sweats ☐ Weight loss ☐ **none of the above**

Endocrine: ☐ Excess sweating ☐ Frequent / Difficulty urinating ☐ Often feeling hovcold ☐ Often hungry ☐ Often thirsty ☐ Pancreatitis ☐ Prostate problems ☐ **none of the above**

Gastrointestinal: ☐ Acid reflux ☐ Blood in stool ☐ Constipation ☐ Decrease in appetite ☐ Diarrhea ☐ Nausea ☐ Vomiting ☐ **none of the above**

Head. Eves. Ears. Nose. and Throat: ☐ Cataracts ☐ Contacts ☐ Dentures ☐ Difficulty Swallowing ☐ Dizziness ☐ Double vision ☐ Eyeglasses ☐ Neck Pain ☐ Nose Bleed ☐ ringing in ears ☐ Sore throat ☐ **none of the above**

Hematoiogical / Lymphatic: ☐ Bleeding abnormalities ☐ Lump in groin/armpit ☐ Swolien glands ☐ **none of the above**

Integumentary (Skin): ☐ Birthmarks ☐ Changes in skin color ☐ Eczema ☐ Growth on skin ☐ Hair loss ☐ Lesions ☐ Piercings ☐ Rash ☐ Recurrent infections ☐ Sensitivity to sunlight ☐ Tattoos ☐ Skin ulcers/wounds in the past ☐ **none of the above**

Muscuioskeletal: ☐ Bursitis ☐ Joint pain/swelling/stiffness ☐ Prior fracture/sprains ☐ Tendonitis ☐ Weakness of limbs ☐ **none of the above**

Neuroiogical: ☐ Confusion ☐ Fainting ☐ Insomnia ☐ Migraines ☐ Nervous disorders ☐ Neuropathy (loss of sensation) ☐ Poor balance ☐ Speech difficulties ☐ **none of the above**

Psychiatric: ☐ Depression ☐ Nervousness ☐ Tension ☐ **none of the above**

Respiratory: ☐ Cough ☐ Wheezing ☐ Difficulty breathing ☐ Shortness of breath ☐ **none of the above**

To the best of my knowledge, the questions above were accurately answered. I understand that providing inaccurate information can be dangerous to my health.

Patient name: _____ Signature of patient / parent / POA: _____ Date: _____

Fees Acknowledgerment

Office Visits: As a patient of Charlton L. Adler. DPM PA. I acknowledge that I maybe charged a $50.00 fee should I "No Show" and/or do not cancel my appointment within 24 hours.

FMLA and Disability Forms: There will be a $25 charge for completing FMLA and disability paper work. Please submit paperwork one week prior to due date. This charge applies to all other paperwork that needs to be completed by the office as well.

Patient Signature: _____ Date: _____

Charlton L. Adler, DPM PA

Finance Charge
A finance charge will be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was added to the account. The finance charge will be computed at an annual percentage rate of one percent (1%) per month or an annual percentage rate of twelve percent (12%). The finance charge on your account is computed by applying the periodic rate (1%) to the overdue balance of our account. The overdue balance of your account is calculated by taking the balance owed thirty (30) days ago, and the subtracting any payments or credits applied to the account during that time. The minimum finance charge is $50.00.

Videotaping / Photography Policy
In an effort to maintain patient privacy. all forms of videotaping and photography are prohibited This includes but is not limited to the reception area and treatment rooms,

Past Due Accounts
if your account becomes past due. we will take the necessary steps to collect this debt, If we have to refer your account to a collection agency you agree to pay all of the collection of the balance to a lawyer, you agree to pay all the lawyer's fees which we incur, plus all court costs. in case of sult, you agree the venue shall be in Hillsborough County, Florida.

Waiver of Confidentiality
You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency the fact that you received treatment at our office may become a matter of public record.

Effactive Date
Once you have signed this document you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

_____ _____

Patient Signature Date

Acknowledgement of receipt of Notice of Privacy Practices

I ack nowledge that I was provided a copy of the Notice of Privacy Practices by Charlton L. Adler, DPM PA and that I have read (or had the opportunity to read. if I so chose) and understood the notice.

_____ _____

Patient Signature Date

I give authorization to discuss my protected health information to the dollowing:

Name	Relationship	Date of birth
Name	Relationship	Date of birth

Medical information release

I authorize the release of medical information tomy insurance company necessary to process my claim. I also authorize the payment of medical benefits directly to my physician. I understand I am financially responsible for charges not covered by this authorization.

