ALABAMA MEDICAL & SURGICAL FOOT CENTER
KEVIN L. WALDROP, D.P.M.
137 N. CHALKVILLE ROAD, TRUSSVILLE, AL 35173
205-655-1114 FAX: 205-661-3585

PATIENT INFORMATION

DATE: _____ SOC. SEC. # _____

PATIENT FULL NAME: _____ BIRTH DATE: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME# _____ WORK# _____ CELL# _____

EMAIL: _____ MARITAL STATUS (circle): M S W D P O

PARENTS NAME (IF MINOR): _____

EMPLOYER/SCHOOL: _____ POSITION: _____ PHONE: _____

FAMILY PHYSICIAN: _____ LAST VISIT & REASON FOR VISIT: _____

PHARMACY: _____ EMERGENCY CONTACT & PHONE _____

INSURANCE

NAME & DATE OF BIRTH OF POLICY HOLDER

_____

SOCIAL HISTORY

DO YOU SMOKE ? (Y) (N) # PER DAY: _____ YEARS: _____

DO YOU DRINK ALCOHOL? (Y) (N) IF YES, HOW OFTEN? _____

PODIATRIC HISTORY

SHOE SIZE: _____ HAVE YOU SEEN A PODIATRIST BEFORE? (Y) (N) IF YES WHO: _____

WHAT ARE YOU SEEING US FOR TODAY? _____

IF DUE TO AN INJURY EXPLAIN, DATE OF INJURY: _____

___ FLAT FEET ___ DIABETIC/FOOT ULCER ___ ATHLETE'S FOOT ___ HEEL/ARCH PAIN

___ FUNGAL NAIL ___ BUNIONS ___ INGROWN NAILS ___ TIRED FEET ___ CORNS CALLUSES

___ ACHILLES TENDON PAIN ___ POOR CIRCULATION ___ TOE PAIN ___ PLANTAR WART

___ COLDNESS IN FEET THAT IS UNCOMFORTABLE

___ PAIN IN FEET/HEELS WITH EXERCISE OR ACTIVITY ___ FEET/TOES NUMB/TINGLE/BURN

Please be aware there is a $20 charge for FMLA paperwork or any work related paperwork to be filled out. Please give 72 hours for completion of paperwork.

PAST/PRESENT MEDICAL HISTORY (PLEASE CIRCLE ANY THAT APPLY)

AIDS	CIRCULATION	HYPERTENSION	RASH
ALLERGIES	TYPE 1 DIABETES	TYPE 2 DIABETES	STROKE
ANEMIA	EPILEPSY	LEG/FOOT CRAMPS	SWELLING IN FEET
ANESTHESIA	GLAUCOMA	LIVER TROUBLE	TUBERCULOSIS
ARTHRITIS	GOUT	NEUROPATHY	ULCERS
ASTHMA	HEART	PSYCHIATRIC	KIDNEY
BLEEDING	HEPATITIS	RADIATION	THYROID

SURGICAL HISTORY (PLEASE CIRCLE ANY THAT APPLY AND LIST BELOW ANY THAT ARE NOT MENTIONED)

APPENDECTOMY	FOOT/ANKLE	HEART	KNEE
GALL BLADDER	C-SECTION	THYROIDECTOMY	BACK
HYSTERECTOMY	EYE	TONSILS/ADENOIDS	HIP

OTHER SURGERIES:

ALLERGIES (CIRCLE ALL THAT APPLY AND LIST BELOW ANY THAT ARE NOT MENTIONED)

ADHESIVE TAPE	SULFA	LATEX	NSAIDs
ASPIRIN	DEMEROL	PENICILLIN	NONE KNOWN
CODEINE/HYDROCODONE	IODINE/DYE	LOCAL ANESTHETICS	

CURRENT MEDICATION LIST

TREATMENT CONSENT

I HERBY CONSENT AND GIVE MY PERMISSION TO THE DOCTOR (AND DOCTORS ASSISTANTS) TO ADMINISTER AND PREFORM SUCH PROCEDURES UPON ME AS THE DOCTOR DEEMS NECESSARY.

SIGNATURE OF PATIENT/ PARENT/ LEGAL GUARDIAN

Medical Information Release Form
(HIPAA Release Form)

Name: _____ **Date of Birth:** _____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____
[ ] Child(ren)_____
[ ] Other_____
[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____
If unable to reach me:

[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] _____

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/____/_____

FINANCIAL POLICY

THE MEDICAL SERVICES PROVIDED BY OUR OFFICE ARE SERVICES YOU HAVE ELECTED TO RECEIVE WHICH MAY IMPLY A FINANCIAL RESPONSIBILITY ON YOUR PART.

INSURANCE: WE PARTICIPATE IN MOST INSURANCE PLANS. IF YOU ARE NOT INSURED BY A PLAN WE PARTICIPATE WITH, PAYMENT IN FULL IS EXPECTED AT EACH VISIT. KNOWING YOUR INSURANCE BENEFITS IS YOUR RESPONSIBILITY.

