Dr. Emmanuel Fuzaylov

"Healthy Feet Mean Healthy Lifestyle"

Name: Age:_____Date Of Birth:
Current Address: Telephone:
Zip: ___ Referred By: Occupation:
Social Security #: Email:
Employer Name: _____ Employer Telephone:
Employer Address:

Medications:

Allergies:
Diabetes:
Hypertension (High Blood Pressure):
Ulcers:
Arthritis:
Cardiac Problems:
Bleeder:
Kidney Disease:
Stroke:
Malignancy: ____
Children:
Operations:

Insurance Information
Medicare: ____ _____
Medicaid:
BCBS:
GHI:
Aetna:
Cigna:
1199:
Empire Plan:
Policy Holder:
D.O.B:
Social Security #:

TO BE FILLED OUT BY PHYSICIAN BELOW:

VASCULAR

COLOR	R	L
Temp		
Edema		
Nutrition		
Hair		
Texture		
Burning		
Claudication		
Dorsal Pedis		
Posterior Tibial		
Varicosities		
Nails		

NEUROLOGIC

Ankle Clonus:
Tendo Achilles:
Patella:
Vibratory:
Babinski:
Parathesias:

CULTURE REPORTS

CHIEF COMPLAINT:

Onset Duration:

Assignment of Benefits

Financial Responsibility

I understand that insurance billing is a service provided as a courtesy and that I am at all times financiall responsible to this office and/or its affiliated entities for any changes not covered by health care benefits. It i my responsibility to notify this office of any changes in my health care coverage. In some cases exact insuranc benefits cannot be determined until the insurance company receives the claim. I am responsible for the entir bill or balance of the bill as determined by the office and/or my health care insurer if the submitted claims o any part of them are denied for payment. I understand that by signing this form that I am accepting financia responsibility as explained above for all payments for medical services and/or supplies received.

Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicar beneficiary, to this office for all covered medical services and supplies provided to me during all courses o treatment and care provided by this office and/or its affiliated entities or otherwise as directed. I understand an agree this Assignment of Benefits will have constitute a continuing authorization, maintained on file with thi office, which will authorize and all for direct payment to this office of all applicable and eligible insuranc benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by thi office.

Authorization to Release Information

I authorize the release of any medical or any other information to the Health Care Financing Administration, my insurance carrier(s), or other entity necessary to determine insurance benefits or the benefits payable for relate medical services and/or supplies provided to me by this office. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance carrier(s), or other medical entity, if requested. The original authorization will be kept on file by this office.

Patient/Insured (print name) Date of Birth Social Security Number

Patient/Insured (signature) Date of Signature

Witness (signature) Date of Signature

ACKNOWLEDGEMENT OF RECEIPT

Of

NOTICE OF PRIVACY PRACTICES

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

Patients Name (Please Print) **Date**

Parent or Authorized Representative (if applicable)

Signature

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

CARRIER

HEALTH INSURANCE CLAIM FORM

PICA

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

PATIENT AND INSURED INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Dr. Emmanuel Fuzaylov
-"Healthy Feet Mean Healthy Lifestyle"

REQUEST FOR PHARMACY INFORMATION

On March 13th, 2015, Governor Andrew M. Cuomo and the New York State Legislature amended the Public Health Law and the Education Law to **extend the implementation date for mandatory electronic prescribing to March 27th, 2016.**

Please provide the information below:

Pharmacy Name: _____

_____

Address: _____

_____

Phone Number: _____