Podiatry Care Specialists | A division of PACE Foot and Ankle Centers

PodiatryCareSpecialists.com

Dedicated to getting you back on your feet as soon as possible.

WEST CHESTER: 610-431-0200
BROOMALL: 610-356-5911

PLEASE COMPLETE THE FOLLOWING INFORMATION AS CLEARLY AS POSSIBLE. THANK YOU.

NAME: BIRTHDATE: / /

ADDRESS:

CITY: STATE: ZIP:

DAYTIME PHONE: EVENING PHONE: CELL:

EMAIL: EMERGENCY CONTACT & PHONE:

☐ SINGLE ☐ MARRIED ☐ PARTNER ☐ DIVORCED ☐ WIDOWED ☐ LEGALLY SEPARATED ☐ MALE ☐ FEMALE

RACE (optional): ☐ Caucasian ☐ African-American ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaskan Native

ETHNICITY (optional): ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

PLEASE PRESENT YOUR INSURANCE CARD(S) TO A STAFF MEMBER TO COPY YOUR POLICY AND GROUP NUMBERS

PRIMARY MEDICAL INSURANCE:

SECONDARY MEDICAL INSURANCE:

SUBSCRIBERS NAME: RELATIONSHIP TO PATIENT:

SUBSCRIBERS DATE OF BIRTH: / / EMPLOYER:

PRIMARY CONCERN: ☐ **LEFT FOOT** ☐ **RIGHT FOOT** ☐ **BOTH FEET** *Please circle all that apply.*

DIABETES CHECKUP	NEUROMA	BUNION	SURGERY CONSULTATION
FUNGUS NAILS	PLANTAR FASCIITIS	HAMMERTOE	ORTHOTICS
INGROWN TOENAIL	HEEL PAIN	ACHILLES TENDINITIS	2ND OPINION
INJURY TO FOOT/ANKLE	SPRAIN OR STRAIN	DIABETIC SHOES	WORK RELATED INJURY
INFECTION OR ULCERATION	PLANTAR WARTS	CORNS, CALLUSES	RASH OR ATHLETE'S FOOT

OTHER:

DESCRIBE PAIN (if any): ☐ Sharp ☐ Dull ☐ Throbbing ☐ Burning ☐ Radiating ☐ Numbness

LOCATION ON FOOT OR ANKLE: ☐ Top ☐ Bottom ☐ Inside ☐ Outside ☐ Toes ☐ Webs ☐ Nails

HOW LONG HAS THIS BEEN A CONCERN FOR YOU: ☐ Days ☐ Weeks ☐ Months ☐ Years **HOW MANY?**

PREVIOUS TREATMENT: *Please circle all that apply.*

REST	ORAL MEDICATION	PREVIOUS MEDICAL TREATMENT
ICE	PHYSICAL THERAPY	FOOT SURGERY
CHANGE IN SHOE GEAR	ORTHOTIC OR FOOT SUPPORT	CORTISONE INJECTION

OTHER:

LAST SEEN BY A PODIATRIST: APPROX. DATE ☐ NEVER SEEN FEMALES: CURRENTLY PREGNANT ☐ YES ☐ NO

HOW WERE YOU REFERRED TO OUR OFFICE?

☐ Primary Care / Family Physician ☐ Internet ☐ Existing Patient ☐ Insurance or Hospital Referral Service ☐ Specialist

☐ Other:

Complete Other Side >

ALLERGIES: *Please circle all that apply.* ☐ **NO KNOWN ALLERGIES**

ASPIRIN	DYES	LOCAL ANESTHETIC	SEASONAL ALLERGIES	OTHER:
CORTISONE	FOOD	NUTS	SULFA	OTHER:
DUST, MOLDS	IODINE	PENICILLIN	TAPE	OTHER:

MEDICATIONS: *Please list any medications that you are taking.* ☐ **NOT TAKING ANY MEDICATIONS**

NAME: DOSE: FREQUENCY:

NAME: DOSE: FREQUENCY:

NAME: DOSE: FREQUENCY:

ANY OTHERS:

PHARMACY NAME & ADDRESS:

