

**MENORAH PARK  
WOUND HEALING CENTER**  
27100 Cedar Road, Beachwood, Ohio 44122



**REGISTRATION FORM**

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**PATIENT INFORMATION**

Today's Date: \_\_\_\_\_

**NAME:** Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_

Sex: M F D.O.B: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Soc. Sec# \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ E-Mail: \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

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**CONTACT AND CONSENT**

Is there someone we may talk to if we cannot reach you?

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

May we leave a message at your home with other residents? YES NO

May we call you at work? YES NO

May we leave a message on your answering machine or voicemail? YES NO

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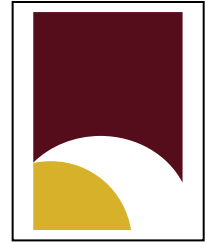
**AUTHORIZATION**

I, with my signature below, authorize Menorah Park/ID Consultants, Inc. to furnish information to the identified insurance carrier (s) for prior carrier(s) for prior authorization, pre-certification or payment of health care services. This information may include claims, copies of medication information, faxes and phone calls concerning care provided or proposed, and I assign all payments for these services to this practice. I understand that I am responsible for co-payments, deductibles, all non-covered services, proper referrals and use of participating lab and radiology provides. I further understand that my contract with my insurance carrier may or may not cover some services and that is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware that I may be responsible for all charges that are incurred and may ultimately be responsible for charges whether covered or not by insurance.

Patient, Parent or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**Please present your Driver's License /State ID along with your Insurance Card to the receptionist.**

**MENORAH PARK  
WOUND HEALING CENTER**



What is the reason for your visit? \_\_\_\_\_  
\_\_\_\_\_

Do you have any **medical conditions** in the following areas? If yes, please explain.

Please answer the following **foot related** questions:

- | Yes                      | No                       |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a history of foot problems?         |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you seen a podiatrist in the past?         |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had foot surgery in the past?          |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had a foot wound in the past?          |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any numbness/tingling in your feet? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do your legs cramp when you walk?               |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have foot pain that wakes you at night?  |
| <input type="checkbox"/> | <input type="checkbox"/> | any other foot related issues: _____<br>_____   |

- | Yes                      | No                       |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes ( <input type="checkbox"/> Insulin Dependent) |
| <input type="checkbox"/> | <input type="checkbox"/> | Vascular Issues  |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Problems  |
| <input type="checkbox"/> | <input type="checkbox"/> | Dialysis   |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Hyperlipidemia   |
| <input type="checkbox"/> | <input type="checkbox"/> | Gout   |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis  |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Problems   |
| <input type="checkbox"/> | <input type="checkbox"/> | Any other issues: _____<br>_____                       |

Please list your **current medications**:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_

Please list all your prior **surgeries**:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Please list any **regular over the counter medications** and/or **vitamin supplements** that you are **currently** taking:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

List any allergies:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

- Do you smoke?  Yes  No  
 Do you drink alcohol?  Yes  No  
 Do you ever use illicit drugs?  Yes  No

Who is your primary care physician? \_\_\_\_\_

Which physician referred you to Dr Nemet? \_\_\_\_\_



# MENORAH PARK WOUND HEALING CENTER

## PRIVACY STATEMENT

**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**

- I. **This is a formal notification, as required by the government concerning the privacy of this practice.** This practice has an obligation to maintain all medical information in the strictest of confidence. ID Consultants, Inc. cannot release information without your written or verbal consent, including medical records, conversations, reminder calls, test results and other confidential information. Patient information about health care is identified as "PHI" or protected health information. **This new policy requires that you, the patient, identify on your registration form specific information authorizing release of information.** You can change this information at any time with either written or verbal notification. Changes can only impact the care or information from that point in time forward.
- II. Your protected health information (PHI) is a part of your medical care, and can be used or disclosed as follows:
  - For your treatment in this practice and other locations under our care. This may include information about infectious disease or immunology evaluation and exam, procedures done related to your care needs, medication management, hospice, VNA support, referral for services, diagnostic tests or treatment related to your medical care. This includes release of information to family and significant others.
  - For obtaining payment for treatment with your identified health care program. This would include any documentation related to this care, including history forms, progress notes, pictures and procedure notes. This would include eligibility verification, prior authorization and claim submission.
  - For operations of this practice, such as enrolling with insurance programs, hospital privileges, quality assurance, pharmacy review and compliance with federal and state laws and regulations.
  - Appointment reminders and health related benefit services only with your consent identified on the registration form
  - Disclosure to your family and friends concerning any related health care information with you on the registration form which can be modified at any time orally, followed by consent.
  - Consent is not required for emergency care and treatment. An emergency is identified as a medical condition that in the judgment of the physician requires information for care on your behalf.

**Certain disclosures can be made without your consent, and they are as follows:**

  - Disclosure required by the government or law enforcement agencies. An example would be victims of abuse
  - Information used for public health purposes, medical examiners or related to a person's death or for the health department for disease tracking
  - Information used for health care oversight, such as a site review by an insurance program.
  - For worker's compensation cases or employment related assessments
- III. Your rights for your health information include: The right to request limits on the uses and disclosure at registration or any time during your care. The right to choose how we send this information to you, including an alternate address. The right to see and obtain copies of your PHI, but there may be copy and postage fees. The right to get a listing of who we have made disclosures to about your PHI. The right to correct your file through an amendment process if appropriate.
- IV. This practice reserves the right to modify or change this Privacy Statement and process at any time. Revision to the Notice will be available upon request by contacting the office. The changes will be effective retroactively to the initial date of this Privacy Notice. An updated Privacy Notice will be posted in the office within 60 days of the revision.
- V. If you have a concern or complaint about how your protected health information is being used, from this time forward you should first contact our Practice Administrator at our Business office to resolve your concerns or you may contact the office of Civil Rights or the Ohio Medicare, GBA Palmetto.

Office of Civil Rights – Regional Manager  
Department of Health & Human Services  
233 N. Michigan Ave., Suite 240, Chicago, IL 60601

Palmetto GBA  
Part B Operations-HIPPA Compliance Concerns  
PO Box 18957, Columbus, OH 43218

Patient Name: \_\_\_\_\_ Date \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Patient unable to sign due to: \_\_\_\_\_  Refused to sign - Date \_\_\_\_\_