

# Podiatry Inc.

## NEW PATIENT INFORMATION FORM

### Demographic Information:

Full Name Including Middle Initial: \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

SSN: \_\_\_\_\_

Sex: Male / Female

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

E-Mail: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

How Did You Hear About Us?  
\_\_\_\_\_

Primary Doctor: \_\_\_\_\_

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

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

Phone Number: \_\_\_\_\_

### Authorization:

I, with my signature below, authorize Podiatry Inc. to furnish information to the identified insurance carriers for prior authorization, pre-certification or payment of health care services. This information may include claims, copies of medical information, faxes and phone calls concerning care provided or proposed, and I assign all payments for these services to Podiatry Inc. I understand that I am responsible for copayments, deductibles, all non-covered services, proper referrals and use of participating lab and radiology services. I further understand that my contract with my insurance carrier may or may not cover some services and that is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware that I am responsible for all charges that are incurred and I am responsible for all charges whether covered or not by insurance.

Patient / Guardian Signature & Date:

\_\_\_\_\_  
Please present Drivers License and Insurance Card to receptionist

### Insurance Information:

Insurance Company: \_\_\_\_\_

Co-Pay Amount (Specialist): \_\_\_\_\_

**Co-Pay is Due Prior to Visit**

Policy ID#: \_\_\_\_\_

Group ID#: \_\_\_\_\_

Policy Holder: \_\_\_\_\_

Self / Spouse / Other

Secondary Insurance: \_\_\_\_\_

Policy ID#: \_\_\_\_\_

Group ID#: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Your Medical History:** Have you ever had any of the following?

Diabetes	Y / N	Hypertension	Y / N	Arthritis	Y / N	Kidney Disease	Y / N
PVD	Y / N	High Cholesterol	Y / N	Gout	Y / N	Dialysis	Y / N
DVT/Blood Clot	Y / N	Heart Disease	Y / N	Acid Reflux	Y / N	Stroke	Y / N
Open Sore	Y / N	Heart Attack	Y / N	Stomach Problem	Y / N	Sickle Cell	Y / N
Neuropathy	Y / N	Bleeding	Y / N	Hepatitis	Y / N	Thyroid Disease	Y / N
Cancer	Y / N	Blood Thinner	Y / N	HIV – AIDS	Y / N	Liver Disease	Y / N

Other Medical Conditions: \_\_\_\_\_

**Your Medications:**

- I take no medications
- I take the following medications (or attach list):

Name	Reason	Name	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Your Surgeries:** (include all major and minor procedures – denote with \* if you had any complications)

\_\_\_\_\_

**Your Allergies:**

- I have no allergies
- I have the following allergies: \_\_\_\_\_

**Your Social History:**

Marital Status:  Single  Married  Partnered  Separated  Divorced  Widowed

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Exercise:  Never  Rare  Occasional  Weekly  Several Times A Week  Daily

Use of Tobacco:  Never  Quit – How Long Ago? \_\_\_\_\_  Smoke \_\_\_\_\_ Packs / Day \_\_\_\_\_ Years

Use of Alcohol:  Never  Rare  Occasional  Moderate  Daily

**Your Family History:** (have your parents, grandparents or siblings had any of the following conditions)

Diabetes Y / N Poor Circulation Y / N Amputation Y / N Cancer Y / N Other: \_\_\_\_\_

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

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

\_\_\_\_\_  
Doctor Signature Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**What type of problem are you experiencing?**

\_\_\_\_\_

**History of your condition:**

- Where is the location of this problem? (please be specific): \_\_\_\_\_
- How long have you experienced this problem? \_\_\_\_\_
- How did it occur: (please circle) trauma / injury / gradual onset / rapid onset / pain off and on
- What are the characteristics of the pain: (please circle all that apply):  
sharp / shooting / burning / aching / throbbing / numbness / stabbing / other: \_\_\_\_\_
- How would you grade the level of the pain on a scale of 0 – 10? (please circle)  
(no pain)    0    1    2    3    4    5    6    7    8    9    10    (severe)
- What makes your condition feel worse? \_\_\_\_\_
- What makes your condition feel better? \_\_\_\_\_
- Have you seen another doctor for this condition? (circle) Yes / No    Name: \_\_\_\_\_
- What treatments have you attempted for this condition: \_\_\_\_\_
- Is there anything else we should know about this problem? \_\_\_\_\_
- Are there any other foot problems you would like to discuss? \_\_\_\_\_  
**(if yes, please request an additional Podiatric History Form from our receptionist)**

**Do you experience any of the following problems to your feet or legs? (circle all that apply)**

Numbness	Excessive Bleeding	Nausea / Vomiting
Tingling	Swelling / Edema	Fever / Chills
Burning	Redness	Nail Changes
Cramping (while walking)	Drainage / Weeping	Dry Skin
Cramping (while at rest)	Varicose Veins	Recent Weight Change
Night Pain (wakes you up)	Skin Discoloration	Stiffness
Cold Feet	Itching	Joint Aches
Stabbing Calf Pain	Blood Clots	Wounds / Ulcers

\_\_\_\_\_  
Signature

Date: \_\_\_\_\_

\_\_\_\_\_  
Doctor Signature

Date: \_\_\_\_\_

# Podiatry Inc.

## PRACTICE PRIVACY STATEMENT

### THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION: PLEASE REVIEW IT CAREFULLY

This is a formal notification, as required by the government concerning the privacy of this practice. This practice has an obligation to maintain all medical information in the strictest of confidence. Podiatry Inc. cannot release information without your permission, including medical records, conversations, reminder calls, test results, and other confidential information. This policy requires that you, the patient, identify on this form specific information authorizing communication of information. You can change this at any time with written or verbal notification. Changes can only impact care from this point forward.

