Advanced Podiatry

Today's Date : _____

PLEASE COMPLETE THIS FORM IN ITS ENTIRETY

How did you learn about our practice?_____

Patients Name:_____
Last First Middle

Home Address: _____

City: _____ State: _____ Zip: _____

SSN: _____ Birth Date:_____ Age :_____ Sex: M F

Home Phone: _____ Cell Phone: _____ Consent to Text: Y N

Email Address: _____ Preferred Communication: Cell Home Work

Race: _____ Language : _____ Ethnicity: Hispanic Non-Hispanic Decline to Answer

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Employer: _____ Occupation: _____

Work Phone: _____ Ext: _____

****** IS THIS A WORK RELATED INJURY OR CONDITION ? YES NO ******

PLEASE PROVIDE THE RECEPTIONIST WITH CURRENT INSURANCE CARDS AND DRIVERS LICENSE

Primary Insurance Plan:	Secondary Insurance Plan:
Group # :	Group # :
Plan ID # :	Plan ID # :
Subscriber :	Subscriber :
DOB:	DOB:

FINANCIALLY RESPONSIBLE PARTY (SIGNER OF FINANCIAL POLICY IF NOT THE PATIENT)

Name:_____
Last First Middle

Home Address: _____City: _____ State: _____ Zip: _____

DOB: _____ SSN: _____ Phone: _____

Employer: _____ Address: _____

City: _____ State: _____ Zip: _____ Work Phone: _____

Emergency Contact Name: _____ Relation:_____

Emergency Contact Phone Number: _____

Advanced Podiatry

Name: _____

Height: _____ **Weight:** _____ **Shoe Size:** _____

Primary Care Doctor, Address and Phone : _____

Pharmacy, Address and Phone : _____

I give consent to request electronic prescription history: YES NO
List of Current Medications:

_____

_____

_

Medication Allergies:

_____

_____

Current Medical History - Please check current medical conditions

AIDS	Y N	Anemia	Y N	Anxiety	Y N	Arthritis	Y N
Asthma	Y N	Back Problem	Y N	Bleeding Disorder	Y N	Blood Clots	Y N
Breathing Problems	Y N	Cancer	Y N	Coronary Artery Disease	Y N	Deformity of Foot	Y N
Depression	Y N	Diabetes	Y N	Dialysis	Y N	Dyslipidemia	Y N
Edema	Y N	Emphysema	Y N	Epilepsy	Y N	Fibromyalgia	Y N
Frostbite of Foot	Y N	Gout	Y N	HIV	Y N	Headache	Y N
Heart Disease	Y N	Heart Murmur	Y N	Hepatitis	Y N	High Cholesterol	Y N
Hypertension	Y N	IBS - Irritable Bowl Syndrome	Y N	Kidney Disease	Y N	Liver Disease	Y N
MRSA	Y N	Mental Illness	Y N	Neuropathy	Y N	Osteoporosis	Y N
Pacemaker	Y N	Peripheral Vascular Disease	Y N	Polio	Y N	Psoriatic Arthritis	Y N
Pulmonary Embolism	Y N	Raynaud's Disease	Y N	Restless Leg Syndrome	Y N	Rheumatoid Arthritis	Y N
Seasonal Allergies	Y N	Skin Disorder	Y N	Sleep Apnea	Y N	Stroke	Y N
Substance Abuse	Y N	Thyroid Disease	Y N	Transplanted Organ	Y N	Tuberculosis	Y N
Varicose Veins of Legs	Y N						

Are you pregnant ? YES NO **Are you nursing?** YES NO

Family History : Is there a family history of the following? (Please specify relation - mother, father, siblings, maternal/paternal grandparents, etc.)

