MID-STATE PODIATRY

PATIENT INFORMATION FORM

DATE: ____/_____/_____

(PLEASE PRINT)

CIRCLE ONE:
MS/MRS/MR/DR NAME: _____ _____ _____ SEX: MALE/FEMALE
LAST *FIRST* *MI*

DATE OF BIRTH: ___/____/____ AGE: _____ SOCIAL SECURITY#: _____

HOME ADDRESS: _____

CITY & STATE: _____ ZIP: _____

EMAIL: _____

HOME PHONE #: (_____) _____-_____

MOBILE PHONE#: (_____) _____-_____

WORK PHONE#: (_____) _____-_____

EMPLOYER: _____ OCCUPATION: _____

EMPLOYER ADDRESS: _____
PLEASE PROVIDE THE FULL ADDRESS

AVERAGE NUMBER OF HOURS ON FEET PER DAY: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE #: (_____) _____-_____

PRIMARY CARE DOCTOR: _____ LOCATION: _____ PHONE #: (_____) _____-_____

DATE LAST SEEN BY PRIMARY CARE DOCTOR ____/_____/_____ WHO REFERRED YOU TO US? _____

PHARMACY: _____ LOCATION: _____ PHONE #: (_____) _____-_____

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?

_____ NO _____ YES NAME(S) _____

WHO IS RESPONSIBLE FOR PAYMENT? _____ RELATIONSHIP TO PATIENT? _____
(IF OTHER THAN SELF)

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (_____) _____-_____

INSURANCE INFORMATION
PRIMARY INSURANCE COMPANY NAME: _____

INSURED NAME: _____ DATE OF BIRTH _____ EMPLOYER _____
(IF OTHER THAN SELF)

POLICY # _____ GROUP # _____

SECONDARY INSURANCE COMPANY NAME: _____

INSURED NAME: _____ DATE OF BIRTH _____ EMPLOYER _____

POLICY # _____ GROUP # _____

PATIENT NAME: _____

DATE OF BIRTH: ____/____/_____

HEIGHT_____ **WEIGHT**_____ **SHOE SIZE**_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

_____ _____

_____ _____

_____ _____

PLEASE LIST ALL PRIOR SURGERIES OR HOSPITALIZATIONS:

TYPE OF SURGERY	DATE	REASON FOR HOSPITALIZATION	DATE

SOCIAL HISTORY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ ☐ SMOKE _____ PACKS/DAY FOR _____ YEARS

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? WHO? _____

EXERCISE FREQUENCY: ☐ NEVER ☐ 1-2 TIMES PER WEEK ☐ 3-5 TIMES PER WEEK ☐ DAILY

TYPES OF EXERCISE: _____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES ☐ CANCER ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE
☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE ☐ RHEUMATOID ARTHRITIS ☐ OTHER

YOUR MEDICAL HISTORY

ALLERGIES: ☐ NO KNOWN DRUG ALLERGIES

☐ MEDICATIONS_____ ☐ ANESTHESIA_____
☐ FOODS _____ ☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N
OTHER CONDITIONS:								

PATIENT NAME: _____

DATE OF BIRTH: ____/____/_____

CURRENT PROBLEM

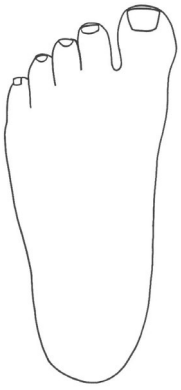
WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ **YES (DESCRIBE)** _____ ☐ **NO**

IF YES, WAS IT A WORK-RELATED INJURY? ☐ **YES** ☐ **NO**

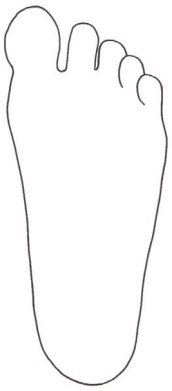
WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

LEFT



TOP OF FOOT

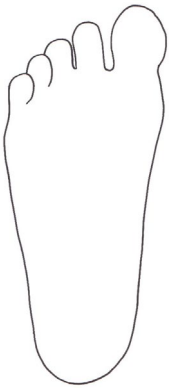
INSIDE OF FOOT



BOTTOM OF FOOT

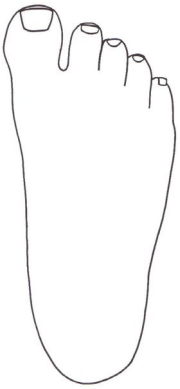
OUTSIDE OF FOOT

RIGHT



BOTTOM OF FOOT

OUTSIDE OF FOOT



TOP OF FOOT

INSIDE OF FOOT

DID YOUR PAIN OR PROBLEM: ☐ **BEGIN ALL OF A SUDDEN** ☐ **GRADUALLY DEVELOPED OVER TIME**

HOW WOULD YOU DESCRIBE YOUR PAIN? ☐ **NO PAIN** ☐ **SHARP** ☐ **DULL** ☐ **ACHING** ☐ **BURNING**

☐ **RADIATING** ☐ **ITCHING** ☐ **STABBING** ☐ **OTHER** _____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)

(NO PAIN) **0 1 2 3 4 5 6 7 8 9 10** *(WORST PAIN POSSIBLE)*

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? ☐ **WALKING** ☐ **STANDING** ☐ **DAILY ACTIVITIES** ☐ **RESTING**

☐ **DRESS SHOES** ☐ **HIGH HEELS** ☐ **FLAT SHOES** ☐ **ANY CLOSED TOE SHOE** ☐ **RUNNING** ☐ **OTHER**_____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? _____

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.