PAST MEDICAL HISTORY: *Please circle all that apply.* ☐ **NO MEDICAL PROBLEMS**

ANEMIA	EYE DISORDERS	HIGH CHOLESTEROL	OSTEOPOROSIS	SCOLIOSIS
ARTHRITIS	FIBROMYALGIA	JOINT IMPLANT	PHLEBITIS	SEASONAL ALLERGIES
ASTHMA	GOUT	KIDNEY DISEASE	PSYCHIATRIC DISORDER	SEIZURES STROKE
BONE DISEASE	HEADACHES	LIVER CONDITIONS	RESPIRATORY PROBLEMS	STOMACH PROBLEMS
CANCER	HEART ATTACK	LUNG PROBLEMS	RHEUMATIC FEVER	THYROID DISEASE
CHEST PAIN	HEART DISEASE	LYME DISEASE	RHEUMATOID ARTHRITIS	TUBERCULOSIS
CIRCULATION PROBLEMS	HEPATITIS	MUSCLE DISEASE	SCAR ENLARGEMENT	ULCERS
DIABETES	HIGH BLOOD PRESSURE	NEUROLOGIC DISEASE	SCIATICA	URINARY PROBLEMS

LIST ANY OTHER MEDICAL CONDITIONS NOT LISTED ABOVE:

PAST SURGICAL HISTORY: *Please list any surgeries you have had.* ☐ **NO PREVIOUS SURGERY**

SURGERY: OTHERS:

FAMILY HISTORY: *Please mark if immediate family members have or had any of the following:* ☐ **UNKNOWN** ☐ **UNREMARKABLE**

CONDITION	BLEEDING PROBLEMS	CANCER	DIABETES	HEART DISEASE	HYPERTENSION	STROKE	LIVING	DECEASED
FATHER								
MOTHER								
SIBLING								
CHILDREN								

SOCIAL HISTORY: *Do you use or have you used any of the following:*

SMOKING: ☐ Never ☐ Former Smoker ☐ Current Everyday Smoker ☐ Occasional Smoker

ALCOHOL: ☐ No ☐ Social ☐ Mild ☐ Moderate ☐ Heavy ☐ Quit

PRIMARY CARE / FAMILY PHYSICIAN OR GROUP:

HEIGHT:	WEIGHT:	**FOR DIABETICS ONLY:** *Please fill out below.*
BLOOD PRESSURE: /	SHOE SIZE:	LAST DOCTOR'S VISIT:
		BLOOD SUGAR: A1c:

I certify that the above information is correct.

PATIENT SIGNATURE: DATE:

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I. Acknowledgement of Practice's *Notice of Privacy Practices*:

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

Name of Patient	Date of Birth	Signature of Patient/Parent/Guardian	Date
_____	_____	_____	_____

II. Designation of Certain Relatives, Close Friends, and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain of my health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my health care. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Print Name:_____ **Date of Birth (required):** _____
Print Name:_____ **Date of Birth (required):** _____
Print Name:_____ **Date of Birth (required):** _____

III. Request to Receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

Home Telephone Number:

_____
____ OK to leave message with detailed information
____ Leave message with call back numbers only

Written Communication Address:

_____
____ OK to mail to address listed above
____ E-mail me at:_____

Work Telephone Number:

_____
____ OK to leave message with detailed information
____ Leave message with call back numbers only

Fax Communication:

_____
____ OK to Fax at the number listed above
____ E-mail me at:_____

Other:_____

IV. The following person(s) <u>are not authorized</u> to receive my Patient Health Information (PHI):

Print Name:_____ **Print Name:**_____
Print Name:_____ **Print Name:**_____

V. The HIPAA Privacy rule requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI. I understand that this accounting will not reflect disclosures that are made in the course of the Practice's ordinary health care activities related to providing patient treatment, obtaining payment for its services or its internal operations. Also, the Practice does not have to account for disclosures for which I have executed an Authorization permitting disclosures of my PHI.

1. The above authorizations are voluntary, and I may refuse to agree to their terms without affecting any of my rights to receive health care at the Practice.

2. These Authorizations may be revoked at any time by notifying the Practice in writing at the Practices mailing address marked to the attention of "HIPAA Compliance Officer."

