PATIENT HISTORY

Patient Name: _____ Date: _____
(First) (Middle) (Last)

Reason for visit: _____

Height _____ Weight _____ Shoe Size _____

Conditions you currently have or have had in the past:

Yes	No		Yes	No		Yes	No	
☐	☐	Acid Reflux/GERD	☐	☐	Congestive Heart Failure	☐	☐	Lyme's Disease current Y N past Y N
☐	☐	ADD/ADHD	☐	☐	COPD/Emphysema	☐	☐	Lymphedema
☐	☐	A-Fib	☐	☐	Dementia	☐	☐	Mentally Handicapped
☐	☐	Anemia	☐	☐	Depression	☐	☐	Migraine Headaches
☐	☐	Anxiety	☐	☐	Diabetes-Insulin_ Non-Insulin__	☐	☐	Multiple Sclerosis
☐	☐	Arthritis- Osteo __ RA __Other __	☐	☐	Fibromyalgia	☐	☐	Neuropathy
☐	☐	Asthma	☐	☐	Glaucoma	☐	☐	Osteoporosis/Osteopenia
☐	☐	Autism	☐	☐	Gout	☐	☐	Parkinson's disease
☐	☐	Bleeding Disorder	☐	☐	Heart Disease	☐	☐	Polycystic Ovarian Syndrome
☐	☐	Blood Clots/DVT/PE			Heart Attack Y N	☐	☐	Psoriasis
☐	☐	Cancer, Type _____			Cardiac Bypass Y N	☐	☐	Seizures
		current Y N			Defibrillator Y N	☐	☐	Sleep Apnea
		remission Y N			Pacemaker Y N	☐	☐	Spinal Stenosis
		resolved Y N	☐	☐	Hepatitis, Type ___	☐	☐	Stroke
☐	☐	Cataracts	☐	☐	Hiatal Hernia	☐	☐	Thyroid Disorders
☐	☐	Cerebral Palsy	☐	☐	High Blood Pressure	☐	☐	Other/Unlisted:_____
☐	☐	Circulation Problems	☐	☐	High Cholesterol			_____
		(does not mean cold feet)	☐	☐	HIV Positive			_____
		Lower Extremity Stents Y N	☐	☐	Kidney Disease			_____
		Lower Extremity Bypass Y N	☐	☐	Liver Disease			

Prior surgeries: _____ _____ _____
_____ _____ _____

Current medications, including vitamins and supplements – Or provide a list: _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Allergies to medications ☐ No Known Allergies
☐Adhesives ☐Aspirin ☐Cephalexin ☐Erythromycin ☐IV Dye ☐Latex ☐Morphine ☐NSAIDS ☐Penicillin ☐Percocet ☐Shellfish ☐Sulfa ☐Tetracycline ☐Vicodin ☐Other:_____

Personal Social History:

Tobacco
Never Smoked _____
Formerly Smoked ____
years ___ year quit _____
Currently Smokes ____
#per day _____ #years ____

Alcohol
Never Used ___
Former Use ___ or Current Use ___
Beer: ___ Wine: ___ Liquor: ___
#Daily ___ #Weekly ___

Recreational Drug Use
Never Used ___
Former Use ___ or Current Use ___
Prescription Opioid ____
Marijuana ___ Cocaine ___
Heroin ___ Other _____

Family History:

High Blood Pressure	☐ Yes	☐ No	Who?	_____
Diabetes	☐ Yes	☐ No	Who?	_____
Heart Problems	☐ Yes	☐ No	Who?	_____
Foot Problems	☐ Yes	☐ No	Who?	_____

Patient/Authorized Representative Signature_____ Date: _____

REVIEW of SYSTEMS

Name: _____

Please circle yes if you have any of these problems occurring on a regular basis

Y	Chills	Y	knee pain
Y	Fever	Y	back pain
Y	weight gain	Y	difficultly walking
Y	weight loss	Y	memory loss
Y	fatigue	Y	dementia
Y	weakness	Y	autism
Y	sweats	Y	mentally handicapped
Y	dizziness	Y	psychiatric problems
Y	fainting	Y	eczema
Y	headaches	Y	excessive skin dryness
Y	frequent colds	Y	rash
Y	sinus infections	Y	psoriasis
Y	nosebleeds	Y	mole changes
Y	gum disease	Y	tattoo
Y	dentures	Y	tremors
Y	hearing aid	Y	dizzy spells
Y	ringing in the ears	Y	swollen glands
Y	ear infection	Y	bleeding disorders
Y	difficulty swallowing	Y	immune disease
Y	hoarseness	Y	seasonal allergies
Y	persistent cough	Y	environmental allergies
Y	shortness of breath	Y	urinary frequency
Y	Tuberculosis	Y	painful urination
Y	chest pain	Y	urinary retention
Y	irregular heart beat	Y	hernias
Y	blood clots	Y	enlarged prostate
Y	cramps in legs or feet	Y	recent pregnancy
Y	lymphedema	Y	blurred vision
Y	constipation	Y	light sensitivity
Y	diarrhea	Y	watery eyes
Y	Nausea		
Y	frequent thirst		

NONE OF THESE

PATIENT INFORMATION

Thank you for choosing our office. In order to serve you properly, we need the following information. PLEASE PRINT. All information will be kept confidential.

