PHYSICIANS FOOTCARE™

PATIENT INFORMATION *(Please print clearly)* Today's date _____/_____/_____

Name _____ SS# _____

Date of birth _____/_____/_____ Gender_____ Ethnicity _____

Mailing Address_____ City/State_____ ZIP_____

Marital Status_____ Spouse Name_____

Preferred Method of Contact (Place a √) Home__ Cell__ Work__ Number_____

EMERGENCY CONTACT PERSON _____ Phone#_____

Email Address _____

INSURANCE INFORMATION

Primary insurance_____ ID#_____

Secondary insurance _____ID#_____

Name of insured _____ Insured person's DOB_____/_____/_____

Sponsor SS# _____

MEDICAL INFORMATION

Reason for visit_____

__ Bunion __ Ingrown nail __ Injury __ Heel pain

__ Wart __ Hammertoe __ Diabetic footcare

__ Surgical 2nd opinion __ Other _____

Family Doctor _____

Address _____

Phone# _____

Last medical exam _____/_____/_____

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

__ Doctor _____

__ TV commercial _____

__ Insurance co. _____

__ Website __ Internet search _____

__ Newspaper _____

__ Billboard _____

__ Friend/family/other patient _____

__ Other_____

PHYSICIANS FOOTCARE™

Please sign all accompanying forms and provide your picture ID and insurance card(s) for photocopying

MEDICAL HISTORY

Today's date _____/_____/_____

Patient Name_____

Do you have or ever had 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	__ 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
HIV	__ yes __ no
Other_____	
Females: Are you pregnant?	__ yes __ no

Any allergies to any of the following?

Penicillin	__ yes __ no
Local Anesthetics *(such as Novacain)*	__ yes __ no
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 occupation? _____

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

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

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

PHYSICIANS FOOTCARE™

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

PHYSICIANS FOOTCARE™

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

PHYSICIANS FOOTCARE™

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

PHYSICIANS FOOTCARE™

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.*

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

PHYSICIANS FOOTCARE™

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 _____