NEW PATIENT INFORMATION

Podiatry Inc.

Phone (216) 245-1290

Name	Social Security Number	Date of Birth

Street Address	City, State	Zip Code

Email Address ______________________

Phone - Home	Phone - Cell	Phone - Work	Ext

Race	Ethnicity	Preferred Language

Primary Care Physician	Date of Last Visit

Preferred Local Pharmacy	Pharmacy Location

Emergency Contact	Relationship	Phone

With whom may we discuss your personal medical information?

Name	Relationship

YES	NO	
		May we leave a message at your home with a family member or friend?
		May we leave a message on voicemail or an answering machine?
		May we call you at your place of employment?
		Are you the primary carrier of your insurance?

If not, who is the primary carrier of your insurance?

Name	Date of Birth	Relationship

Whom may we thank for your referral? ______________________

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 on request.

Printed Name - Patient/Guardian	Signature	Date

I, with my signature below, authorize Podiatry Inc. to furnish information to the identified insurance carriers for prior authorization, pre-certification or payment of healthcare 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 carrie 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 - Patient/Guardian	Signature	Date

Medical History

Podiatry Inc.

Name ______________________ Birthdate ______________________ Date ______________________

Do you now or have you ever had -

YES	NO	General	YES	NO	Infectious Disease	YES	NO	Vascular
____	____	Fever	____	____	HIV/AIDS	____	____	Leg Pain When Walking
____	____	Chills	____	____	Hepatitis	____	____	Blood Clots
____	____	Fatigue			**Hematology**	____	____	Leg Pain At Night
		Skin	____	____	Anemia	____	____	Varicose Veins
____	____	Rashes	____	____	Easy Bruising	____	____	Glaucoma
____	____	Itching	____	____	Poor Healing			**Musc. Skel.**
____	____	Dryness			**Endocrine**	____	____	Muscle Pain
		Respiratory	____	____	Diabetes	____	____	Joint Pain
____	____	Chronic Cough	____	____	Hypothyroid	____	____	Muscle Spasm
____	____	Productive	____	____	Hyperthyroid	____	____	Gout
____	____	Bronchitis			**Neurologic**	____	____	Arthritis
____	____	Pneumonia	____	____	Numbness			**Psychiatric**
		Cardiac	____	____	Tingling	____	____	Anxiety
____	____	Chest Pain	____	____	Burning	____	____	Depression
____	____	Shortness of Breath	____	____	Loss of Balance	____	____	Mood Swings
____	____	Stroke			**G.I.**			**Cancer**
____	____	Angina	____	____	Nausea	____	____	Melanoma
____	____	Hypertension	____	____	Vomiting	____	____	Basal Cell
____	____	High Cholesterol	____	____	Acid Reflux	____	____	Squamous Cell
____	____	Congestive Heart Failure			**Urinary**	____	____	Other -
____	____	Heart Attack	____	____	Kidney Failure			______________

Other Medical Conditions

____

Medications

____

____ No Medications ____ Initial for consent to pull medications through Surescripts.

Surgeries - Include all major and minor procedures.

____

Did you have any problems with anesthesia? If so, what? ______________________________

Allergies ____ I have no known allergies.

____

Social History Occupation ______________________________

____	Single	____	Married	____	Partner
____	Separated	____	Divorced	____	Widowed

Exercise

____	Walk	____	Run	____	Cycle
____	Weights	____	Swim	____	Aerobics
____	Yoga	____	Other		

Tobacco Use

____	No/Never	____	Quit →	____	How long?
____	Smoke	____	Packs per Day? →	____	How long?

Alcohol

____	Never	____	Rare	____	Occasional
____	Moderate	____	Daily		

Family History - Parents, Grandparents, Siblings

YES	NO		YES	NO	
____	____	Diabetes	____	____	Amputation
____	____	Poor Circulation	____	____	Cancer

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 it is my responsibility to inform the doctor and office staff of any changes in my medical status.

______________________ ____________ ______________________ ____________

Patient Signature Date Physician Signature Date

Podiatric History

Podiatry Inc.

Name ____________________ Date of Birth ____________

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 circle all that apply.)

Sharp Shooting 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 see another physician for this condition? _______ Yes _______ No

If yes, 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 with or because of your feet or legs? (Mark 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
_______ Cold Feet	_______ Itching	_______ Joint Aches
_______ Stabbing Calf Pain	_______ Blood Clots	_______ Wounds/Ulcers

____________________ ____________________ ____________

Patient/Guardian Signature Physician Signature Date

Financial Policy

Podiatry Inc.

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

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 may be charged a $50.00 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 the surgery unless cancellation is due to insurance denial or medical necessity.

12. Medical record requests must be received in writing and 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 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.

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

14. 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.

Print Name ______________________ Signature ______________________ Date ______________