Podiatry Inc.

NEW PATIENT INFORMATION **(216)-245-1290**

Last Name: _____ **First Name:**_____ **M.I.**____

SSN: _____-_____-_____ **DOB:** ____/____/_____ **E-Mail Address:** _____

Street Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Home Telephone: (___)____-_____ **Cell Phone:** (___)____-_____ **Work Phone:** (___)____-_____ **Ext:** _____

Race: _____ **Sex:** M / F /Other:____**Ethnicity:** _____ **Preferred Language:** _____

Whom may we thank for your referral?(circle one) Google/Internet Facebook Doctor_____

Friend/Family:_____ Insurance Co. Other:_____

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

Preferred Local Pharmacy: _____ **Pharmacy Location/Phone #:** _____

Emergency Contact: _____ **Relationship:** _____ **Phone #:** (___)____-_____

With whom may we discuss your personal medical information?

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Yes / No **May we leave a message at your home with a family member or friend?**
Yes / No **May we leave a message on voicemail or an answering machine?**
Yes / No **May we call you at your place of employment**?

Yes / No **Are you the primary carrier of your insurance**?

If not, who is the primary holder? _____ **D.O.B.** ___/___/_____ **Relationship:** _____

Podiatry Inc. adheres to all regulations and requirements set forth by the HIPAA Privacy Act. This includes all information regarding your personal health information. A copy of our complete practice privacy statement is available upon request.

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 records, fax and telephone calls concerning care provided or proposed, and I assign all payments for these services to Podiatry Inc. I understand that I am responsible for co-payments, 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 it 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.

Printed Name: _____ **Signature:** _____ **Date:** _____/_____/_____
Patient/Guardian Patient/Guardian

3733 Park East Dr. #240
Beachwood, OH 44122

1236 SOM Center Rd.
Mayfield Heights, OH 44124

8382 Mentor Ave.
Mentor, OH 44060

116 East Ave. #4
Tallmadge, OH 44278

Podiatry Inc.

MEDICAL HISTORY

(216)-245-1290

Last Name: _____ **First Name:**_____ **M.I.**____ **D.O.B.**___/___/_____**Date:** __/___/____

MEDICAL HISTORY (Check all that apply):

Diabetes	☐	Angina/Chest Pain	☐	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:**_____

Are you currently experiencing any of the following (Check all that apply)?

General		**Hematology**		**Vascular**		**Cancer**		**G.I**	
Fever	☐	Poor healing	☐	Pain in legs		Melanoma	☐	Nausea	☐
Chills	☐	Easy bruising	☐	when walking	☐	Basal cell	☐	Vomiting	☐
Fatigue	☐	**Endocrine**		Cramps	☐	Squamous cell	☐	Acid Reflux	☐
Skin		Increased	☐	Pain in legs at		Other:_____		Diarrhea	☐
Rashes	☐	Urination	☐	night	☐	**Musculoskeletal**		Constipation	☐
Itching	☐	Thirsty	☐	Varicose veins	☐	Muscle pain	☐	**Eyes**	
Sores	☐	**Neurologic**		**Cardiac**		Back pain	☐	Blurred Vision	☐
Respiratory		Numbness	☐	Leg swelling	☐	Muscle spasm	☐	Blindness	☐
Chronic cough		Tingling	☐	Chest pain	☐	Joint pain/stiffness	☐	**Psychiatric**	
productive	☐	Burning	☐	**Urinary**		**Ears**		Anxiety	☐
Shortness of		Loss of		Kidney failure	☐	Dizziness	☐	Depression	☐
breath	☐	Balance	☐	Frequency	☐	Difficulty Hearing	☐	Mood swings	☐

MEDICATIONS: (prescription, over the counter, vitamins & supplements) _____ Initial here if you 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: _____ Initial here if you have no known allergies; otherwise, list below

_____

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? _____years; Smoke - Packs per Day _____How Many Years? _____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**

Podiatry Inc.

PODIATRIC HISTORY

(216)-245-1290

Date: ____/_____/_____

Last Name: _____ **First Name:**_____ **M.I.**____ **D.O.B.**_____/_____/_____

What type of problem are you experiencing? _____

Where is the location of this problem? (please be specific) _____

How long have you had this problem? _____

How did it occur? ___ Trauma ___ Injury ___Gradual Onset ___ Rapid Onset ___ Pain Off and On

What are the characteristics of the pain? (Please mark all that apply)

___ Sharp ___ Shooting ___Stinging ___ Burning ___ Aching ___ Throbbing ___Stabbing ___ Numbness

How would you grade your pain on a scale of 0 – 10 with 10 being severe? (Please circle)

0 1 2 3 4 5 6 7 8 9 10

What makes the pain feel worse? _____

What makes the pain feel better? _____

Have you seen another physician for this condition? ____ Yes ____ No Who? _____

What treatments have you attempted for this problem? _____

Is there anything else you would like us to know about this problem? _____

Are there any other problems you would like to discuss? _____

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

Numbness	☐	Cold feet	☐	Cramping in		Joint pain/stiffness	☐	Nausea	☐
Tingling	☐	Blod clots	☐	legs walking	☐	Wounds/Ulcers	☐	Vomiting	☐
Burning	☐	Stabbing calf		Cramping/Pain		Recent weight	☐	Diarrhea	☐
Redness	☐	pain	☐	at rest	☐	changes		Fever	☐
Itching	☐	Dry skin	☐	Varicose veins	☐	Excess Bleeding	☐	Nail changes	☐
Drainage	☐	Kidney failure	☐	Leg swelling	☐	Chills	☐	Weeping legs	☐

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**

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: _____/_____/_____

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