_____ _____

Patient Signature Date

Charlton L. Adler, DPM PA

Appointments
If you are unable to keep an appointment please call the office to reschedule at least 24 hours in advance. Patients with three missed appointments may be asked to transfer their records to another doctor. Patients who are more than 15 minutes late may be asked to reschedule.

Transferring Records
If you want to have copies of your records, you must authorize us to include all relevant information, including your payment history upon request. If you are requesting your records to be transferred from another doctor of organization to us, you authorize us to receive all relevant information including your payment history. There will be a $10 copying fee per film for x-rays of a $5 copying fee per CD for digital x-rays.

Financial Policy
This is an agreement between Charlton L. Adler, DPM PA , as creditor and the patient/debtor named on this form. in this agreement the word "you", "your", and "yours" means the patient/debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us", and "our" refer to the Charlton L. Adler, DPM PA By executing this agreement you are agreeing to pay for all services rendered.

Insurance
Insurance is a contract between you and your insurance company.(We are not a party to this contract, in most cases). We will bill your primary Insurance company only if we are a contracted participating provider, we also accept secondary insurances. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility, you agree to pay any portion of the charges not covered by insurance.

Verification of Benefits
We may assist you, at our discretion, in verifying your insurance coverage in an effort to verify exactly what podiatric coverage is available on your policy. Please be sure to give your insurance information to our staff prior to your appointment date. You as tha policyholder are primarily responsible to verify benefits. We cannot guarantee payment of the benefits and subsequently you may be responsible for any coinsurance deductibles, or fees for non-covered services that may result.

Referrais
If your insurance company requires referral and/or preauthorization/pre-certification you are responsible for obtaining it. We will not be able to obtain a referral on the date of service. Options at this point will be to reschedule the appointment or to pay at the time of service. We suggest you call your primary doctor at least 24 hours in advance to confirm that your referral has been generated and faxed. The most reliable method is to obtain it yourself.

Workers Compensation
We require written approval/authorization by your employer and/or worker,s compensation carrier prion to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal injury
If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We do not accept letters of protection and subsequently cannot bill your attorney for charges incurred due to a personal injury case.

Divorce
In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for the child will be responsible for those subsequent charges. If the divorce decree requires the other parent pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Required Payments
Any co-payment, deductibles or coinsurances, fees for non-covered services, or outstanding balances must be paid at the time of service.

Payments Options
You may choose to pay cash, check, credit card,or care credit on the day that the treatment is rendered.

Returned Checks There is fee (currently $25) for any checks returned by the bank.

Monthly Statement
If you have a balance on your account, we will send you a monthly statement. It will show separately the balance, any new charges to the account, and the finance charge, if any.

Payments
Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Charlton L. Adler DPM PA
1380 NE Miami Gardens Dr. Suite North Miami Beach, FL 33179
21150 Biscayne Blvd. Suite 106 Aventura, FL 33180

Consent for Treatment:

I voluntarily consent to the reading of care, including treatment, administration of anesthetic and performance of diagnostic and/or surgical procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

Assignment of Benefits:

I hereby assign payment directly to the physician(s) accepting the assignment of medical benefits applicable changes. I understand that I am financially responsible for the charges not covered by this assignment or for any and all charges which the insurance carrier declines to pay. it is further agreed that any credit blance resultng from payment of the insurance of other sources may be applied to any other accounts owed to said physician(s) by the insured or his/her family.

Release of information:

The physician(s) may disclose all or part of the patient's record to any person or corporation which is or may be liable to a contract to physician(s) or to the patient family member or employer. I authorize any physician, nurse, or other healthcare professionals who has attended me or any hospital at which I have been confined to furnish Dr. charlton adler or any authorized representative any and all information that may be regarding my physical or mental condition and treatment render therefore, and if necessary allow them or any physician appointed by them to examine any x-ray picture taken of me or records regarding my physical or mental condition or treatment. A photocopy of this instrument may be used instead of the original.

Lifetime authorizaton:

Medicare and Medicaid patients certification payment classification authorization to release information and payment request. I certify that the information given by me in applying for payment under title and/or title XIX or Social Security act is correct. I authorize any holder or medical or other informatoon about me to be released to the social security administration or its intermediary carries, any information needed for this or related Medicare, Medicaid, or any other third-party claim. I request that payment or authorized benefits be made on my behalf. I assign the benefits payable for physician(s) service. I understand that I am responsible for my health insurance deductible and co-insurance.

Signature:_____ Date:_____