3. The revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.

4. I may see and copy the information described in this form, if I ask for it, and that I will get a copy of this form after I sign it.

5. This form was completely filled in before I signed it and I acknowledge that all of my questions were answered to my satisfaction, that I fully understand this authorization form, and have received an executed copy.

6. This authorization is valid as of the date I have signed below and shall remain valid for a period of year.

_____ _____

Name of Patient (Printed) Signature of Patient Date

Podiatry Care Specialists, P.C. Payment Policy

Thank you for choosing our office to provide you with medical care. We are committed to serving you with quality and affordable health care.
Your complete understanding of the following office payment policy is an essential element of your care and treatment. Please feel free to ask us any questions that you may have. After reviewing this, kindly sign in the space provided at the bottom of this page.

1. **Insurance**. We participate in most insurance plans, including Medicare. If you are not insured with a plan that we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with, but do not have active coverage, you will be responsible for any unpaid charges. Knowing your insurance benefits is **your responsibility**. Please contact your insurance company with any questions you may have regarding coverage.
2. **Co-payments and deductibles**. All co-payments and known deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles can be considered a violation of our contract with your insurance company.
3. **Non-covered services**. Please be aware that some and perhaps all of the services you receive may be non-covered or considered not necessary by Medicare or other insurers. We will inform you of this prior to treatment and if agreed upon, payment in full for providing these services will be expected at the time of the visit.
4. **Proof of insurance**. All patients must complete or update our personal information form prior to seeing the doctor. We must obtain a copy of your current insurance card and driver's license or picture ID to verify proof of insurance. We must be provided the subscriber's name and date of birth, if you are not the subscriber. Many insurance companies will reject claims if the subscriber's information is not complete. If you or the subscriber's insurance changes, you must notify the front desk immediately upon check-in. Please understand if we ask periodically about insurance changes, as the Affordable Care Act has brought about many coverage changes.
5. **Referrals/Authorizations**. We are required to follow the guidelines of insurance plans which mandate a referral from your primary care physician prior to seeking podiatric care. Therefore, you are financially responsible for the services received, unless your referral is presented or is current at the time of this visit. Full credit will be given if a valid and timely dated referral is presented to our office within 48 hours. Please remember that obtaining a referral is **your responsibility** and not a requirement of our staff. If you do not wish to be responsible for a visit without the proper authorization, you have the option to reschedule your visit until the referral is obtained or received.
6. **Claims submission**. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. You are responsible for complying with their request and failure to reply to them promptly, will usually lead to a rejected claim. A rejected claim because of you not providing your insurance company with the requested information, will lead to your accountability for payment for the services rendered in question. Please be aware that any balance of your claim from what your insurance company paid, or if the claim is denied, is your responsibility. Your insurance benefit is a contract between you and your insurance company.
7. **Coverage changes**. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.
8. **Patient billing**. Invoices are sent out every 30 days. Your prompt payment will assist us in keeping the cost of healthcare down. A rebilling charge of $10 per month will accrue on all accounts over 60 days past due. Payment arrangements can be made on a case by case basis. We realize that temporary financial dilemmas may affect timely payment of your account. If problems do arise, we encourage you to contact us promptly for assistance in managing your account. We accept the following payment methods: Cash, Check, VISA, and MasterCard. There is a service fee of $25 for all returned checks. Please be aware that if a balance remains unpaid, we may refer your account to collections.
9. **Missed appointments**. Please honor our 24 hour reschedule policy, which states that there may be a charge for appointments broken or not cancelled within 24 hours, except for an understandable reason. Repetitive broken or cancelled appointments and/or a pattern of not keeping appointments may result in our practice providing you with means to transfer health care to another qualified provider.
10. **Privacy statement**. Any information disclosed in your records will remain confidential and will not be used for any other reason except in providing quality care and treatment, as well as to submit your claim to your insurance company, and contact you as needed.

I have read and understand the payment policy and agree to abide by its guidelines.

PATIENT NAME (PRINT)_____ **DATE**_____

PATIENT SIGNATURE_____

If other than patient:
SIGNATURE OF RESPONSIBLE PARTY_____

RELATIONSHIP TO PATIENT – PARENT SPOUSE POWER OF ATTORNEY CAREGIVER