❑ Arthritis	❑ Asthma	❑ Bleeding Problems	❑ Blood Clot	❑ Cancer
❑ Diabetes	❑ High Blood Pressure	❑ Heart Disease	❑ Kidney Disease	❑ Liver Disease

Other: _____

Social History:

Do you smoke? No Yes Former

If yes, how much per day ? _____

Do you drink alcohol? No Occasional Moderate Heavy

Substance Abuse: No Yes

Do you drink caffeinated beverages? No Yes: _____

Marital Status: _____

Surgical History: Please check down below

❑ **None**	❑ Pacemaker	❑ Angioplasty	❑ Appendix	❑ Cataracts
❑ Colonoscopy	❑ C-Section	❑ Gallbladder	❑ Heart Bypass	❑ Heart Stent
❑ Hip Replacement	❑ Knee Replacement	❑ Tonsils	❑ Other: _____	

Have you ever had any surgical procedure on your foot/ankle? Yes or No

If yes, please describe: _____

Do you have any artificial joints? Yes or No , Where? _____

Do you have an artificial heart valve? Yes or No

Review of Systems: Please check the box if you currently have any of these symptoms or check "NONE"

Musculoskeletal	❑ Ankle Pain ❑ Arch Pain ❑ Ball Pain	❑ Bottom of foot pain ❑ Flat feet	❑ Heel Pain ❑ Toe Pain ❑ Top of foot pain	**NONE**
Integumentary	❑ Athletes Foot ❑ Callus/Corns ❑ Cracked Heels	❑ Ingrown toenail ❑ Keloids ❑ Nail Changes	❑ Nail Fungus ❑ Ulcers ❑ Warts	**NONE**
Neurological	❑ Numbness ❑ Paralysis	❑ Seizures ❑ Tingling/Burning	❑ Tremors ❑ Weakness	**NONE**
Endocrine	❑ Loss of hair from	❑ Head or Body	❑ Lower limbs	**NONE**
Gastrointestinal	❑ Abdominal Pain ❑ Blood in Stool ❑ Constipation	❑ Decreased Appetite ❑ Diarrhea	❑ Heartburn ❑ Vomiting ❑ Ulcers	**NONE**
Cardiovascular	❑ Ankle Swelling ❑ Cold feet/hands	❑ Leg Pain ❑ Leg Swelling	❑ Palpitations ❑ Vascular Disease	**NONE**
Genitourinary	❑ Blood in Urine ❑ Decreased Urination	❑ Excessive Urination ❑ Kidney Stones	❑ Incontinence ❑ Painful Urination	**NONE**
Respiratory	❑ Chest pain ❑ COPD	❑ Coughing ❑ Shortness of Breath	❑ Wheezing	**NONE**

What is the reason for your visit today?

_____

_____

How long has this bothered you? Days: _____ Weeks: _____ Months: _____ Other: _____

What treatments have you tried and have they been effective?

_____

Have you experienced any trauma or injury to the area?

_____

_____

The pain quality is: Burning Constant Dull Sharp Shooting Throbbing Tingling Tearing

