



PATIENT INFORMATION *(Please print clearly)*

Today's date ____/____/____

Name _____ SS# _____

Date of birth ____/____/____ Gender _____ Ethnicity _____

Mailing Address _____ City/State _____ ZIP _____

Marital Status _____ Spouse Name _____

Phone# _____ Cell# _____ Work# _____

EMERGENCY CONTACT PERSON _____ Phone# _____

Email Address _____ Preferred language _____

INSURANCE INFORMATION

Primary insurance _____ ID# _____

Secondary insurance _____ ID# _____

Name of insured _____ Insured person's DOB ____/____/____

Sponsor SS# _____

MEDICAL INFORMATION

Reason for visit _____ Family Doctor _____

Bunion Ingrown nail Injury Heel pain Address _____

Wart Hammertoe Diabetic footcare Phone# _____

Surgical 2nd opinion Other _____ Last medical exam ____/____/____

HOW DID YOU LEARN OF OUR OFFICE? *(Check all that apply and give names where space is given)*

Doctor _____ Newspaper _____

Insurance co. _____ Friend/family/other patient Yellow Pages

Website _____ Other _____

Please sign all accompanying forms and provide your picture ID and insurance car(s) for photocopyin



MEDICAL HISTORY

Today's date ____/____/____

Patient Name _____

Do you have or ever had any of the following?

Any allergies to any of the following?

- Diabetes yes no
- Abnormal heart condition yes no
- Heart murmur yes no
- Arthritis yes no
- Kidney or lung problem yes no
- Hepatitis or liver disease yes no
- Blood clots (phlebitis) yes no
- Stomach ulcer yes no
- Seizures or epilepsy yes no
- Abnormal bleeding from a cut yes no
- Difficulty healing yes no
- Other _____
- Females: Are you pregnant? yes no

- Penicillin yes no
- Local Anesthetics yes no
(such as Novacain)
- Aspirin yes no
- Adhesive tape yes no
- Latex yes no
- Iodine/shellfish yes no
- List any other allergies _____
- _____
- _____
- Any other medical problems _____
- _____
- _____

Do you currently take any medication? yes no *(If yes, please list them and reason for taking them.)*

Have you ever been hospitalized or had any surgery in the past? yes no

If yes, list nature and year of hospitalization and type of surgery (include out-patient surgery).

Do you smoke? yes no Former smoker? yes no Ever a smoker? yes no

Do you drink alcohol? Never Occasionally Regularly

What is your foot or ankle problem? _____

What is your occupation? _____

Do you have a family history of any of the following?

- Diabetes yes no
- Heart disease yes no
- Blood clots yes no
- Bleeding problems yes no
- Stroke yes no
- Cancer yes no

Patient signature

____/____/____
Date

Physician's signature



PATIENT MEDICAL REVIEW OF SYSTEMS

Do you have or have you had any of the following symptoms in the past three months?

Head | Nose | Eyes | Ear | Throat

- Headache
- Stroke (head bleed)
- Seizures
- Ear ache
- Retina/visual problems
- Sinusitis
- Upper respiratory infection
- Cold or flu
- Sore throat

Gastrointestinal | Stomach | Liver

- Heartburn
- Stomach ulcers
- Hepatitis/liver disease
- Abdominal (belly) pain
- Nausea/vomiting
- Bleeding difficulties
- Diarrhea
- Constipation
- Bloody or tarry stools

Cardiac | Heart | Circulation

- Shortness of breath when active
- Use several pillows to sleep
- Heart attack
- Rhythm problems
- Chest pain
- Murmur
- Leg pain walking Leg pain at rest

Urinary Bladder

- Burning
- Excessive urination
- Bloody urination
- Urinary tract infection
- Difficulty urinating
- Discharge

Respiratory | Lung

- Cough
- Tuberculosis
- Asthma
- Shortness of breath at rest
- Pulmonary embolism

Musculoskeletal | Joints | Muscle | Bone

- Arthritis – Where? _____
- Stiffness
- Low back pain
- Weakness
- Fractures (broken bones)
- Spasms
- Paralysis (inability to move)
- Numbness
- Radiating pain
- Burning pain

_____/_____/_____
Patient signature Date Physician's signature



FINANCIAL POLICY

We at Physicians Footcare are committed to providing you with the best possible care. If you have Medical Insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Unless **INSURANCE ARRANGEMENT** has been approved in advance by our staff, payment for services is due at the time services are rendered. We accept cash, credit, and money orders only. We will be happy to help you process your insurance claim at each visit.

