

PATIENT REGISTRATION

Patient Information	Patient Name: Last		First	M.I.	Gender: M F	
	By what name do you preferred to be addressed?				Marital Status:	
	Patient's Address:					
	City:			State:		Zip:
	Home Phone:		Cell Phone:		E-mail Address:	
	Social Security #:			Birth date:		Age:
	Employer:		Phone:		Occupation:	
	Emergency Contact:				Phone:	

Insurance	Insurance Name:		Policy ID:			
	Name of insured (if other than self):				Birth Date:	
	Name of insured's employer:			Insured's work phone number:		
	Patient relation to subscriber:					
	Name of person responsible for paying the bill (the Guarantor):					
	Guarantor's Address:			Guarantor's Phone:		

L & I Injury	Date Of Injury:		Type of Injury: <input type="checkbox"/> Work <input type="checkbox"/> Auto <input type="checkbox"/> Other			
	Has a claim been filed? <input type="checkbox"/> Yes <input type="checkbox"/> No		Claim #:		Where was claim filed?	
	Cause of injury:					

Referral	Referred By: <input type="checkbox"/> Web search (Google, Yahoo) <input type="checkbox"/> Online yellow pgs <input type="checkbox"/> Insurance Web Site or Book					
	<input type="checkbox"/> Phone Book yellow pgs <input type="checkbox"/> Dr. : _____					
	<input type="checkbox"/> Patient of office/Relative: _____ Thank you					
	address: _____					
OR are you a <input type="checkbox"/> Previous patient of this office						
Primary Doctor: _____ Seen last: _____						
Pharmacy Used: _____ Location: _____						

Signature	<u>Release of Benefits Information</u>					
	I authorize my insurance benefits to be paid directly to the doctor. I understand that the doctors' office will bill my insurance as a courtesy and that I am responsible at the time of service for all co-payments, deductibles and non-covered services. I authorize the release of information required to process my claims. (If not signed payment due at time of service)					
	ALL CO-PAYMENTS DUE ON DAY SERVICE.					
	DO WE HAVE PERMISSION TO: LEAVE A MESSAGE ON YOUR ANSWERING MACHINE <input type="checkbox"/> YES <input type="checkbox"/> NO					
	LEAVE A MESSAGE AT YOUR PLACE OF EMPLOYMENT <input type="checkbox"/> YES <input type="checkbox"/> NO DISCUSS YOUR MEDICAL CONDITION WITH ANY MEMBER OF YOUR HOUSEHOLD <input type="checkbox"/> YES <input type="checkbox"/> NO IIF YES, WITH WHOM?					
	RELATIONSHIP _____					
Patient Signature: _____						
Date: _____						
Parent of Authorized Representative (If applicable)						

Medical History - Confidential Information

Patient name: _____

Lower Extremity Medical History

What is the chief complaint(s) which brings you to our office for medical treatment? (Include foot, ankle, leg, knee and hip complaints)

Former foot and ankle physician:
Name: _____

Last visit: _____

Any previous injuries or problems to the feet, ankles or legs?

Symptoms

Which Side: Right Left Both

Type of Pain: Dull Achy Throbbing
 Burning Sharp Shooting

Area of Pain: _____

Onset: Slow Sudden Traumatic

Duration: Days Weeks Months Years

Has pain gotten: Better Worse Same

What aggravates condition? Walking Running

 Standing Shoes

What have you tried to help pain?
Anti-inflammatory Changing shoes

 Decrease activities

Arch Supports or Orthotics Ice Stretch

Other: _____

How long does pain last? _____

Have you ever had a similar pain? (describe, including treatments received)

Exercise and Orthotics

In what athletic activities do you participate?

Days per week exercising? _____

Do you wear store-bought arch supports? Yes No

If yes who made them: _____

How old are the orthotics: _____

Allergies and Drug Intolerance

Adhesive/Tape Aspirin

Codeine Iodine

Local Anesthetics Penicillin

Seafood Sulfa

No known drug allergies _____

Medications

List all medications you are taking:

General

What is your weight: _____

What is your height: _____

What is your shoe size: _____

Mental / Emotional

Yes No Eating Disorder

Yes No Anxiety

Yes No Depression

Yes No Psychiatric

Yes No Alcoholism

Surgeries, Injuries, Illness

List surgeries, serious injuries, and illness not previously listed:

Social History

Your occupation? _____

Do you smoke? Yes No

Are you a past smoker? Yes No

Years Smoked: _____

Drink Alcohol? Yes No

How Much: _____

Recreational Drugs? Yes No

What: _____

Pregnant or possible pregnant? Yes No

Marital Status:

Married Single Widowed

General Medical History

Mark to indicate if you or a family member have any of the following:

Personal

Anemia

Arthritis: Type: _____

Artificial Heart Valve or Joints

Asthma

Back problems

Bleed easily

Cancer

Chemical Dependency

Chest Pain

Circulatory Problems

Diabetes

Epilepsy

Fibromyalgia

Gout

Heart Disease

Hemophilia

Hepatitis

High Blood Pressure

HIV Positive

Kidney Problems

Leg Cramps

Lung/Respiratory

Menopause

Mental Illness

Phlebitis/Clots

Psoriasis

Rheumatic Fever

Stroke

Thyroid Problems

Tuberculosis

Ulcers-Stomach

Venereal Disease

Weight Change, Recent. _____ lbs.