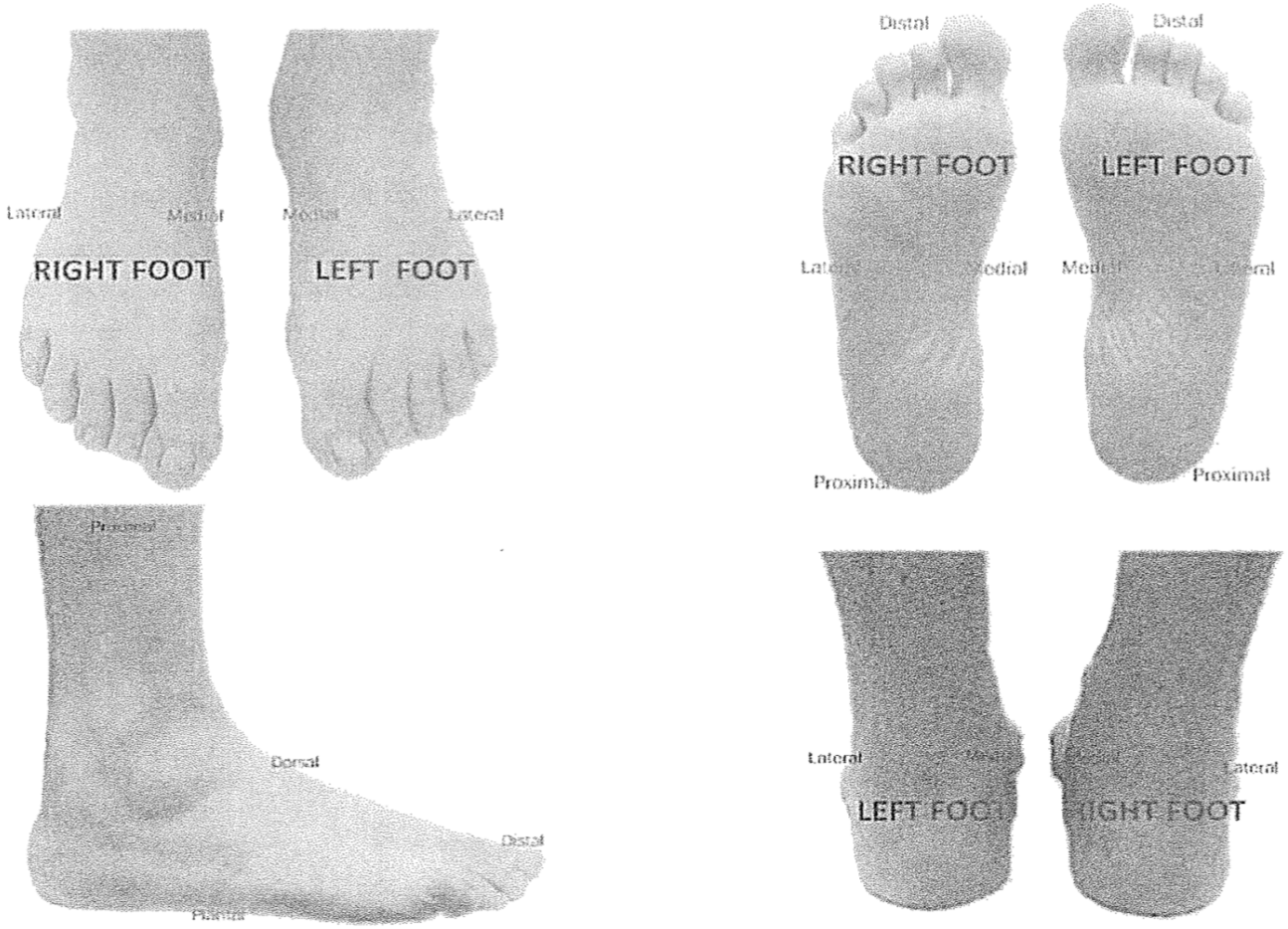
One a scale of 0-10, how would rate your pain? (0 being no pain and 10 being the worst) ? _____/10

What makes the pain worse? Running Walking Standing Certain Shoes Pressure Other: _____

Associated Symptoms: Weakness Numbness Swelling Redness Warmth Instability Radiating pain Drainage

Alleviating Factors: Rest Ice Elevation Other:_____

Please circle where on your feet/ankles you are having pain:



PLEASE READ AND SIGN:

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____ Date: _____

Advanced Podiatry

Acknowledgement of Receipt of Notice of Privacy Practices

Effective Date January 2014

Name of Patient: _____

Do you authorize us to release any information to any other persons (spouse, parent, friend child)?No information, such as test results or appointment changes, can be given to any other person unless listed below.
Please list name and relation:

	Name	Relation to Patient
1)	_____	_____
2)	_____	_____
3)	_____	_____

May we leave a detailed message regarding test results or other information on your voicemail? YES NO

If your disability insurance carrier requests information about you either verbally or in writing, may we provide requested information? YES NO

I HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED THE ADVANCED PODIATRY NOTICE OF PRIVACY PRACTICES

_____ _____

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE **DATE**

If your personal representative's signature appears above, please describe the relationship to the patient:

_____

_____

(Completion by Advanced Podiatry Staff)

Document of Good Faith Efforts to Obtain Acknowledgement

Patient Name: _____ Date: _____

The patient presented for service on the date set forth above and was provided with a copy of Advanced Podiatry's Notice of Privacy Practices ("Notice"). A good faith effort was made to obtain the patient's written acknowledgement of receipt of the notice. However, an acknowledgement was not obtained for the following reason(s):

_____ Patient refused to sign acknowledgement

_____ Patient was unable to sign acknowledgement because: _____

_____ Other Reason: _____

Name of Employee Completing Form: _____

Signature: _____ Date: _____

FINANCIAL POLICY, ASSIGNMENT OF BENEFIT AND RELEASE OF BILLING INFORMATION

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

INSURANCE: We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

MEDICARE: We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. However; that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any copayments, which are usually 20% of the allowed amount for an item or service.

