* RICHMOND * CHESTER * COLONIAL HEIGHTS * KILMARNOCK *

PATIENT INFORMATION

Name: ______________________________

Date of Birth: ______________________________

Social Security Number ______________________________

Address: ______________________________

City: State: Zip: ______________________________

Home Phone ______________________________

Work Phone ______________________________

Cell Phone ______________________________

E-Mail Address ______________________________

The best time to contact me is:

______________________________ ☐ A.M. ☐ P.M.

☐Home Phone ☐Work Phone ☐Cell Phone ☐E-Mail

Employer & Occupation: ☐ Retired

____

Gender: ☐ Male ☐ Female

Martial Status:

☐ Minor ☐ Single ☐ Engaged ☐ Married

☐Widowed ☐Divorced ☐Separated ☐Other

Primary Care Physician

____

Phone #

____

Date Last Seen: ______________________________

INSURANCE INFORMATION

Primary Insurance Company: ☐ Self-Pay

____

ID# ______________________________

Group# ______________________________

Are you the Policy Holder? ☐ Yes ☐ No

Policy Holder Name: (if not self)

____

Relationship to Patient:

☐ Parent ☐ Spouse ☐ Other______________

Do you have Secondary Insurance?

☐ Yes ☐ No

If Yes, through which Insurance Company?

____

ID# ______________________________

Group# ______________________________

Are you the Policy Holder? ☐ Yes ☐ No

Policy Holder Name: (if not self)

____

Relationship to Patient:

☐ Parent ☐ Spouse ☐ Other______________

RESPONSIBLE PARTY - PATIENTS UNDER 18

Accompanying Adult Name:

____

Relationship to Patient:

☐ Parent ☐ Other ______________________

Signature ______________________________

EMERGENCY CONTACT INFORMATION

Name:

____

Phone #

____

Relationship to Patient:

PRIMARY PHARMACY

____

Address/Location: ______________________________

City: ______________________ Zip: ______________

Phone # ______________________________

PRIMARY LANGUAGE

☐ English ☐ Spanish ☐ French ☐ Chinese ☐ Arabic ☐ Japanese ☐ Other________________________________

Secondary Language (if applicable):

☐ English ☐ Spanish ☐ French ☐ Chinese ☐ Arabic ☐ Japanese ☐ Other ______________________________

RACE

☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ White/Caucasian

☐ Native Hawaiian or Pacific Islander ☐ Other ____

ETHNICITY

☐ Hispanic or Latino ☐ Not Hispanic or Latino

FAMILY HEALTH HISTORY

Are you adopted? ☐ **Yes** ☐ **No** **If you answered YES, then you may skip to the next section.**

Father: ☐ **Living** ☐ **Deceased** Did he suffer from any of the following significant health conditions?

❑ No Past History of Significant Health Problems

❑ Alcoholism	❑ Congestive Heart Failure	❑ Diabetes	❑ Kidney Disease
❑ Anemia	❑ Cancer – **Type?** _________________	❑ Epilepsy/Seizures	❑ Liver Disease
❑ Anxiety	❑ Congenital Anomaly	❑ Acid Reflux (GERD)	❑ Heart Attack
❑ Asthma	❑ COPD	❑ High Cholesterol	❑ Osteoarthritis
❑ Birth Defects	❑ Crohn's Disease	❑ Hyperlipidemia	❑ Osteoporosis
❑ CAD	❑ Depression	❑ Hypertension	❑ Stroke

❑Other:

____

Mother: ☐ **Living** ☐ **Deceased** Did she suffer from any of the following significant health conditions?

❑ No Past History of Significant Health Problems

❑ Alcoholism	❑ Congestive Heart Failure	❑ Diabetes	❑ Kidney Disease
❑ Anemia	❑ Cancer – **Type?** _________________	❑ Epilepsy/Seizures	❑ Liver Disease
❑ Anxiety	❑ Congenital Anomaly	❑ Acid Reflux (GERD)	❑ Heart Attack
❑ Asthma	❑ COPD	❑ High Cholesterol	❑ Osteoarthritis
❑ Birth Defects	❑ Crohn's Disease	❑ Hyperlipidemia	❑ Osteoporosis
❑ CAD	❑ Depression	❑ Hypertension	❑ Stroke

❑Other:

____

Do any of your other immediate family members suffer from any significant health problems? ☐ **Yes** ☐ **No**