Family Member

NOTICE OF PRIVACY PRACTICES

We understand that health information about you and *your* health is personal. We are committed to protection your health information. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this office, whether made by your personal doctor or others working in this office. This notice will inform you about the ways we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private.
- Give you this notice of your legal duties and privacy practices with respect to health information about you. Follow the terms of the Notice of Privacy Practices that is currently in effect.

How we may use and disclose health information about you:

- For treatment For payment
- For appointment reminders As required by law
- Public health risks
- Health oversight activities Lawsuits and disputes Law enforcement
- Coroners, heath examiners and funeral directors. To avert a serious threat to health and safety
- As required by the Military of Veterans Administration National security
- Worker's Compensation

Your rights regarding health information about you:

- Rights to inspect and copy. We may charge you .88 for each page, up to 30 pages .67 there after, and a \$20 clerical fee for staff time to locate and copy your protected health information. Postage will be charged if you want the copies mailed to you. X-rays copies will be billed at \$12 per film sheet. We ask a 2 day notice to be given. Legally, we are given 30days within which to provide you with your copies.
- Right to amend
- Right to request confidential communications
- Right to a paper copy of this notice (full notice is available upon request)

Changes to Notice of Privacy Practices:

We reserve the right to change this notice. We will post a copy of the current notice in our facility with the current effective date on the first page.

Complaints:

If you believe that your privacy rights have been violated you may file a complaint with us. All complaints must be in writing. Please contact HIPAA Officer to file a complaint.

Acknowledgement of Receipt of this Notice:

This acknowledgment will become part of your records.

Please print name: _____

Signature: _____

Date: _____

Parent of Authorized Representative (If applicable) _____

FINANCIAL POLICY

Thank you for choosing Family Foot Center to be your podiatric physicians. We are committed to your treatment being successful, as you, the patient, are our first and foremost concern. As part of our service, we try to contain the cost of healthcare. In an effort to do this, we have implemented a Financial Policy.

The following is a statement of our **FINANCIAL POLICY** which we request you read and sign prior to any treatment. To avoid any misunderstandings, please contact us should you have any questions about our policies.

INSURANCE: Please do not expect us to know the terms, conditions and individual coverage limits of your insurance policy. If you have questions regarding benefits and eligibility please contact your insurance carrier to determine what your benefits are. This includes verifications as to whether one of our doctors is a contracted provider with your insurance carrier. Please note that you are ultimately responsible for payment for all services that are not covered by your insurance plan.

NO INSURANCE: If you do not have insurance or the doctor is not participating with your insurance plan, please be prepared to fully cover the fees for each visit at the time of treatment. Payment arrangements will be made prior to your visit with the physician.

PAYMENT: Payments for the balance due, co-payments, deductibles, etc. are due at the time of service and may be made by *cash, check, or credit card. (VISA or MASTERCARD)*. There will be a \$25.00 charge for all returned checks. Delinquent accounts will be referred for collection at the discretion of the office manager.

CO-PAYMENTS & DEDUCTIBLES: We require that all deductibles, co-payments, and other non-covered services be paid by you at the time of your visit. We will add a billing fee of \$5.00 if you do not pay your co-payment at the time of service.

INTEREST: Please be advised that any account balance owing past 30 days will be assessed with a 1.5% interest per month (or 18% annually).

MISSED APPOINTMENTS: Please help us serve you better by keeping scheduled appointments. If it is necessary to cancel, please call our office 24 hours in advance. This allows us to accommodate our other patients. We reserve the right to charge for missed appointments.

ORTHOTICS: Orthotics are a non-covered service by some insurance plans. Please check with your insurance company prior to the examination and casting for orthotics to determine your orthotic benefits. A deposit of \$200.00 is requested at the time of the examination and casting and full payment is due when the orthotics are dispensed. Orthotics are non-refundable nor non-returnable.

SUPPLIES: For your convenience we make some supplies available for purchase in the office. If you choose to purchase these items, payment is due at time of purchase. We cannot bill for these items.

I have read and agree to the terms set forth in the above financial policy. I am financially responsible for any balance due.

Printed patient name: _____

Signed _____ Date _____

Parent of Authorized Representative (If applicable) _____