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company.

COPAYMENTS AND DEDUCTIBLES: All co-payments and deductible must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

CREDIT CARD ON FILE: All patients must keep a credit card on file to be used for your outstanding balance.

SELF PAY: Payment in full is due at the time of service if you do not have health insurance.

NON-COVERED SERVICES: Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payment of these services.

REFERRALS/AUTHORIZATIONS: We are <u>required</u> to follow the guidelines of your managed care plan which mandates us that when you visit a specialist such as ours, you must have a referral from your primary care physician prior to seeking specialty care. Therefore, you are financially responsible for the services received, unless your referral is presented at the time of this visit. If you do not have a referral from your primary care physician at the time of a visit, you will be financially responsible for all services received due in full upon completion of the visit. Full credit will be given if a referral is presented to our office within 48 hours of this visit. You will also be given the option to reschedule your appointment.

CLAIM SUBMISSION: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

PATIENT BILLING: You will be sent up to three notices for your financial responsibility (copays, co-insurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After the third and last notice, your account may be forwarded to collections. Please let the billing office know if you have any difficulties resolving your bill. Payment arrangements can be made on a case by case basis. We accept the following payment methods: Cash, Check or VISA/Mastercard/Discover. An additional $25.00 will be added to your statement if the check is returned for insufficient funds. In the event that your insurance company should happen to send payment to you, the patient, we expect that you would forward it to our office to be applied to your balance.

I have read the above policy regarding my *financial responsibility* to Advanced Podiatry for medical services provided. I agree to pay Advanced Podiatry any balance unpaid by my insurance carrier for myself or the below named person.

PATIENT ACKNOWLEDGE OF NOTICE OF PRIVACY PRACTICES: By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices, and that I have (or had the opportunity to read if I so chose) and understand the Notice and agree to it's terms.

Assignment of Benefits

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to **Advanced Podiatry** all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information and acknowledge I was provided with a copy of the Notice of Privacy Practices and understand and accept it's terms:
<u>FINANCIALLY RESPONSIBLE PARTY:</u>

PRINT Name: _____ Signature: _____

Date: _____

ADVANCED PODIATRY LLC

General Consent for Treatment

You have the right to be informed about your condition, so that you may make the decision whether or not to undergo any of the recommended surgical, medical or diagnostic treatments, after knowing the risks and complications involved. At this point in time, no specific treatment plan has been advised or recommended. This consent is simply to ask for your permission to conduct an evaluation necessary to determine the appropriate treatment(s) for any pertinent condition(s).

By signing below you are indicating that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and you consent to treatment at Advanced Podiatry, LLC. The consent will remain fully effective until it is revoked in writing.

You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a podiatrist, and/or mid level provider (Medical Assistant or Nurse Practitioner) and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me in to seek care at this practice.

I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s). I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____	_____
Signature of Patient or Personal Representative	Date
_____	_____
Printed Name of Personal Representative	Relationship to Patient
_____	_____
Signature of Witness	Employee Job Title
_____	_____
Printed Name of Witness	Date

CREDIT CARD AUTHORIZATION FORM

PATIENT NAME: _____ **DATE OF BIRTH:**_____

TYPE: MASTERCARD / VISA / DISCOVER / AMERICAN EXPRESS / OTHER: _____

CARDHOLDER NAME (as shown on card): _____

CARD NUMBER: _____ _____ _____ _____

EXPIRATION DATE: _____/_____

CARDHOLDER ZIP CODE: _____

GUARANTOR NAME: _____

PHONE: _____ **EMAIL:** _____

I, _____, authorize Advanced Podiatry LLC to charge my, above listed, card for the agreed upon service balance. I understand that my information will be saved on file for future transactions on my account. Should my outstanding balance exceed $500.00, payment will be drafted up to $500.00 monthly until the balance is paid in full. The before-mentioned outstanding balance is exclusive of new visit deductible, copayments and coinsurance charges due at the time of service.

PATIENT/GUARANTOR SIGNATURE: _____

PATIENT/GUARANTOR NAME: _____

DATE: _____