Patient registration

Dr. Keith Penera, DPM
PODIATRIC MEDICINE AND SURGERY

Patient information (please print)

Last name _____ **First** _____ **Middle** _____

Preferred name _____

Other name(s) you are also known as _____ **DOB** ____/____/____

Gender identity ☐ Man ☐ Woman ☐ Intersex ☐ Genderqueer ☐ Prefer not to disclose
☐ Other _____

Sex assigned at birth ☐ Man ☐ Woman ☐ Intersex ☐ Genderqueer ☐ Prefer not to disclose
☐ Other _____

Relationship status ☐ Single ☐ In a relationship ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Required information

Address _____ **Apt.** _____

City _____ **State** _____ **ZIP** _____

Phone numbers (please check box of your preferred contact number)

☐ **Home** _____ ☐ **Cell** _____

☐ **Work** _____ ☐ **Work ext.** _____

Email _____

By providing your email above, you acknowledge the emails may contain your Protected Health Information and will be sent unencrypted. There is a risk of interception or disclosure of the contents of these emails.

Emergency contact

Last name _____ **First** _____ **Relationship** _____

Address _____ **Apt.** _____

City _____ **State** _____ **ZIP** _____

Home phone _____ **Cell** _____

Work _____ **Work ext.** _____

Required information

Ethnicity (select one)
☐ Hispanic or Latino or Spanish origin
☐ Not Hispanic, Latino or Spanish origin
☐ Prefer not to disclose

Race (select one)
☐ American Indian/Alaska native
☐ Black or African American
☐ Native Hawaiian or Pacific Islander
☐ Asian
☐ White or Caucasian
☐ Prefer not to disclose

Preferred language _____

Occupation _____

Have you ever been a patient of Dr. Keith Penera, DPM before? ☐ Yes ☐ No

If yes, state the location/provider _____

Responsible party information (do not complete if patient is responsible party)

Relationship to patient _____

Last name _____ **First** _____ **Middle** _____

Driver's license number _____ **DOB** _____/_____/_____

Address _____ **Apt.** _____

City _____ **State** _____ **ZIP** _____

Email _____

Home phone _____ **Cell** _____

Work _____ **Work ext.** _____

Authorization to treat

I (and/or the undersigned on behalf of the patient) voluntarily consent to allow Dr. Keith Penera,DPM and staff to provide such evaluation and/or care and treatments as an outpatient on a continuing basis and as an inpatient as necessary, as Dr. Keith Penera,DPM and staff may decide is advisable and necessary.

I understand that although care is reviewed and supervised by Dr. Keith Penera,DPM, actual care may be rendered by physician extenders (i.e., physician assistants, nurse practitioners, certified nurse midwife). I further understand that residents, medical students, physician assistant students, nurse practitioner students, nursing students, pharmacy students or other allied health professional students may assist in my treatment.

I am advised that such treatment may include physical examination, X-ray examination, laboratory procedures, other office procedures as well as inpatient procedures as required.

I understand that should I execute a Durable Power of Attorney for Health Care or other Advance Directive, I will provide an executed copy to my physician. I further understand that I will notify my physician of any changes in the Directive.

I understand that I will be informed about the course of my treatment. Also, I am free to terminate my treatment with my physician at anytime.

Assignment of benefits

I hereby assign medical and/or surgical benefits, private insurance, and any other health plan benefits to Dr. Keith Penera,DPM. A copy of this assignment is considered valid as the original.

_____ _____

Form completed by (print) Date

_____ _____

Signature Relationship to patient

Financial responsibility

I understand that I am financially responsible for all charges, whether or not paid by my insurance, unless specifically exempted by my insurance company's contract with Dr. Keith Penera,DPM.

I, _____, hereby certify that I am eligible
Name of patient

for _____, benefits effective _____.
Insurance name Effective date

I have chosen **Dr. Keith Penera,DPM** to be my medical provider. I understand that if the above is not true, I am responsible for all charges related to services provided to me. Also, if the above is not true, I agree to pay in full for all services received within 30 days of receiving a bill from **Dr. Keith Penera,DPM.**

_____ _____
Signature of patient or responsible party Date

Acknowledgment of receipt of Dr. Keith Penera,DPM Notice of Privacy Practices

By signing this document, I acknowledge that I have been provided a copy of the Notice of Privacy Practices. This notice explains how my personal information can be used and disclosed by this medical office.