Summary of *Notice of Privacy Practices*

This summary is provided to assist you in understanding the Notice of Privacy Practices. This Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information.

USES AND DISCLOSURES OF HEALTH INFORMATION:

We will use and disclose your health information to treat you or to assist other healthcare providers in treating you. We will also use and disclose your health information to obtain payment for the services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation, and training of students.

USES AND DISCLOSURES BASED ON YOUR AUTHORIZATION:

Except as stated (in the Notice of Privacy Practices), we will not use or disclose your health information without your written authorization.

USES AND DISCLOSURES NOT REQUIRING YOUR AUTHORIZATION:

In the following circumstances, we may disclose your health information without your written authorization:

- To those holding Power of Attorney regarding your healthcare.
- For limited research purposes.
- For the purposes of public health and safety.
- To government agencies for the purpose of audits, investigations, and other oversight activities.
- To government authorities for the prevention of child abuse and/or domestic violence.
- To the Federal Drug Administration (FDA) to report product defects or incidents.
- To law enforcement authorities to protect public safety or to assist in apprehending criminals.
- When required by court orders, search warrants, subpoenas and as otherwise required by law.

PATIENT RIGHTS:

As our patient you have the following rights:

- To access to and/or a copy of your health information.
- To receive an accounting of disclosure made of your health information.
- To request a restriction of how your health information is used or disclosed.
- To request that our practice communicates with you in confidence.
- To request that we amend your health information.
- To receive a copy of *Notice of Privacy Practices.*

Additional information regarding HIPAA rules and regulations can be found at: http://www.hhs.gov/ocr/privacy/

Mid-State Podiatry Policies

All patients are obligated to provide proof of insurance in the form of a readable, current insurance card and a valid driver's license. Should the patient be a minor, the insurance guarantor's/guardian's driver's license will then be accepted. If your insurance plan requires a $ co-payment for a specialist, you will need to submit your payment when you arrive for your appointment.

Some items and services (e.g., out-patient surgeries, durable medical equipment) may require a deposit. Cast boots and ankle braces have a $50 deposit.

ORTHOTICS POLICY _____ ←*Initial here*

Casting for orthotics (a rigid, durable shoe insert) requires a $150 deposit. Few plans do cover orthotics at 100%. If your insurance does not cover orthotics or if durable medical equipment is subject to a deductible per your plan, you will be responsible for the assessed charges. The fee for custom molded orthotics is $420. Be advised that **orthotics may not be returned** as they are customized for each individual patient.

MEDICARE PATIENTS: Mid-State Podiatry agrees to charge only the amount for Medicare approved services to Medicare patients. Any deductibles, co-payments or non-covered services will be billed to the patient and/or their secondary insurance. Please note that routine foot care (trimming of toenails or calluses) is not covered by Medicare unless the patient has diabetes with complications or peripheral vascular disease. Medicare also limits or denies reimbursement on some durable medical equipment and general medical supplies. List provided below:

Custom Molded Orthotics: $420	Ambulatory Cast boot: $276	Post Operative Shoe: $25
Lamb's Wool: $20	Ace Wrap: $15	Urea Cream: $30
Recover of Orthotics: $35 - $50	Routine Foot Care: $35- $100+	Ankle Brace: $125

ALL OTHER INSURANCE PLANS: For the above listed items, non-Medicare insurance, i.e., BCBS, Cigna, Aetna, Humana, etc., coverage depends on each individual's policy. The policy holder's employer determines that policy, unless self-insured. As coverage varies, this practice cannot guarantee insurance payment for services. For a detailed summary of coverage, patients are advised to contact their insurance carrier or refer to their policy handbook. Additional details regarding insurance coverage and payments for specific dates of service are located on your Explanation of Benefits (EOB) from your insurance carrier. Questions regarding coverage should be directed to your insurance carrier.

The patient or patient's guardian is responsible for all non-covered services, deductibles, co-payments, and coinsurance assignments. Please note that if your insurance company has not responded to a claim after 45 days, the patient or the patient's guarantor will be responsible for payment on services.

PAYMENT POLICY _____ ←*Initial here*

- After the insurance payments are applied to a patient's account, the outstanding balance must be reconciled upon receipt of the billing statement. If there is no response from the patient or patient's guarantor within 45 days, the balance will be reported to a collection agency and an additional fee of $35 will be assessed. Services may be suspended until payment or payment arrangements have been made, except for emergency cases. **If you are experiencing financial hardship, please contact our office immediately to arrange a payment plan.**
- Self-pay patients must pay the full amount due on the date of service. No exceptions.
- This practice can accept payment in the form of cash, personal check, American Express, Visa, MasterCard, or Discover Card. Please note that the fee for a returned check is $30 and future payment may be required to be in the form of cash or credit card.
- Disability paperwork will incur a $15 fee. Additional claim paperwork will be $5 per set. This fee is the responsibility of the patient.

Please note, original x-rays are property of this office and must be maintained in your medical record.

○**No use of electronic devices in the exam room.**

○**I have read and understand the above noted payment policies for Mid-State Podiatry**.

○**I acknowledge that I have read and understand the privacy practices (HIPAA) located on the reverse of this form. I may request a copy from the office.**

Signature of patient/guardian: _____ Date: _____