Advanced Foot Specialists

New Patient Forms

Patient Name:_____Date of Birth:_____Sex:____M____F

Social Security #:_____Employed:___Y___N Occupation:_____

Address: _____

Street City State Zip

***Cell**#:_____Home #:_____Work #:_____

Email:_____ Status: Married Single Divorced Widowed Partnered

Emergency Contact Name/Relationship:_____Phone #:_____

Primary Physicians Name: _____

Physician Contact Number:_____Date Last Seen: _____

Insurance Information

Primary Insurance Name:_____ID #:_____

Policy Holder's Name:_____Date of Birth #: _____

Secondary Insurance Name:_____ID #:_____

Secondary Policy Holder's Name:_____Date of Birth #: _____

Relationship to Primary/Secondary Policy Holder:_____

How did you hear about us: (Please circle)

Physician Internet Newspaper Social media Insurance Friend/Family

*Referring Doctor's name_____*Referring Friend/Family's name_____

Patients Name:_____ **Shoe Size:** _____

Reason for your visit:_____ **Pain Level:** _____

Height:_____ **Weight**: _____ **Alcohol Intake**: Yes/No If yes, how often?_____

Smoker:_____pack(s)/day X_____years **Previous smoker**: YES NO; How much/long: _____

Constitutional: Are you currently experiencing (please circle): Nausea Vomiting Fever Chills Night sweats

Rash Peeling Skin Itching Blisters Bruises Brittle hair loss Cold toes/color changes

Leg pain while walking Swelling Numb feet/legs Burning feet/legs Tingling feet/legs

Pharmacy Name:_____ **Pharmacy City:**_____

Medications: List current medications & dosage:

_____ _____

_____ _____

_____ _____

Past Medical History: If you now have or have ever had any of the following conditions, please circle/be specific:

ADD/ADHD	Cancer_____	Hepatitis_____	Neurological Disorder
Alcohol/Drug Dependency	Circulation Issues	High Blood Pressure	Osteoarthritis
Alzheimer's/ Dementia	Currently Pregnant	Hypothyroid	Osteoporosis
Anemia	Diabetes Type I or Type II	Immune Disease	Rheumatoid Arthritis
Anxiety	Dialysis	Kidney Disease	Skin Disease
Asthma	Depression	Liver Disease	Stomach Ulcer
Back Problems	Gout	Lung Disease	
Bleeding Disorder	GI Disease	Lymphedema	
Bipolar Disorder	Heart Attack/Disease	Metal Allergy	

If **Diabetic**, how many years since diagnosis:_____

Who manages your diabetes?_____ Phone #:_____

Last A1C?_____/Date: _____

Allergies: Yes No If yes, please list name/reaction:_____

Family History: Please circle any medical conditions that run in your **family** and write which member(s) affected:
Diabetes _____ Gout _____ Heart Disease _____ Hypertension _____ Other_____

Surgeries: List all surgeries you have had. Begin with the most recent. Please give the year.

_____

_____

_____

Treatment Consent

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctors deems necessary.

_____ _____
Signature of Patient, Parent, Guardian, or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian, or Personal Representative Relationship to patient

_____

Acknowledgement of Receipt of Notice of Privacy Practices

We are required by law to provide you, or allow your review if, the Notice of Privacy Practices of Advanced Foot Specialists, which states how we use and/or disclose your Protected Health Information (PMI).
In review, some of the ways we use and/or disclose your PHI are for the following purposes:

- Treatment: we may disclose information necessary for your medical treatment and care. We may disclose information to those involved in your healthcare (ex. physicians, family members, pharmacies, labs, etc.)
- Payment: we may disclose information needed to file claims and bill for medical services
- Health care operations: we may disclose PHI to carry out certain health care operations (ex. surveys, etc.)
- Public health

In order for us to be able to share this information with others, we need you to list the people we may contact.

I, _____ give permission to Advanced Foot Specialists, to disclose PHI to:

_____.

For written communications, circle one: home address work address other address _____

For oral communications, circle one: home number cell number work number other_____

I hereby by acknowledge receipt of the Notice of Privacy Practices of Advanced Foot Specialists or have had the opportunity to review the Notice and accept it as written.

Signature: _____

Date: _____

FINANCIAL RESPONSIBILITIES/POLICIES

At Advanced Foot Specialists, we strive to give you the best care. In order to serve this purpose, it is important that you understand the mechanisms of reimbursement. Please read this Financial Responsibility Form and sign at the bottom to acknowledge that you understand your accountability. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Co-payments and co-insurances are your responsibility. Your insurance company expects us to collect them from you at the time of your service. Understand that you will be expected to pay your co-payment for each and every date of service.
- You are responsible for your deductibles. The deductible is determined by your individual contract with your insurance carrier. We do not have information about each person's deductible amount, and how much of that has been met. You will be responsible for finding out all information about your deductible prior to your appointment in the office.
- If insurance payments are sent to you erroneously, you are responsible for forwarding them to our office.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctors. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within 60 days, you will receive a bill.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- Past due accounts are subject to collection proceedings. All costs 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.
- Patients who are 90 days past due to their balance will be sent to collections unless a payment plan has been put into place.
- There is a service fee of $35.00 for all returned checks. Your insurance company does not cover this fee.
- In fairness of all of our patients, we understand that emergencies occur, but repeated no shows or cancellations with less than 24 hours' notice will result in a fee of $25.00. You will be asked to pay before you are seen by the doctor.

Signature of Patient/ Responsible Party:_____ Date:_____

Printed Name of Patient/ Responsible Party:_____ Date:_____