Podiatry Inc.

MEDICAL HISTORY UPDATE

216-245-1290

Date:____/____/_____

Last Name: _____ **First Name:**_____ **M.I.**___ **DOB:** ____/____/_____

Reason for Your Visit:_____

Primary Care Physician: _____**Date of Last Visit:** ____/____/_____

Insurance: _____

Local Pharmacy:_____

MEDICAL HISTORY (Check all that apply):

Diabetes	☐	Angina	☐	GERD	☐	Dementia	☐
Congestive Heart Failure	☐	Coronary Artery Disease	☐	Hepatitis	☐	Neuropathy	☐
High Cholesterol	☐	Heart Attack	☐	Ulcer	☐	Peripheral Artery Disease	☐
High Blood Pressure	☐	Over Active Thyroid	☐	Kidney Failure	☐	Stroke	☐
Low Blood Pressure	☐	Under Active Thyroid	☐	Kidney Stones	☐	Transient Ischemic Attack	☐
Asthma	☐	Acid Reflux	☐	Anemia	☐	Bronchitis	☐
Arthritis	☐	Cirrhosis	☐	DVT/Blood Clot	☐	Pneumonia	☐
Gout	☐	Colitis	☐	HIV/AIDS	☐	Cancer	☐

Other Medical Conditions: _____ **If Diabetic, recent A1c:**_____

MEDICATIONS: _____ I take no medications

_____INITIAL FOR CONSENT TO PULL MEDICATIONS IN THROUGH SURESCRIPTS, FILL OUT BELOW or PROVIDE A LIST

_____

_____

SURGERIES: (include all major and minor procedures)

_____

Did you have any problems with anesthesia? Y / N If yes what? _____

ALLERGIES: _____ I have no known allergies.

_____

SOCIAL HISTORY:

Marital Status: ___Single ___Married ___Partnered ___Separated ___Divorced ___Widowed

Occupation: _____ **Exercise:** Y / N If yes what type? _____

Tobacco Use: ___Never ___ Quit ___How Long Ago? ___ Smoke ___Packs per Day ___How Many Years? ___

Alcohol Use: ___ Never ___ Rare ___Occasional ___ Social ___ Moderate ___ Daily

FAMILY HISTORY: (parents, grandparents or siblings)

Diabetes: Y / N **Poor Circulation:** Y / N **Amputation:** Y / N **Cancer:** Y / N **Heart Disease:** Y / N **Lung Disease:** Y / N **Gout:** 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.

_____ ___/___/_____ _____ ___/___/_____

Patient's/Guardian's Signature **Date** **Doctor's Signature** **Date**

Revision 2; 4-28-19

Podiatry Inc.

FINANCIAL POLICY **216-245-1290**

1. It is your responsibility to present your insurance ID card and a 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 the said 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 visits unless arrangements have been made with our financial counselor.

9. The billing department will send out statements for any unpaid balances. Each additional statement, after the first one, will be charged a $10 processing fee and that fee will subsequently be added to your current balance.

10. You are ultimately responsible for payment of charges for services you receive from a Podiatry Inc. Physician.

11. Cancellations for any scheduled appointment or procedure must be received at least 24 hours prior to the scheduled appointment. Patients who fail to keep and/or cancel a scheduled appointment may be charged a $50.00 No Show Fee.

12. Cancellations for scheduled surgery must be received at least 5 days prior to the scheduled surgery date. There is a $100.00 cancellation fee for scheduled surgeries that are cancelled less than 5 business days from the date of the surgery unless cancellation is due to insurance denial or medical necessity.

13. Medical record requests must be received in writing and at least 3 business days or 72 hours, whichever is greater, prior to the date needed. No fee will be charged to a patient requesting their medical record for the first time. Any additional requests made after the initial one will be subject to a fee according to State of Ohio law. Fees must be received prior to record delivery. Medical records will be mailed to the authorized address. An official records release form must be signed by the patient prior to release of records.

14. 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-brand formulary drugs, letters for employers, school, health clubs and any other administrative items not covered by insurance.

15. During the course of your care outside diagnostic services or additional durable medical equipment may be required. The provider of these services will bill your insurance company separately and you will be responsible for all charges as determined by your insurance company policy to these individuals. Podiatry Inc. does not have any responsibility for those services or fees.

Patient's Name: (print) _____ **Patient's/Guardian's Signature:**_____

Date: _____/_____/_____

3733 Park East Dr. #240
Beachwood, OH 44122

1236 SOM Center Road
Mayfield Heights, OH 44124

8382 Mentor Ave.
Mentor, OH 44060

116 East Ave. #4
Tallmadge, OH 44278

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