MEDICARE: WE ARE A PARTICIPATING MEDICARE PROVIDER. MEDICARE AS WELL AS YOUR SECONDARY INSURANCE (IF ANY) WILL BE BILLED FOR YOU. HOWEVER, THAT DOES NOT MEAN THAT ALL SERVICES ARE COVERED. PATIENTS ARE RESPONSIBLE FOR PAYING THEIR ANNUAL DEDUCTABLE IF IT HAS NOT YET BEEN MET. YOU ARE RESPONSIBLE FOR ANY CO-PAYMENTS, WHICH ARE USUALLY 20% OF THE ALLOWED AMOUNT FOR AN ITEM OR SERVICE.

SECONDARY INSURANCE: YOUR MEDICAL CLAIM WILL BE FORWARDED TO YOUR SECONDARY INSURANCE (IF ANY EXCEPT **MEDICAID**, BECAUSE MEDICAID DOES NOT PAY FOR PODIATRY IN THE STATE OF ALABAMA) AFTER PAYMENT AND/OR EXPLANATION OF BENEFITS (EOB) IS RECEIVED FROM YOUR PRIMARY INSURANCE COMPANY.

CO-PAYMENTS, CO-INSURANCE, DEDUCTABLES: ALL CO-PAYMENTS, CO-INSURANCE, AND DEDUCTABLES **MUST** BE PAID AT THE TIME OF SERVICE. THIS ARRANGEMENT IS PART OF YOUR CONTRACT WITH YOUR INSURANCE COMPANY. IF WE HAVE TO BILL YOU FOR A COPAY OR DEDUCTIBLE WE MAY CHARGE A 15$ BILLING FEE.

SELF PAY ACCOUNTS: PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE.

NON-COVERED SERVICES: PLEASE BE AWARE THAT SOME OF THE SERVICES YOU RECEIVE MAY NOT BE COVERED OR NOT CONSIDERED REASONABLE OR NECESSARY BY MEDICARE AND OTHER INSURERS. YOU ARE RESPONSIBLE FOR PAYMENTS OF THESE SERVICES.

MEDICARE DOES NOT PAY FOR TRIMMING OF CORNS, CALLUSES, OR NAILS UNLESS YOU HAVE BEEN DIAGNOSED WITH DIABETES AND BEING TREATED BY A DOCTOR FOR DIABETES.

CLAIM SUBMISSION: WE WILL SUBMIT YOUR CLAIMS AND ASSIST YOU IN ANY WAY WE REASONABLY CAN TO HELP GET YOUR CLAIM PAID. YOUR INSURANCE COMPANY MAY NEED YOU TO SUPPLY CERTAIN INFORMATION DIRECTLY. IT IS YOUR RESPONSIBILITY TO COMPLY WITH THEIR REQUEST. **PLEASE BE AWARE THAT THE BALANCE OF YOUR CLAIM IS YOUR RESPONIBILITY WHETHER OR NOT YOUR INSURANCE COMPANY PAYS YOUR CLAIM.** YOUR INSURANCE BENEFIT IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY.

PATIENT BILLING: OCCASIONALLY AFTER PAYMENT AND/OR EXPLANATION OF BENEFITS ARE RECEIVED FROM YOUR INSURANCE COMPANY THERE IS A CO-INSURANCE OR DEDUCTABLE THAT WE WERE NOT AWARE OF AT THE TIME OF SERVICE. YOU WILL BE SENT 3 STATEMENTS OF YOUR FINANCIAL RESPONSIBILITY AFTER THE FINAL NOTICE; YOUR ACCOUNT MAY BE FOWARDED TO COLLECTIONS. ALL COST INCURRED INCLUDING, BUT NOT LIMITED TO, COLLECTION FEES, ATTORNEY FEES AND COURT FEES SHALL BE YOUR RESPONSIBILITY IN ADDITION TO THE BALANCE DUE TO THE OFFICE. PLEASE LET THE BILLING OFFICE KNOW IF YOU HAVE ANY DIFFICULTIES RESOLVING YOUR BILL. PAYMENT ARANGEMENTS CAN BE MADE ON A CASE TO CASE BASIS. AN ADDITIONAL $ 15.00 FEE WILL BE ADDED TO YOUR ACCOUNT IF WE HAVE TO BILL YOU FOR FEES DUE AT THE TIME OF SERVICE. THIS INCLUDES CO-PAYS, DEDUCTIBLE, CO-INSURANCE AND ANY NON-COVERED SERVICES BASED UPON YOUR INSURANCE BENEFIT INFORMATION AT TIME OF SERVICE.

I HAVE READ THE ABOVE POLICY REGUARDING MY FINANCIAL RESPONSIBILITY TO ALABAMA MEDICAL & SURGICAL FOOT CENTER FOR MEDICAL SERVICES PROVIDED. I AGREE TO PAY ALABAMA MEDICAL & SURGICAL FOOT CENTER ANY BALANCE UNPAID BY MY INSURANCE CARRIER FOR MYSELF OR THE BELOW NAMED PERSON.

ASSIGNMENT OF BENEFITS

I, THE UNDERSIGNED, CERTIFY THAT I (OR MY DEPENDANT) HAVE COVERAGE WITH MY INSURANCE AS PRESENTED AND ASSIGN DIRECTLY TO ALABAMA MEDICAL & SURGICAL FOOT CENTER ALL INSURANCE BENEFITS, PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF DEDUCTIBLES, CO=PAYMENTS, CO-INSURANCE, AND/OR NO-COVERED SERVICES. I HERBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENTS 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.

PATIENT OR GUARDIANS SIGNATURE:_____

DATE:_____