Family Foot Health Specialists, P.C.

Patient Information

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Age: _____ Gender: M / F SSN: _____

Mailing Address: _____ City: _____ State: _____ Zip code: _____

Phone #: _____ Cell Phone#: _____ E-mail address: _____☐

Emergency Contact: _____ Phone Number: _____ Relationship: _____

How reminders are to be made by: Phone / Mail / Email / Text (sms)

Marital Status: Single / Married / Divorced / Widow(er) Race: _____

Primary Language: _____ Ethnicity: Hispanic or Latino / Non-Hispanic or Latino

Employer: _____ Phone#: _____

Who is your Primary Doctor; Date Last Seen: _____

First Name: _____ Last Name: _____ Phone #: _____

Practice Name: _____ Practice Location: _____

Reason for Your Visit Today (please specify): _____

Pharmacy: (please tell us which pharmacy you use) Name: _____

Phone #: _____ Location: _____

Primary Insurance Information

Name: _____ Phone Number: _____

Subscriber ID#: _____ Group #: _____

Policy Holder: _____ Relationship to Patient: _____

Secondary Insurance Information (If any)

Name: _____ Phone Number: _____

Subscriber ID#: _____ Group #: _____

Policy Holder: _____ Relationship to Patient: _____

Responsible party

Spouse / Parent / Guardian / Power of Attorney

Name: _____ Date of Birth: _____ Gender: M / F

Address: _____ City: _____ State: _____ Zip code: _____

Phone Number: _____ SSN: _____ Relationship: _____

Note: Please provide any and all proof of Guardianship or POA to our Office at time of visit.

CAN YOU PLEASE TELL US HOW YOU HEARD ABOUT US?

Was it a: Insurance Provider List: ☐ Yellow Pages: ☐ Website: ☐ Drove by / Location: ☐ Radio / T.V.: ☐

Or was it a: Doctor / Physician: ☐ Name: _____

Current / Past Patient: ☐ Name: _____

Other: ☐ Please describe: _____

Family Foot Health Specialists, P.C.

Patient History

Patient Name: _____ Date: _____

Chief Concern: _____

Injury and Location: _____

Signs and symptoms: _____

Duration: _____ Severity of Pain (rate 1-10): _____

Past Medical History:

	Yes	No		Yes	No		Yes	No
Burning Feet	☐	☐	Heart Problems	☐	☐	Liver Disease	☐	☐
Blood Clots	☐	☐	High Cholesterol	☐	☐	Lung Disease	☐	☐
Circulation Problems	☐	☐	Hypertension	☐	☐	Thyroid Disease	☐	☐
Diabetes	☐	☐	Kidney Disease	☐	☐	Stroke	☐	☐

Other: _____

Review of Systems:

Musculoskeletal	Yes	No	**Endocrine**	Yes	No	**Dermatology**	Yes	No
Arthritis	☐	☐	Insulin Dep Diabetes	☐	☐	Dry Scaly Skin	☐	☐
Gout	☐	☐	Non-Insulin Dep Diabetes	☐	☐	Warts	☐	☐
Joint Stiffness	☐	☐	Open Sores	☐	☐	Muscle Soreness	☐	☐
Orthotics	☐	☐	Other_____					

Surgery History: _____

Medications: _____

_____

Allergies: **Latex:** ☐ Yes ☐ No **Iodine:** ☐ Yes ☐ No **Tape/Adhesives:** ☐ Yes ☐ No

Drug Allergies: ☐ Yes ☐ No If yes: _____

Drug Reaction: _____

Vital Signs:

Height: _____ Weight: _____ Shoe size: _____ BP: _____ BMI: _____

A1c: _____ Current Flu Shot: ☐ Yes ☐ No If Minor Patient, Current with Immunizations: ☐ Yes ☐ No

Fasting Blood Sugar: _____

FAMILY HISTORY: Has any relative suffered the following? (Please indicate only close relatives)

☐ Arthritis:	☐ Asthma:	☐ Cancer:	☐ Diabetes:	☐ Heart Disease:
☐ High Blood Pressure:	☐ High Cholesterol:	☐ Kidney Disease:	☐ Liver Disease:	☐ Lung Disease:
☐ Migraine:	☐ Obesity:	☐ Stroke:	☐ Tuberculosis:	☐ Thyroid Disease:

☐ Premature family history of heart attack (Before age 55): ☐ Other: _____

SOCIAL AND ENVIRONMENTAL HISTORY

Pregnant: ☐ Yes ☐ No Number of Children: _____ Exercise: ☐ Never ☐ Moderate ☐ Often

Smoker: ☐ Yes ☐ No How many years: _____ Packs per day: _____ When did you quit: _____

Drink Alcohol: ☐ Yes ☐ No How much per week: _____ Drink Caffeine: ☐ Yes ☐ No Cups per week: _____

Drugs (non Dr. prescribed): ☐ Yes ☐ No

Dr. Initial: _____ Date: _____

Family Foot Health Specialists, P.C.

Financial Policy

Family Foot Health Specialists, P.C. would like to take this moment to say "Welcome to our practice!" We want to THANK YOU for selecting us for your foot care needs.