_____ _____
Printed name Date

_____
Signature

Cellular telephone number communications

By providing my cellular telephone number to Dr. Keith Penera,DPM and staff on this form, I agree to receive automated calls, prerecorded messages and/or text messages related to my health care from Dr. Keith Penera,DPM and staff, its affiliates and their respective physicians. I acknowledge that the Texting Terms of Use will be included in the first text message I receive. I acknowledge and agree that the text messages, which will be sent via unencrypted means, may contain Protected Health Information (PHI) and there is some risk of disclosure or interception of these messages. I may revoke or withdraw this consent at any time. Withdrawal of consent for text messages or automated calls can be made by replying STOP to the text messages or calling **1-800-403-4160.**

_____ _____
Signature of patient or personal representative Date

_____ _____
Personal representative's name Relationship to patient/minor

Open Payments notice to patients

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at **openpaymentsdata.cms.gov**

_____ _____
Patient or representative signature Date

Advance health care directive acknowledgment

Dr. Keith Penera,DPM, in compliance with the Patient Self-Determination Act of 1990, ensures a patient's right to self-determination by inviting patients to participate in decisions about their health care. This is accomplished through the planning and communication of their medical treatment wishes through an Advance Health Care Directive Acknowledgment Form.

My initials next to one of the followings statements indicates my current Advance Directive status.

Initials	Statement
	I have provided a copy of my Advance Health Care Directive Form to Dr. Keith Penera,DPM to be placed in my chart. ☐ Scanned to EHR
	I will provide a copy of my Advance Health Care Directive to Dr. Keith Penera,DPM.
	I do not have an Advance Health Care Directive at this time. I understand that it is my responsibility to discuss this matter with my primary care provider.

My signature acknowledges that I have informed Dr. Keith Penera,DPM of my right to participate in making decisions about my medical treatment by executing an Advance Health Care Directive.

Patient signature	Printed Name	Date
Witness signature	Printed Name	Date

For office use only:

☐ Written and verbal information was provided to the patient. (Advance health care directive packet)

Comments: _____

*Special release needed for HIV test results.

If you are a guardian or court-appointed representative, you must provide a copy of your legal authorization to represent the patient.

The company does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities. We provide free services to help you communicate with us. This includes letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call 1-800-403-4160, TTY 711. ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-800-403-4160, TTY 711. 請注意 ：如果您說中文 (Chinese)， 我們免費為您提供語言協助服務。 請致電 ：1-800-403-4160, TTY 711 。

Dr. Keith Penera, DPM
PODIATRIC MEDICINE AND SURGERY

Authorization for use and disclosure

I authorize Dr. Keith Penera, DPM and its parent, subsidiary and affiliated organizations to use and disclose my individually identifiable health information between themselves for the purpose of providing me with better treatment, payment facilitation, care coordination and/or case management. Dr. Keith Penera, DPM takes our patient's privacy very seriously and will only use this information as required and permitted under the law.

Type of information: I authorize these entities to use and disclose all of my health information including medical, pharmacy, dental, vision, mental health, substance use, HIV/AIDS*, psychotherapy, reproductive, genetic, communicable disease and health care program information. This information may include information relating to visits, admissions, treatment, claims, case management or care coordination.

I understand and agree that:

- This authorization is voluntary.
- I may not be denied treatment, payment for health care services or enrollment or eligibility for health care benefits if I do not sign this form.
- This authorization will expire two years from the date I sign it. I may revoke or modify this authorization at any time by notifying in writing; however, the revocation/modification will not have an effect on any actions taken prior to the date my revocation is received and processed.

I certify that I have read the foregoing and have the right to request a copy. As the patient or the patient's guardian, conservator or general agent, I agree to accept the above terms.

Signature of patient or personal representative

Date

Personal representative's name

Relationship to patient/minor