If yes, please detail them below:

Relationship: ________________________ **Condition(s):** ____

Relationship: ________________________ **Condition(s):** ____

Relationship: ________________________ **Condition(s):** ____

MEDICAL HISTORY

Smoking Status: ☐Non-Smoker ☐Yes → ☐Current Smoker Every Day ☐Current Smoker Some Days

How many packs per day ____________________ For how many years ________________ ☐ Former Smoker

Alcohol Use: ☐ Non- Drinker ☐ Yes → If Yes, how much and how often? ________________________________

Caffeine Use: ☐ None ☐ Yes → If Yes, how much and how often? ____

PLEASE LIST ANY HOSPITALIZATIONS NOT INCLUDING SURGERIES:

ARE YOU DIABETIC? ☐ **No** ☐ **Yes**

If Yes, are you on: ☐ Insulin ☐ Oral Medication ☐ Controlled with Diet

PLEASE PLACE A CHECK MARK NEXT TO ANY OF THE FOLLOWING CONDITIONS PERTAINING TO YOUR MEDICAL HISTORY

- ❑ Angina
- ❑ Heart Attack
- ❑ Hepatitis
  Type? A B C
- ❑ High Cholesterol
- ❑ HIV/AIDS
- ❑ Hypertension/High Blood Pressure
- ❑ Irregular Heartbeat
- ❑ Kidney Disease
- ❑ Epilepsy/Seizures
- ❑ Liver Disease
- ❑ Prone to Infections
- ❑ Stroke
- ❑ Thyroid Disease
- ❑ Glaucoma

RESPIRATORY

- ❑ Asthma
- ❑ Bronchitis
- ❑ Chronic Obstructive Pulmonary Disease (COPD)
- ❑ Tuberculosis

GASTROINTESTINAL

- ❑ Abdominal Pain
- ❑ Colitis
- ❑ Irritable Bowel Syndrome
- ❑ Acid Reflux
- ❑ Crohn's Disease
- ❑ Stomach Ulcers

HEMATOLOGICAL & VASCULAR

- ❑ Anemia
- ❑ Blood Clots
- ❑ Blood Transfusions
- ❑ Neuropathy
- ❑ Cancer → **If yes, what type?** ____________________________________
- ❑ Sickle-Cell Disease
- ❑ Peripheral Artery/Vascular Disease
- ❑ Poor Circulation

Are you currently taking any Blood Thinners? ☐ **Yes** ☐ **No**

MUSCULOSKELETAL

- ❑ Arthritis
- ❑ Back Pain
- ❑ Gout
- ❑ Knee Pain
- ❑ Hip Pain
- ❑ Joint Pain
- ❑ Rheumatoid Arthritis
- ❑ Muscle Pain

OTHER MEDICAL CONDITIONS

- ❑ Alzheimer's Disease
- ❑ Anxiety
- ❑ Dementia
- ❑ Depression
- ❑ Fibromyalgia
- ❑ Lou Gehrig's Disease (ALS)
- ❑ Multiple Sclerosis
- ❑ Parkinson's Disease
- ❑ Other: ___________________________________

____

____

PODIATRY HISTORY (PLEASE CHECK ANY BOXES THAT APPLY)

- ❑ Ankle Sprain(s)
- ❑ Arch Pain
- ❑ Athlete's Foot
- ❑ Broken Ankle
- ❑ Broken Foot Bone(s)
- ❑ Bunions
- ❑ Cramps in Legs/Feet
- ❑ Flat Feet
- ❑ Foot Numbness
- ❑ Fungal Nails
- ❑ Gait (Walking) Problems
- ❑ Heel Pain
- ❑ High Arch Feet
- ❑ Ingrown Toenails
- ❑ Hammertoes
- ❑ Leg or Foot Ulcers
- ❑ Lower Back Pain
- ❑ Neuromas
- ❑ Orthotics/Shoe Inserts
- ❑ Toe Walking
- ❑ Warts

❑ Other: ____

____

SURGERY HISTORY

- ❑ No Prior Surgical History
- ❑ Appendix Removed
- ❑ Brain Surgery
- ❑ Heart Bypass Surgery
- ❑ Hysterectomy
- ❑ Gall Bladder Removed
- ❑ Pacemaker
- ❑ Hip Replacement
- ❑ Knee Replacement

❑ Other: ____

HAVE YOU HAD ANY OF THE FOLLOWING FOOT/ANKLE SURGERIES?

