Portsmouth Foot Care

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[Please complete all 4 pages]

Name_____ DOB_____ Age _____ SSN _____

Address_____City_____State_____Zip_____

Home Ph _____ Work_____ Cell_____

Email Address_____ **Marital Status:** S M W D Sep **Gender:** F M
(EMAIL REQUIRED FOR PATIENT OR CLOSE FAMILY MEMBER)

Patient's Employer_____**Position**_____

Referred by _____

Primary Physician_____ **Date of last visit**_____

EMERGENCY CONTACT: Name_____ Phone_____ Relationship_____

Address _____Employer & Phone_____

Spouse's Name_____ Date of Birth_____

Spouse's Employer _____ Phone _____

Describe why we are seeing you today: _____

_____How long has this been bothering you?_____

Any past problems or surgical procedures on your feet or ankles?_____

_____

General Health Information

Shoe Size _____ Current Weight _____ Height _____ Are you pregnant? Y N

Are you Diabetic? Y N If yes, do you take insulin? Y N Number of years?_____

Have you had an y serious illnesses or major surgeries?_____

_____

Do you have any drug allergies? Y N (If yes, please list)_____

Do you have any problems with local anesthetics (Novacaine, Lidocaine)? Y N _____

Are you under a physician's care? Y N _____May we contact your physician about your health? Y N

Name of preferred Pharmacy_____ Location_____

Medications that you take regularly:

_____

_____

Check any of the following you have or had a problem with:

___Heart ___Skin ___Circulation ___Stomach Ulcers ___Gout ___Hormones ___ Arthritis

___ Frequent Infections ___Tuberculosis ___Healing ___Kidneys ___Bladder ___Anemia ___ Lungs

___Intestines ___Cancer ___Liver ___Spleen ___Neurological Disorder ___Rheumatic Fever

___High Blood Pressure ___ Eye, Ear, Nose, or Throat ___ Emotional or Psychiatric Disorder ___ Phlebitis or Blood Clots

___Asthma or Breathing Difficulty ___Unexplained Fever or Weight Loss

Do you have artificial joints? Hip: Y N Knee: Y N Other:_____

Do you have a Heart Valve implant? Y N

Family:

Mother: ___Living ___Deceased Cause of Death:_____

Father: ___Living ___Deceased Cause of Death:_____

Brother(s): ___Living ___Deceased Cause of Death:_____

Sister(s): ___Living ___Deceased Cause of Death:_____

Is there a family (blood relative) history of:

___Heart disease ___Bunions ___Arthritis ___Hammertoes ___Bleeding Disorder ___Flatfeet ___Stroke

___Neurological Disorder ___Circulation problems in legs or feet

Do you smoke? Y N _____# of packs per day Previously smoked? Y N _____# of years

Do you drink alcohol or beer? Y N ___Light usage (1-2 per week) ___Moderate (1-2 per day) ___Heavy (more than 2 daily)

Employment: ___Sit at job ___Stand at job ___Stand & walk at job ___Retired

Any additional information that we may need:_____

_____

Authorizations

I authorize the treating physician to disclose complete information concerning the medical findings and treatment of the undersigned from the initial office visit until date of the conclusion of such treatment, to those individuals who in, the treating physician's sole determination are required to receive such information for the purpose of medical treatment, medical quality assurance and peer review. I also authorize the release of any medical information necessary to process insurance claims and payment of medical benefits to the treating physician for services rendered. The patient also agrees that he/she is responsible for any bills incurred at this office that the insurance plan does not cover. I understand all of the above and hereby state that the information is correct to the best of my knowledge.

Signed (insured person)_____ **Date**_____

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OUR FINANCIAL POLICY

Many doctors have terminated problematic insurance plans. We are wholeheartedly against that, while it may send a message to the insurance industry, its ultimate result is damaging to the physician-patient relationship. Thank you for choosing us as your health care provider. We appreciate your trust in us and we appreciate the opportunity to serve you. As you may know, our office and physicians in general continue to struggle trying to get insurance companies to pay us in a timely manner. Most insurance companies unfairly delay payments to your doctor despite you paying increased premiums year after year and they are inexplicably and non-negotiably slowly reducing reimbursement payments to doctors. In order to just stay in business, we find ourselves being forced to make some hard decisions. As a result, we implemented a new Financial Policy, which we require that you read, agree to and sign prior to any treatment.

PATIENT PAYMENTS

Payment is due at the time of service. You may use cash, check, credit card or debit card to pay your account. Payment arrangements may be requested in cases of financial hardship and must be approved by the practice manager.

INSURANCE PAYMENTS

We make no claims to know what services your insurance covers. While we make a good faith attempt to verify coverage, we are not able to guarantee that the information given to us by your insurance is correct. It is your responsibility alone to know what services may or may not be covered by your insurance. We encourage you to refer to your benefits manual if you have any questions about covered services. In addition, be aware that some and perhaps all of the services provided may be non-covered services by your insurance. You will be responsible for payment of all non-covered services at the time they are rendered. Finally, in the event you provide incorrect insurance information that delays payment, you may be asked to pay billed charges and seek reimbursement from your insurance provider directly.

THIRD PARTY PAYORS

Our office does not bill third party payors such as PIP (Personal Injury Protection) for a motor vehicle accident, or attorneys.

MISSED/LATE CANCELED APPOINTMENTS

Please give us at least 24 hours notification if you cannot keep an appointment. This courtesy will allow others to be seen. We do realize that emergencies arise and therefore do not charge for that first missed or late canceled appointment. However, you will be charged $25 for subsequent missed or late cancelled appointments and $100 for missed/late canceled surgery appointments.

RETURNED CHECKS

There is a $40 fee for any check that is returned.

We welcome the opportunity to discuss any aspect of our financial policy. Please ask to speak to our office manager or billing manager if you have any questions, comments, or concerns. We sincerely regret having to create such a policy and hope you understand our reasoning. We thank you for the support and look forward to seeing you in the future.

Patient Authorization

I have read, understand, and agree to abide by the terms stipulated above. I request that payments of benefits be made to Your Hometown Foot Care, Inc. I hereby authorize the release of any information necessary to determine liability for payment and obtain reimbursement on any claim. I further authorize the use of my signature below on all insurance submissions for services rendered or to be rendered. I agree that a photocopy of this agreement shall be as valid as the original. This authorization shall remain valid until revoked by me in writing.

DATE_____

PATIENT NAME_____ DATE OF BIRTH_____
RESPONSIBLE PARTY:
NAME_____ DATE OF BIRTH_____ SSN_____-_____-_____

PATIENT SIGNATURE (OR PARENT OF MINOR/LEGAL GUARDIAN) _____

NAME OF PERSON COMPLETING FORM IF OTHER THAN PATIENT_____

RELATIONSHIP TO PATIENT_____

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MEDICAL INFORMATION RELEASE FORM

HIPPA RELEASE FORM

NAME_____ Date of Birth _____/____/_____

EMAIL ADDRESS_____

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

[ ] Spouse/Other:_____

[ ] Physicians Office:_____

[ ] Other:_____

[ ] Do not release any information to anyone.

Patient Signature: _____ Date: _____

[ ] I do not have an Email Address for my patient portal, but I give permission for you to use this email address:

Email Address: _____