Patient Name_____ **Nickname**_____
First MI Last

Date of Birth _____ **Sex** Male/ Female/ Undifferentiated

Address: _____
Street City State Zip

Preferred phone home/cell/work_____

Alternate phone home/cell/work_____

Email address _____ **Marital Status** single/married/widowed/divorced

Occupation _____ **Employer** _____

Primary Care Physician _____ Phone _____

Emergency Contact: Name_____ Phone_____
Relationship: Spouse/Child/Sibling/Friend/Other

Race (circle one) White/ African-American/ Asian/ American Indian or Alaska Native / Native Hawaiian/Pacific Islander

Ethnicity (choose one) Hispanic/Latino ___ Not Hispanic or Latino ___

Preferred Language: English _____ Other (please specify) _____

Is your visit related to an accident? WC ____ Auto _____ Date of Injury _____
Claim number_____

PRIMARY INSURANCE

Subscriber's Name _____ **Relationship** _____ **Birthdate**_____

Insurance Company _____

SECONDARY INSURANCE

Subscriber's Name _____ **Relationship**_____ **Birthdate**_____

Insurance Company _____

ASSIGNMENT AND RELEASE

Patient Name:_____ **Date of Birth:**_____

I consent to Dr. Michaele A. Crawford to administer podiatric care and to perform such minor operative procedures and/or other appropriated studies as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

I consent to the use of photography to be used as a part of my medical record documentation.

I hereby authorize the processing of the medical insurance either by the electronic or manual method by the above listed provider(s). My signature authorizes payment for benefits due for medical and/or surgical expenses. I further authorize the assignee to release all medical and/or insurance claim information necessary to secure the payment(s). I recognize my financial obligation of any co-payment, co-insurance or deductible and non-covered services that may be required. This agreement shall remain in effect until revoked by me in writing. A copy of this assignment is considered as valid as an original.

X_____ DATE_____
Signature of Patient (or parent/guardian if Patient is a minor).

HIPPA PRIVACY

I prefer to be contacted by:

Telephone ____ Email ____

May We leave a message? (circle all that apply)
on voice mail, patient only, patient/spouse, anyone who answers phone

I give my permission to discuss my account and medical information with:

Name: _____ Phone _____Relationship_____

Name: _____ Phone _____Relationship_____

Name: _____ Phone _____Relationship_____

I have received and had the opportunity to read a copy of the office's Notice of Privacy Practice.

X_____ DATE_____
Signature of Patient (or parent/guardian if Patient is a minor).

Written Financial Policy

Thank you for choosing Crawford Podiatry. Our primary mission is to deliver the best and most comprehensive care to our patients. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

All co-pays and deductibles are due at the time of service.

Any other charges that may have not been paid by your insurance company will be due within 30 days or prior to your next appointment at our office.

Payment Options:

We accept these forms of payments:

- ✓ Mastercard, American Express, Discover Card, VISA
- ✓ Cash
- ✓ Check

Please note:

For patients with medical insurance, we are happy to work with your carrier by directly billing them for reimbursement for your treatment. You are still responsible for co-pays at the time of service.

Crawford Podiatry charges $20 for returned checks.

If you need to discuss a payment plan, please feel free to contact Kim at: 724-282-0900.

If you have any questions, please do not hesitate to ask. We are here to help you get the care you need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

Michaele A. Crawford, DPM/LLC

HIPPAA PRIVACY STATEMENT

NOTICE OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY.

At Michaele A. Crawford, DPM/LLC, we are committed to protecting the privacy of your personal and health information. All of our employees are required to sign confidentiality agreements and are required to comply with our confidentiality policies.

We may disclose your protected health information for purposes of payment only with your written consent (which we have obtained). For Example, we may submit a claim to an insurer, or forward a copy of a statement you have provided by mail or fax. We must obtain your written authorization for any other use or disclosure. You may revoke your consent or authorization at any time in writing. This will not apply to information used or disclosed while the consent or authorization was in effect.

We will provide access to your information, without your consent or authorization, when required to do so by law or regulation. Access my be granted to public health and law enforcement authorities, health care oversight agencies, government benefits programs, employers (in cases of work related illness or injury), courts and administrative tribunals.