- ❑ Ingrown Nail Removal
- ❑ Bunion Removal
- ❑ Joint Fusion(s)
- ❑ Ankle Replacement
- ❑ Fracture Repair
- ❑ Hammertoe Repair
- ❑ Plantar Fasciotomy
- ❑ Foot Amputation ________________
- ❑ Toe Amputation ________________

❑ Other: ____

MEDICATIONS

(INCLUDE ALL PRESCRIPTIONS, OVER-THE-COUNTER & VITAMINS – PLEASE LIST MG AMOUNT ALSO)

____

____

____

____

____

____

ALLERGIES

- ❑ No Known Allergies
- ❑ Tape/Adhesive
- ❑ Aspirin
- ❑ Codeine
- ❑ Betadine
- ❑ Iodine
- ❑ Latex
- ❑ Local Anesthetic
- ❑ NSAID's
- ❑ Penicillins
- ❑ Seafood/Shellfish
- ❑ Sulfur/Sulfa Drugs
- ❑ Corticosteroids
- ❑ Novocaine

❑ Other: ____

❑ Food/Contact Allergies:____

CHIEF COMPLAINT

Please describe what brings you here today: ____

Did you suffer an Injury? ☐**No** ☐**Yes** → **If yes, please specify:** ______________________________

Please describe your pain on a scale of 1 to 10: ________________

Describe the type of pain (please circle, if any): Sharp Aching Throbbing Shooting

Electrical Sensation Pins & Needles Burning Numbness Pressure

Location of Primary Complaint: ____

How long has your problem been present? 1-3 Days 3-7 Days 1-2 Weeks 3-6 Weeks

6-8 Weeks 3-6 Months 6-9 Months 9-12 Months Greater than 1 Year

Onset of Condition/Injury: Gradual Onset Over Time Sudden Onset from Activity or Injury

Course/Progression of Condition: Severe Worsening Moderate Worsening Mild Worsening

Steady/Unchanging Mild Improvement Moderate Improvement Good Improvement

Pain/Condition aggravated by: Any weight bearing Standing Walking Running Exercise

Bending Stooping Pressure to the Ball of Foot Pressure from Shoes Jumping

Have you attempted any treatments to relieve your problem? ☐**No** ☐**Yes** → **If yes, circle:**

Rest Ice Elevation Change Shoe Gear Over-the-Counter Padding Stretching

Trimming out Nail Yourself Applying Skin Cream Applying Topical Antibiotic Ointment

Anti-Inflammatory Medication (Motrin, Aleve, Tylenol, Aspirin, etc.)

How much improvement/relief have you achieved with previous treatments? None

Mild Improvement Moderate Improvement Good Improvement Worsening of Condition

❑ I have not had any previous treatment

What is your activity level at work? ☐ **Full-Time** ☐ **Part-Time** ☐ **Unemployed** ☐ **Retired**

Sitting Standing Walking Considerable Movement Heavy Duties/Lifting

Please list any additional information that may be helpful regarding your condition and treatment: ____

____

____

HAVE YOU EVER BEEN TO A PODIATRIST BEFORE? ☐ **No** ☐ **Yes**

If yes, how long ago? ____

NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers to whom may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above, to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care options. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient or Responsible Party Name: ______________________________

Relationship to Patient (if not patient): ______________________________

Signature: ______________________________ Date: ______________

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* OFFICE USE ONLY *

I've attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: ______________________ Initials: __________

Reason: ____

Are you on Medicare?
□ No □ Yes

If you answered "YES", then please read and sign this page.

Dear Medicare Patient,

The Foot Center, Inc. would like to take this opportunity to explain Medicare's rules and regulations for covered and non-covered foot care.

The Foot Center, Inc. participates with Medicare and the proper contractual adjustments will be made for services paid: However, the patient is responsible for twenty percent (20%) of all charges including their yearly deductible, office visits, and/or routine foot care, unless a secondary insurance will cover.

Routine foot care is billed directly to the patient. This is per Medicare's request. We will be glad to print you a claim (upon your request) for your records.

Medicare considers the cutting of mycotic nails, trimming of nails, and removal of corns and calluses as routine foot care. Medicare Part "B" does not cover these services under normal conditions.