Balances older than 30 days are subject to additional collection fees and 1/5% interest per month. We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

You must, however, fully understand the following:

1. Insurance is a contract between YOU and YOUR INSURANCE COMPANY
2. Our fees generally fall within the acceptable range by most insurance companies, and are therefore covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of U.C.R. — defined as Usual, Customary, and Reasonable fees for this region. Thus, our fees are considered Usual, Customary, and Reasonable fees by most insurance companies. This does not apply to companies who reimburse based on an arbitrary “schedule” of fees, which bears no relationship to the current standard fees and cost of care in this area.
3. Not all services are covered benefits on your contract. Some insurance companies arbitrarily refuse to cover certain services. We have NO control over this.
4. **MEDICARE PATIENTS:** We would like you to understand that taking **ASSIGNMENT** means that YOU are responsible for the **YEARLY DEDUCTIBLE** and for the **20% CO-INSURANCE** of what Medicare allows. You are responsible for services your co-insurance does not cover. If your co-insurance does not pay this amount, YOU are responsible for it.

Unlike some offices, the **FILING OF INSURANCE CLAIMS** is a **COURTESY** we have always extended to our patients. However, all charges are **YOUR** responsibility, **NOT** your Insurance Company's. We will make our **BEST EFFORT** to collect from them, but, if despite our best efforts, we are **NOT** successful, **YOU** are responsible for the unpaid balance. We realize temporary financial problems may affect timely payment of your account. We do not want financial problems to get in the way of our good relationship with you. If such problems do arise, we encourage you to contact us promptly for assistance in managing your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, **PLEASE** do not hesitate to ask us. We are sincere about our desire to help you in any way we can.

Signature

Date



INSURANCE and/or MEDICARE ASSIGNMENT AGREEMENT

I authorize the payment of MEDICAL BENEFITS to be made on my behalf to Physicians Footcare for any services provided to me. I authorize the release of any medical information held by Physicians Footcare to the health care financing administration and its agents to process my claims.

Signature

Date



PRIVACY POLICY/MEDICAL RELEASE AND BENEFITS ASSIGNMENTS

I, _____, have been informed of the Physician Footcare Notice of Privacy Policies and understand that my protected health information may be released to other healthcare providers, hospitals, insurance companies, etc. as outlined in the Privacy Policy. I also hereby authorize the release of any medical records or X-rays to my insurance company, referring physician, and/or my attorney. I also hereby authorize payment of my insurance carrier directly to Physicians Footcare for any charges incurred for medical treatment at said facility in which care is rendered.

By signing below, I certify that I have read the above statement and agree.

Patient or guardian signature

Date

*** In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures on their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.*

Please check the best way/ways (all that apply) to contact you and provide the relevant information.

- Home phone _____
- Cell phone _____
- Work phone _____
- Fax Number _____
- Email _____
- Written communication (address) _____

I authorize the Physicians Footcare doctors and staff to talk to and release information to the following individuals regarding my healthcare. (Please check all that apply and provide names.)

- Spouse – name: _____
- Child/children – name(s): _____
- Other: _____ Relationship: _____
- Other: _____ Relationship: _____

***HIPPA Privacy Notice Act: By signing below, you are stating you have received a copy of HIPPA statement from Physicians Footcare.*

Patient or guardian signature

Date



CONSENT FOR TREATMENT

If I should have poor circulation, I understand this is a condition that may/will get worse. I understand there are certain risks, diseases, and complications that are associated with poor circulation, even with professional care and treatment.

I understand that I have the following treatment options:

1. No treatment
2. Special/wider shoes
3. Padding
4. Soaks
5. Periodic treatment to make me more comfortable
6. Antibiotics and/or other medications
7. Limits to my walking/weight-bearing time
8. Change in occupation
9. Surgery

I understand that with any treatment of my condition, including surgery, the following risks exist:

1. Infection
2. Delayed healing
3. Wound deterioration or breakdown
4. Additional danger of artery/vein clotting (blood clot)
5. Skin tissue death/skin ulcer
6. Loss of toe, foot, limb, or life
7. Adverse drug reaction

These risks are present in all treatment/operations. I further understand that if I have a poor circulation condition, my risk for complications is increased. If I have one or more of these complications, I UNDERSTAND FUTURE CARE AND TREATMENT MAY BE MORE DIFFICULT AND OUTCOMES MORE UNCERTAIN.

NON-TREATMENT OF MY FOOT PROBLEMS also presents serious risks to me. My foot problems could get worse and I may develop new complications such as infection, skin ulcer/breakdown, and loss of toe, foot, limb, or life.

I UNDERSTAND AND ACKNOWLEDGE THAT MY PODIATRIST WILL TREAT ONLY MY FOOT (and ankle) CONDITIONS AND WILL NOT DIRECTLY TREAT ANY OTHER PROBLEMS OR SYSTEMETIC CONDITIONS SUCH AS, BUT NOT LIMITED TO, PERIPHERAL VASCULAR DISEASE OR DIABETES.

By signing below, I confirm that I have read the information and understand the risks and I consent to an evaluation and possible treatment from my podiatrist.

Patient Signature _____ Date _____

Witness Signature _____ Date _____

Physician Signature _____ Date _____