Stacey A. Sarmiento D.P.M.
Diplomate, American Board of Podiatric Surgery

Gates Podiatry Center
2211 Lyell Avenue, Ste 103
P-(585) 426-4460 F-(585) 426-4475

Please fill out front & back of each form completely!

Today's Date______________________

Patients full name:

Last:________________________________ First:____________________________ M:_________ Sex M F

Patient SS #:________________________________ Date of Birth:______________________________

Address: ____

City:________________________________ State:______________ Zip Code: __________

E-Mail: ____________________________

Home#:______________________ Work#:____________________ Cell#:______________________

Messages may be left with: Anyone OR Patient only, Home Work Cell, OR Do NOT leave a message

Marital Status: S M D W P Name of Spouse/Partner____

Ethnicity: Hispanic or Latino NOT Hispanic or Latino

Primary Language: English Italian Spanish Other: ___________________________________

Race: American Indian Asian African American Pacific Islander Caucasian

How did you hear about Gates Podiatry/Dr. Stacey Sarmiento? ______________________________

Name of Emergency Contact: _____________________________ **Relationship:** ___________________

Phone number of Emergency Contact:____

Pharmacy: _______________________ Location: ___________________ Phone: _________________

Name of Primary Physician: ___________________________ Date last seen: _____________________

Phone________________________________ Fax______________________________________

Address____

Employer Name: _______________________________ Occupation: ______________________________

Business Phone ___________________________ Full Time Part Time Student Retired

Address____

Have you previously seen a Podiatrist (Foot Doctor)

If Yes, Name of Doctor: ____ When: ________________

Patient Name: ______________________________________ Date of Birth ___/___/___

Height__________________ Weight_____________ Shoe Size______________

Please state REASON for VISIT: ____

<u>DO</u> you get a flu shot? Yes or No

Is this an injury related to Worker's Comp? Yes No

Is this the result of an auto accident? Yes No

<u>Allergies:</u> No known allergies (Circle if applies)

Antibiotics (Please list specific antibiotics) ______________________________________
Adhesive Tape
Iodine
Latex
Shellfish
Other____

<u>Medical History(Circle all that apply)</u>

AIDS/HIV
Alcoholism
Allergies
Alzheimer Disease
Anemia
Ankle/Leg Swelling
Aneurysm
Anxiety
Appendicitis
Arteriosclerosis
Arthritis
Asthma
Back Problems
Bipolar
Boils
Broken bones
Bronchitis
COPD
Cancer
Cerebral Palsy
Chicken Pox
Circulation Problems
Cold Feet
Cold Intolerance
Dementia
Depression
Dermatitis
Diabetes
Emphysema
Epilepsy
Eye Vision Problems
Fatigue
Fibromyalgia
Gastric Reflux
Glaucoma
Gout
Headaches
Heart Attack
Heart Burn
Heart Disease
Hepatitis
High Blood Pressure
High Cholesterol
Joint Pain
Leg Cramps
Liver Disease
Lupus
Measles
Morning Stiffness
Multiple Sclerosis
Muscle Pain
Mumps
Neuropathy
Non-Healing Wounds
Nose Bleeds
Pace Maker
Panic Attacks
Parkinson Disease
Pneumonia
Polio
PVD
Rheumatic Fever
Rheumatoid Arthritis
Ringing In Ears
Scarlet Fever
Shingles
Shortness of Breath
Sleep Problems/Apnea
Stroke
Thyroid
Tremors
Ulcers
Venereal Disease
Vertigo
Weight Changes
Whooping Cough

Surgical History (Circle all that apply)

Foot Surgery: Type ______________________________ Date: ________________ Right/Left

Angioplasty
Ankle Surgery
Appendectomy
Back Surgery
Biopsy
Brain Surgery
Breast Surgery
Carpal Tunnel Surgery
Chest Surgery
C-Section
Eye Surgery
Gallbladder Surgery
Gastric Bypass
Heart Surgery
Hernia Repair
Hip Surgery
Hysterectomy
Kidney Surgery
Knee Surgery
Leg Surgery
Lymph Node Removal
Mastectomy
Pacemaker
Shoulder Surgery
Thyroidectomy
Tonsillectomy
Tonsilloadenoidectomy
Tubal ligation
Valve Surgery
Vascular Surgery
Wisdom Teeth Removal
Wrist Surgery

Other Surgical History (Please List) ____

Social History: (Circle all that apply)

Smoking: Yes-Packs per day__________
Quit Smoking:
When?_________________________
Never Smoked

Vaping: Yes Never Occasional Quit
Alcohol: Yes Never Occasional Quit
Recreational Drugs:
Yes Never Occasional Quit

Family History: (Circle all that apply)

Arthritis
Cancer
Diabetes
Heart
Hypertension (High Blood Pressure)
Unknown

Signature____ Date ________________

Gates Podiatry Center
Dr. Stacey Sarmiento
(585) 426-4460

Permission to Treat and Bill Insurance Company

I authorize Dr. Sarmiento to provide any insurance company, claim administrator, and/or consulting healthcare professionals' information concerning health care advice, treatment and/or supplies provided. This information will be used for the purpose of evaluating and administrating claims for benefits otherwise payable to me.