Under certain medical conditions, Medicare may pay for these above-listed procedures. For Medicare to consider these charges payable, the claims must include an underlying condition that may require professional foot care as well as the name of the physician treating that condition and the date of the last office visit with that physician. The following is a list of the most common diagnoses that may require professional care:

Congestive Heart Failure	Peripheral Vascular Disease	Ischemia
Diabetes	Poor Circulation	Traumatic Injury

It is very important that you inform the physicians at The Foot Center, Inc. of your health complications and the physician(s) treating them.

Please keep in mind that if you do not meet the specific conditions set by Medicare, you will be responsible for the costs of your visit. If you would like further information, please call our billing department at 1-800-256-4004, or contact Medicare directly.

Please sign below and return this form to the front desk. This will be kept with your medical records at The Foot Center.

Patient Signature: ____ Date: ____________________

Financial Policy for The Foot Center, Inc.

1) As a courtesy, we will bill your insurance for all office visits. *Please remember*, your insurance coverage is a contract between you and your insurance company, and not a substitute for payment. The patient is responsible for any portion of services not covered by your insurance due to deductibles, coinsurance, or copayments on the day of service. This includes all office visits, procedures, injections, and medical devices. Insurance copayments are due when you arrive for your appointment. If you are unable to pay your copay when you arrive for your appointment, you may be asked to reschedule your appointment unless other arrangements have been made with the Office Manager or approval has been given by the Doctor. Under special circumstances, payment plan arrangements can be made. These arrangements are made with the Office Manager prior to you being seen. Our office may set this up for you as a courtesy depending on the circumstance. You will be sent a monthly statement. However, it is your responsibility to know your monthly due date, which will be determined at the time your payment arrangement is contracted. After one missed payment, your arrangement will be voided and the account will be sent to an outside agency for collections.

2) OUTSTANDING BALANCES: Once your claim(s) are filed with your insurance company and payment is received or denied, you will receive a statement informing you of the balance you are responsible for paying. You must pay this balance within 30 days to avoid any penalties. We urge you to keep your account current to avoid any misunderstandings with our office. Account balances past due over 60 days will receive a late fee of $25 and a monthly finance fee of 2% of the total outstanding balance. All account balances past due over 120 days will be sent to an outside agency for collections. <u>At that point, the account is out of our hands</u>. If you need to make special payment arrangements, it is your responsibility to contact The Foot Center before your account is sent to collections. Accounts sent to an outside collections agency/attorney will be assessed 33% of the total balance plus any additional cost, court, or legal fees that may occur as a result of your delinquency. If your account is sent to collections, you may also run a risk of being discharged from the practice and be required to transfer your care to another provider. You will be responsible for all incurred collections fees and/or attorney's fees as well as costs associated with these services.

3) MISSED APPOINTMENTS: We ask that you let us know about cancellations or rescheduling at least 24 hours in advance. If you miss your appointment without contacting the office to cancel or reschedule, you will be a charged a No-Show fee of $50 for the missed appointment. Habitual missed appointments are grounds for dismissal from the practice.

4) There is a $35 charge for all returned checks. You will be responsible for paying this charge.

5) HMO or PPO claim denials due to no referral or authorization are the patient's responsibility. Office staff will notify and assist you in referral/pre-certification procedures, but final responsibility lies with the patient to comply with their specific insurance's requirements. All referrals must be received by our office prior to seeing the Doctor.

<u>ASSIGNMENT OF BENEFITS</u>

I, the undersigned, do hereby certify that I (or my responsible party) have insurance coverage with ______________________________ and do assign directly to The Foot Center, Inc. all insurance benefits, payable to me for the services rendered. I also understand that I am responsible for payment of any and all deductibles, coinsurance, copayments, and/or for any other non-covered services. If my account becomes delinquent, and is forwarded to a collections agency or an attorney, I understand I also am responsible for any and all fees incurred. I hereby authorize The Foot Center, Inc. to release all information necessary to secure payment of benefits. I authorize release of medical information to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

Signature: ____

Printed Name:____ **Date:** ______________________

HMO INSURANCE WAIVER FORM

I, ______________________________ understand that I must have a referral prior to service at this office. If I do not obtain one beforehand, I understand that I am responsible for any and all costs accrued for my services. If the account becomes delinquent and is forwarded to a collections agency or an attorney, I understand that I am responsible for any and all additional fees incurred.

This agreement is effective ____________________ (Today's Date) between myself and The Foot Center, Inc.

Patient Signature: ____

Witnessed: ____