



DR. SCOT F. BERTOLO  
Doctor of Podiatric Medicine & Surgery

**Patient Information**

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

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_

Email: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Sex: M F

Ethnicity/Race: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Referred By (How did you find us?): \_\_\_\_\_

Family Physician: \_\_\_\_\_

Date of Last Visit: \_\_\_\_\_

**Please review and complete both sides of this document**

Initial

**Consent for Care & Information Release**

I hereby authorize Dr. Scot Bertolo to obtain my history and physical information, and administer treatment as deemed necessary in the diagnosis and care of my foot/ankle condition(s). In addition, I authorize insurance payment directly to the above named person for services rendered.

Initial

**Patient Privacy Notice**

In accordance with the Federal HIPAA Act of 1996, I have had the opportunity to read the Notice of Privacy Statement posted. I further acknowledge that a copy is available to me. I understand my patient rights and how my information may be used during normal healthcare operations. I understand that my information will not be disclosed for any other reason other than healthcare and billing purposes, without my consent.

Initial

**Appointment Cancellation**

I understand that I must provide at least 24 business hours notice if I need to cancel or reschedule my appointment. I also understand that if I miss **two** appointments and fail to cancel them at least 24 hours prior to the time of appointment, that Urban Podiatry will be unable to schedule any further appointments.

Initial

**Payment Responsibility**

There may be certain circumstances when insurance coverage **does not** pay for services Dr. Bertolo feels are medically necessary. By initialing I understand that I am ultimately responsible for all medical expenses incurred that are not paid by my insurance. After three months any unpaid insurance claims will become my responsibility and are due immediately.

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

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(If other than patient)

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please review and complete both sides of this document**

