Long Island Foot Care, P.C.
Emilio A. Goez, DPM, DPM , Dr. Nicole M. Castillo, DPM
Dr. Marcin Romanczyk, DPM, Dr. Anthony Goez, DPM
294 West Merrick Road, Suite 8
Freeport, NY 11520

Authorization for Use of Signature on File for Claim Authorization

Date: _____
Enrollee Name: _____
Patient Name: _____

I, _____ authorize Dr. Emilio A. Goez, Dr. Nicole Castillo, Dr. Marcin Romanczyk. Dr. Anthony Goez to mark the section "ENROLLEE'S OR AUTHORIZED PERSON'S SIGNATURE" with the notation "SIGNATURE ON FILE".
This section authorizes:

1. The release of any medical information necessary to process claims.
2. Payment of medical benefits to the undersigned physician or supplier of services described below.

This authorization will remain in force until terminated in writing by the enrollee.
I understand and agree that health and accident policies are an agreement between an insurance carrier and me. In case of denial or termination of benefits I, the undersigned, understand that I am responsible for payment in full for services rendered.

X_____ _____
Patient/Authorized Signature Date

Physician/Podiatrist Signature: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (attached to clipboard)

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 so chose) and understood the Notice.

_____ _____
Parent or Authorized Representative (if applicable) Date

X_____ _____
Signature Date

Consent to Obtain Medication History/Consentimiento Para Obtener El Historial De Medicamentos

Patient medication history is a list of prescription medicines that our practice providers, or other providers, have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history. The collected information is stored in the practice electronic medical record system (EHR/EMR) and becomes part of your personal medical record. Medication history is especially important in helping healthcare providers treat your symptoms and/or illness properly and in avoiding potentially dangerous drug interactions.
It is especially important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make drug history information available, and your drug history might not include drugs purchased without using your health insurance. Also, over-the-counter drugs, supplements, or herbal remedies that patients take on their own may not be included.
By signing this consent form, you are giving your healthcare provider permission to collect and giving your pharmacy and your health insurer permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.
I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

X_____ _____
Signature Date

Email/Text Messaging Consent – Consentimento de correro electronico o texto

We now provide our patients with the option to participate in our online patient communication system. These features include appointment confirmation via email Text Message.
I consent receiving appointment confirmation via (please mark one / por favor marke uno):

☐ Email/Correro Electronico: _____

☐ Text Message/Mensaje De Texto: _____

X_____ _____
Signature Date