Your protected health information (PHI) is a part of your medical care, and can be used or disclosed as follows:

- For your treatment in this practice and other locations under our care. This may include information about your evaluation and exam, procedures done related to your care needs, medication management, home healthcare coordination, referral services, and diagnostic tests. This includes release of information to family members and significant others of your choosing.
- For obtaining payment for treatment with your identified health insurance companies. This would include any documentation related to this care, including registration forms, progress notes, pictures and procedure notes. This would include eligibility verification, prior authorization and claim submission.
- For operation of this practice, such as enrolling in insurance programs, hospital privileges, quality insurance, pharmacy review and compliance with federal and state laws and regulations.
- Appointment reminders with your consent identified as signature on this form.
- Disclosure to your family and friends concerning any related health care information.
- Consent is not required for emergency care and treatment. An emergency is identified as a medical condition that in the judgment of the doctor requires information exchange for care on your behalf.

**May we leave a message at your home? (circle below)**

**With Family or Friend: Yes or No**

**On Voicemail: Yes or No**

**May we call you at work? (circle) Yes or No**

Certain disclosures can be made without your consent, and they are as follows:

- Disclosure required by the government or law enforcement agencies.
- Information used for public health purposes or medical examiners.
- Information used for health care oversight, such as a site review by insurance companies
- For worker's compensation cases or employment related assessments.

Your rights for your health information include: The right to requests limits on the uses and disclosure at registration or at any time during your care. The right to choose how we send this information to you, including an alternate address. The right to see and obtain copies of your PHI, but there may be copy and postage fees. The right to get a listing of who we have made disclosures to about your PHI. The right to correct your file through an amendment process if appropriate.

This practice reserves the right to modify or change this privacy statement at any time.

Revision to this Notice will be available upon request by contacting the office. The change will be made retroactively to the initial date of this privacy notice.

If you have a concern or a complaint about how your PHI is being used, from this time forward you should notify our Practice Administrator to resolve your concerns or you may contact the office of Civil Rights or the Ohio Medicare, GBA Palmetto. Addresses are available upon request.

Please Circle: I agree to above / I do not agree to above / Unable to sign

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

# Podiatry Inc.

## FINANCIAL POLICY

1. It is your responsibility to present your insurance ID card and driver's license or other form of photo ID at the time of your visit. In accordance with your insurance company's member handbook, it is your responsibility to provide accurate insurance information.
2. If you do not have insurance or do not present a valid insurance card, you will be responsible for payment at the time of service. We will provide you with a copy of our billing statement so that you can attempt to obtain reimbursement from your insurance company.
3. It is your responsibility to ensure that our physicians are in your insurance network.
4. If your insurance plan requires a referral, it is your responsibility to obtain this prior to being seen by our physicians. If this referral is not obtained and your claim is denied, the unpaid balance will be your financial responsibility.
5. All co-payments are due at the time of visit. Post dated checks are not accepted.
6. The fee for a returned check is \$25.00.
7. Once benefits are verified and your financial responsibility is calculated, you will be notified of your payment amount and due date. After you have been notified of such amount, all balances will be due PRIOR to any further office visits, procedures, or surgeries.
8. Payment is due for rendered services 10 days from receipt of your billing statement. Unpaid balances must be paid in full prior to any additional visit unless arrangements have been made with our financial counselor.
9. You are ultimately responsible for payment of charges for services you receive from a Podiatry Inc. Podiatrist.
10. Cancellations for any scheduled appointment or procedure must be received at least 24 hours prior to the scheduled appointment. Cancellations for scheduled surgery must be received at least 5 days prior to the scheduled surgery date.
11. Patients who fail to keep and/or cancel a scheduled appointment/procedure may be charged a \$40.00 No Show Fee. There is a \$100.00 cancellation fee for scheduled surgeries that are cancelled less than 5 business days from the date of surgery unless cancellation is due to insurance denial or medical necessity.
12. Medical records requests must be received in writing at least 72 hours prior to the date needed. No fee will be charged to a patient requesting their medical record for the first time. Any additional requests after the initial one will be subject to a fee according to the State of Ohio law. If a third party requests your medical record and you grant them permission, fees will be assessed according to State of Ohio law. Fees must be received prior to record delivery. Medical records will be mailed to the authorized address.
13. Administrative Services: There is a \$25.00 charge for **each** required Administrative Service payable prior to service completion. This Administrative Service Fee covers specific administrative services including but not limited to: forms completion for family medical leave and disability, letters for insurance authorizations for brand or non-formulary drugs, letters for employers, school, health clubs and any other administrative item not covered by insurance.
14. During the course of your care, outside diagnostic services or additional durable medical equipment may be required. These providers will bill your insurance company separately and you will be responsible for all charges as determined by your insurance company policy to those individuals. Podiatry Inc. does not hold any responsibility to those services or fees.

**I have read and understand the Podiatry Inc. Financial Policy. I agree to be bound by its terms. I also understand and agree that Podiatry Inc. may amend such terms from time to time.**

Name (printed) \_\_\_\_\_ Signature \_\_\_\_\_

Date \_\_\_\_\_