No Insurance:	Payment in full is due at the time of service. It will vary depending on the severity of your problem.
Private Insurance:	You must have a current insurance card and be prepared to pay any deductibles and/or copayments that may apply. We will file a claim to your insurance as a courtesy.
Medicaid:	You must have a current MEDICAID Card and a referral from you primary Doctor.
Medicare:	You must have a current MEDICARE Card and be prepared to pay your deductible and 20% of the allowed charges. Medicare regulations suggest that the Doctor should inform you in advance if some certain charges may not be covered. Your signature below indicates that you fully understand the above information and agree to be personally and fully responsible for payment of services not covered.

For your convenience, we accept payments by Cash, Personal Check, Visa, MasterCard and Discover. There will be a $ 35.00 charge to your account for each returned NSF check issued by you.

Please remember you are responsible for your co-pays, deductibles, co-insurance and non-covered services after reimbursement rates set by you insurance carrier have been paid.

If your insurance company hasn't paid your claim in full within 60 days, you will be contacted and asked to pay your balance in full. This matter will then be between you and your insurance carrier.

Any and All outstanding balances must be paid in full within 60 days of the date of service. If a payment is not received, the account could be turned over for collection. Any and all reasonable amounts incurred in the collection of a Past Due Account, will be added to the Original Amount and be your responsibility (i.e. Service Fee's, Collection Agencies Fee's, Attorney's Fee's, Court Costs, Processing Fee's, etc.). In addition, accounts with outstanding amounts will be charged at an Interest rate of 1.5% per month (18% APR) of the unpaid balance until the account balance is resolved. I fully understand and agree to the above Financial Policy.

Patient / Responsible Party Signature: _____ Employee: _____

Relationship to Patient:

Spouse / Parent / Guardian / Power of Attorney

Records Release / Signature on File

I request that payment of authorized benefits be made on my behalf for any service furnished to me by the listed provider. I authorize any holder of medical information about me to release any information needed to determine these benefits or the benefits payable to the related services to the Insurance Agent. I also give permission to Family Foot Health Specialists, P.C., its Associates, and its assistants to examine, perform tests, to administer treatment and to perform such procedures, including minor operative procedures as it may deem necessary in the diagnosis and / or treatment of my foot and ankle condition, including use of photographs, when necessary.

_____ _____

Signature Date

X-Rays:

If you are a female patient: (In the course of my treatment I understand that the Doctor might require X-Rays (Radiographs), I agree to inform the Doctor, their Assistants or Technologists if I am or may be pregnant.)

_____ _____

Signature Date

Pictures / Photographs:

I give authorization to the Doctor and/or their Assistants, to take pictures and they will be a permanent part of my record. These pictures become the property of Family foot Health Specialists, P.C. and may or may not be used for teaching, educational lectures or publications. If these pictures are used, they will have no information relating to you the Patient.

_____ _____

Signature Date

Family Foot Health Specialists, P.C.

This is a brief summary of your rights and protections under the ***Federal Health Information Privacy Law****. A complete* ***Notice of Privacy Practices*** *available upon request.*

Your health Information is protected by Federal Law

- Most doctors, nurses, pharmacies, hospitals, clinics, many other health care providers, health insurance companies, HMOs, most employer group health plans and certain government programs, such as Medicare and Medicaid must follow this law.
- The information protected by this law includes information your doctors, nurses and other health care providers put in your medical record, conversations you doctor has about your care or treatment with nurses and others, you and your health insurer's computer system, billing information about you at your clinic and most other health information about you held those who must follow this law.

Providers and Health Insurers who are required to follow this law must comply with your right to

- Ask to see and get a copy of your health records
- Have corrections added to your health information
- Receive a notice that tells you how your health information may be used and shared
- Decide if you want to give your permission before your health information can be used or shared for certain purposes, such as for marketing
- Get a report on when and why your health information was shared for certain purposes
- If you believe your rights are being denied or your health information isn't being protected, you can
    - File a complaint with your provider or health insurer
    - File a complaint with the U.S. Government

The Law Sets Rules and Limits on Who Can Look at and Receive Your Information

- To make sure that your information is protected in a way that does not interfere with your health care, your information can be used and shared for your treatment and care coordination
- To pay doctors and hospitals for your health care and help run their businesses
- With your family, relatives, friends and others you indentify who are involved with your health care bills, unless you object
- To make sure doctors give good care and offices are clean and safe
- To protect the public's health, such as by reposting when the flu is in your area
- Your health information **CANNOT** be used or shared without your written permission unless this law allows it. For example, with your authorization, your provider generally cannot
    - Give your information to your employer
    - Use of share your information for marketing or advertising purposes
    - Share private notes about your mental health counseling sessions

The Law Protects the Privacy of Your Health Information

- Providers and health insurers who are required to follow this law must keep your information private by teaching the people who work for them how your information may and may not be used and shared
- Taking appropriate and reasonable steps to keep your health information secure

For more information, you can learn more about your health information privacy and your rights in a fact sheet called "Your Health Information Privacy Rights" from the website www.hhs.gov/ocr/hippa/.

_____ _____

Signature Date