We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

We are required to abide by the terms of the most current notice in effect.

We reserve the right to change the terms of our notice and to make the new notice provisions effective for all protected health information that we maintain. We will provide you with the revised notice by mail.

PATIENT RIGHTS

You have the right to look at or get copies of your protected health information with limited exceptions. You must make a request in writing. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you $1.00 for each page and $5.00 for each x-ray disc where applicable.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the information below.

CONTACT PERSON: Michaele A. Crawford, DPM/LLC

ADDRESS: 164 Point Plaza Butler, PA 16001

TELEPHONE: 724-282-0900 **FAX:** 724-284-1233

E-MAIL: dr.crawford@zoominternet.net

PATIENT BILL OF RIGHTS

All patients are guaranteed the following freedoms:

To seek consultation with the physician(s) of their choice.

To contract with their physician(s) on mutually agreed terms.

To be treated confidentially, with access to their records limited to those involved in their care or designated by the patient.

To use their own resources to purchase the care of their choice.

To refuse medical treatment even if it is recommended by their physician.

To be informed about their medical condition, the risks and benefits of treatment and appropriate alternatives.

To refuse third-party interference in their medical care, and to be confident that their actions in seeking or declining medical care will not result in third-part-imposed penalties for patients or physicians.

To receive full disclosure of their insurance plan in plain language, including: contracts, incentives, cost, coverage, qualifications, approval procedures, referrals, appeals and gag rule.

You have the right to get copies of your protected health information with limited exceptions.

You must make a request in writing. You may also request access by sending us a letter to the address at the end of this notice.

If you request copies, we will charge $1.00 for each page and $5.00 for each x-ray disc where applicable.

PATIENT FREEDOM OF PROVIDER STATEMENT

I have been referred to Michaele A. Crawford, DPM/LLC for medical products. I further understand that Michaele A. Crawford, DPM/LLC will bill me or my insurance company separately.

I understand my rights and responsibilities in this referral process and transaction. I also understand that I have the right to choose any qualified vendor to provide me with the above-mentioned medical products. I have freely chosen Michaele A. Crawford, DPM/LLC as my provider for this product(s).

COMPLAINT RESOLUTIONS

You have the right to freely voice grievances and recommend changes in care or services without fear of reprisal or unreasonable interruption of services. Service, equipment and billing complaints communicated to Michaele A. Crawford, DPM. These complaints will be documented and handled in a professional manner. All complaints will be investigated and acted upon in a reasonable amount of time.

QUESTIONS AND COMPLAINTS

CONTACT PERSON: Michaele A. Crawford, DPM/LLC **ADDRESS:** 164 Point Plaza Butler, PA 16001

PHONE: 724-282-0900 **FAX:** 724-282-0900 **EMAIL:** dr.crawford@zoominternet.net

Dr. Michaele A. Crawford, DPM,LLC
164 Point Plaza
Butler, PA 16001
Phone: 724-282-0900
Fax: 724-284-1233

POLICIES AND PROCEDURES

It is our goal to provide all of our patient's excellent care. We would like you to be aware of the office policies. If you have any questions please ask a staff member.

Appointments
Appointments are scheduled on a first come first served basis.

After Hours
If you are experiencing a true medical emergency go to the nearest ER. Other wise call the office at 724-282-0900 and leave a message. If we have called your home using a different number **DO NOT** call that number, it will not be answered after hours.

Arrival
Please arrive 5 minutes before your scheduled appointment to check in. If you arrive more than 15 minutes late for your appointment you may be asked to reschedule. If you do not keep a scheduled appointment a $20 no show fee will be charged to your account. After no shows for 3 appointments you will be discharged from the practice

Co-pay
Your co-pay is due at the time of service, if you do not pay your co-pay a $5 billing fee will be applied to your account. We accept cash, check, Visa, Mastercard and Discover.

Returned Checks
There will be a $25.00 fee for all returned checks.

Referrals
Some insurance plans require a referral from your PCP. You are responsible to know your insurance plan's requirements and to request that referral from your PCP. We are unable to obtain referrals for you. If you do not have a referral at the time of your appointment you will be asked to reschedule.

Medication Refills
When you need a refill please call the office. We need a 2 day notice to process medication refills. If it has been longer than one year since you have been treated in our office, you may be asked to schedule an appointment before the refill is granted.

Self Pay
If you do not have insurance you must pay for the visit in full on the day of the service.

Insurance Plans
It is each patient's responsibility to be aware of what their insurance plan covers. It is not our responsibility to check for you. We will obtain prior authorizations when necessary, when the doctor orders testing or medical equipment for you.