I hereby give my permission to Dr. Sarmiento and her assistants to diagnose administer medications and perform such procedures as may be deemed necessary in the diagnosis/treatment of my feet, ankles and related conditions. I understand and agree that because of human variance and response, it is not possible to warrant the outcome of any medical care or service.

I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that Gates Podiatry Center will retain ownership rights to these photographs, videotapes, digital, or other images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in Gates Podiatry Center's policy. Images that identify me will be released and/or used outside the institution only upon written authorization from me or my legal representative.

Patient's Signature: ______________________________

Date: ____________________

If completed by a patient's personal representative, please print and sign your name in the space below

Personal Representative (Print) ______________________________
Personal Representative's Signature ______________________________
Relationship ______________________________

Revised 3/2017

ACKNOWLEDGEMENT & RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

____

Patient Name (please print)

____

Parent or Authorized Representative (if applicable)

AUTHORIZATION TO RELEASE INFORMATION

I authorize my Primary Physician as well as the following individuals to have access to my "Protected Health Information".

Please list names:

Emergency Contact: ____________________________________

Phone #: ____

List any other person(s) you authorize to have access to your information:

______________________________ *Phone*________________________

______________________________ *Phone*________________________

______________________________ _____________________________

Patient Signature *Date*

For office use only

Complete this section if this form is not signed and dated by the patient's personal representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of Gates Podiatry Notice of Privacy Practices but was unable to for the following reason:

- o Patient refused to sign
- o Patient unable to sign
- o Other________________________

Employee___________________ Date:__________________

Patient Financial Policy

Your understanding of financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our staff.

1. As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.

2. Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check.

3. Accepting assignment means that we will accept what your insurance company pays for the services rendered that they pay. The patient is responsible for co-payments, deductibles and non-covered services, items and fees. In these circumstances, payment of **YOUR** portion must be paid at the time of service.

4. There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.

5. We will gladly discuss your proposed treatment and answer any questions you may have. Upon request, we will provide you with an estimate of our fees for a planned procedure or course of treatment. You must realize however that:

   - Your insurance company is a contract between you and the insurance company. We are not a party to the contract. We cannot determine the benefits your insurance company provides you, this is the patient's responsibility.
   - All Health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
   - You agree to have the insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for the payment.

6. All appointments that need to be cancelled must be done 24 hours prior to the appointment. If you fail to cancel the appointment, and do not come in, you will be charged a fee of $25.00.

7. All Office Products/Merchandise purchased are prohibited from being returned to Gates Podiatry Center

8. Requests for billing, copies of your account and completion of forms are not included in office fees and will be billed separately. Your x-rays and charts are part of your permanent medical record and remain the property of our office. Copies of x-rays can be made for a fee of $15 per film, and copies of medical records for .75 per page.

9. There will be a fee of $5.00 to complete disability or workers compensation paperwork, per set. Please allow ample time (1 week) for the forms to be completed.
   There will be an additional $5.00 fee per set, needed within 48hrs.

10. There will be a $35.00 fee for all returned checks.

11. Past Due Accounts; If a bill is not paid within 30 days, there will be a late fee of $15.00 and an invoice fee of $5.00 per billing cycle. Accounts older than 90 days will be sent to collections and/or an attorney, you will be responsible for all collections and/or attorney fees.

We must emphasize that as your Podiatric Care Provider, our relationship is with you, not your insurance company. Filing of your insurance claims is a courtesy service that we extend to our patients. The charges are your responsibility from the day services are rendered.

I the undersigned have read and fully understand the policy of the Gates Podiatry Center, and agree to follow this policy.

Patient Signature ______________________________ Date ________________

Parent or Authorized Representative (if applicable)

______________________________ ______________________________

Print Name of Legal Representative — Signature of Legal Representative

____

Relationship of Legal Representative

Gates Podiatry Medication Form

Name:____**Date:**_______________________

Birth Date: ___/___/______

List all: Medicines/Vitamins you are currently taking, Prescriptions, Over the counter medications (examples: Aspirin, antacids) and herbals (example: ginseng, glucosamine). Include "medications taken as needed" (example: nitroglycerin)

Name of Medications, Vitamins etc.	Dosage	Dose Per Day	Reason for Taking