FOOTDRx

PATIENT REGISTRATION

PATIENT INFORMATION:

Full Name: ____

Address: ____

City, State, Zip Code: ____

Cell Phone: _______________________Work Phone: ____________________________

Email: ____

Birth Date: __________________ Age: ____________ Female ☐ Male ☐

Employer: ____________________________________ Occupation: _________________

Height: ________________Weight: _______________ Shoe Size: __________________

MARITAL STATUS (PLEASE CIRCLE)

☐Single /☐ Married / ☐ Divorce / ☐ Separated / ☐Widowed / ☐Partnered

EMERGENCY CONTACT / GUARDIAN / SPOUSE INFORMATION:

Emergency Contact / Guardian / Spouse Name: _______________________________________

Birth Date: ______________Phone: ______________________ Relationship: _______________

INSURANCE INFORMATION:

Primary Insurance: _____________________________ Member ID: __________________

Policyholder's Name: _________________________________ Birth Date: _____________

Policyholder's Relationship to Patient: ____

Secondary Insurance: ________________________________ Member ID: ____________

Policyholder's Name: _________________________________ Birth Date: _____________

Policyholder's Relationship to Patient: ____

REQUIRED FOR ALL MEDICARE / MEDICARE HMO PLANS / HMO REFERRAL:

Primary Care Physician (PCP): ____

PCP Address: ____

PCP Phone: _____________________________**PCP Fax #:** _______________________

Approximate Date of Last Appointment with PCP: _______________________________

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PHARMACY INFORMATION:

All prescriptions must be sent electronically. If you do not have a preferred pharmacy, your prescription will be sent to our default pharmacy which is Capsule Pharmacy.

Pharmacy Name: ____

Pharmacy Address: ____

Pharmacy Phone #: _________________________Fax#: _____________________

Are you currently taking any medications? ______Yes _____No

REASON FOR TODAY'S VISIT:

Please indicate which foot problems you are currently experiencing. (Check all that apply)

	Left	Right		Left	Right
Ankle Pain			Heel Pain		
Athlete's Foot			Ingrown Toenails		
Bunions			Plantar Warts		
Corns/Calluses			Plantar Fasciitis		
Diabetic			Stress Fracture		
Flat Feet			Swelling in Ankles/Feet		
Foot or Leg Cramps			Tired Feet		
Foot Injury			Toenail Fungus		

Other: ____

MEDICAL HISTORY: Please indicate if you have or had any of the following: (Check all that apply)

AIDS/HIV		Edema		Osteoporosis	
Anemia		Fibromyalgia		Pacemaker	
Angina		Foot Deformity		Peripheral Vascular Disease	
Arthritis		Frost Bite		Poliomyelitis	
Artificial Joints		Gout		Pulmonary Embolism	
Asthma		Headaches		Raynaud's Disease	
Back Pain		Heart Disease		Rheumatoid Arthritis	
Bleeding Disorders		Hepatitis		Seizures/Epilepsy	
Blood Clot		Hernia		Stroke	
Cancer		Hypertension		Substance Abuse	
Coronary Artery Disease		Kidney Disease		Thyroid Problems	
Deep Vein Thrombosis		Leg or Foot Ulcers		Tuberculosis	
Diabetes		Liver Disease		Varicose Veins	
Dialysis		Lung Disease		Other:	
Dyslipidemia		Organ Transplant			

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SURGER IES / HOSPITALIZATIONS:

____

____

ALLERGIES: (CHECK ALL THAT APPLY)

Adhesive/Tape		Demerol		Novocain	
Anticoagulant Therapy		Iodine		Penicillin	
Aspirin		Latex		Seafood	
Codeine		Local Anesthetics		Sulfa	

Other:

____

____

SOCIAL HISTORY / (CHECK ALL THAT APPLY)

SMOKING STATUS:

Never Smoker______ Former Smoker ______ Current Smoker (everyday) _______

Current Smoker (some days) ______Tobacco – Years of Use: ___________

ALCOHOL INTAKE:

Occasional _________ Moderate ________ Heavy __________

PHYSICAL ACTIVITY / EXERCIS

Please list all physical activities/exercises you participate in and how often these activities are performed: ____

____

CONSENT TO CALL

Our office offers automated phone calls to your mobile phone for specific features such as appointment reminders, test results, and more. Please check one of the following options:

______ Yes, I want to receive automated calls from the practice.

______ No, I do not want to receive automated calls from the practice.

PRACTICE CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient Signature: ______________________________________ Date: __________________

FOOTDRx

NOTICE OF PRIVACY PRACTICES

HIPAA COMPLIANCE

ACKNOWLEDGEMENT OF AGREEMENT

This notice describes how health information may be used and disclosed and how you can access this information. Please review it carefully. At **FOOTDRx,** we have always kept your health information secure and confidential. Federal law requires us to use or disclose your health information to those involved in your treatment. For example, a review of your file by another physician we may involve in your care. We may disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company. We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer. We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy. We may use your information to contact you. For example, we may call to confirm your appointments. As we may need to contact you from time to time, we will use whatever address or telephone number you prefer. If you are not home, we may leave this information on your answering machine or with the person answering the phone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law. If this practice is sold, your information will become property of the new owner. Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request. You have the right to know of any use or disclosures we make with your health information beyond the above normal uses. You have the right to transfer copies of your health information to another practice. We will mail your files for you. You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee. You have the right to request an amendment to your health information. Give us your amendment request in writing. We will include your file. If we agree to an amendment we will not remove, nor alter earlier documents, but will add new information. You have a right to receive a copy of this notice. If we change any of the details of this notice, we will notify you in writing. This notice is effective January 1, 2010.

I have read and/or requested a copy of **FOOTDRx's** Notice of Privacy Practices.

Patient's Name (Print): ____

Signature: ____

* Patient Signature or Parent/Legal Guardian Signature if patient is under the age of 18.

Date: ______________________

FOOTDRx

FINANCIAL STATEMENT POLICY

The Doctors and office staff at **FOOTDRx** know that your insurance coverage is very important to you. You are responsible for knowing the benefits, limitations, deductibles and/or restrictions that your policy may stipulate. In order to avoid any misunderstandings, we ask that you confirm your benefits with your insurance carrier. Please understand that the exact determination of benefits occurs at the time your insurance company processes and pays the claim. Every effort will be made to notify you should a difference occur between what was expected and what was actually paid. You will also receive notification directly from your insurance carrier concerning the benefits paid from your visit.

We must emphasize that our relationship is with you. While filing of insurance claims is a service that we extend to our patients, it is your responsibility that the charges are paid in full. Any known out-of-pocket expenses including deductibles, co-pays, co-insurance, and/or non-covered services or supplies are due at the time of service. Any amounts denied for any reason by your insurance carrier not known to us are due at the time of claim processing.

Accounts that are unpaid are considered delinquent. These accounts will be referred to our collection agency and/or attorney for collection or to small claims court. You, the patient or responsible party, shall be responsible for all costs incurred for collections. These may include collection fees, attorney fees, and/or court costs. Payment is expected at the time of treatment for all deductibles, co-pays, and co-insurance. I understand and agree that I am financially and legally responsible for full payment of my bill for services and that any failure of my insurance carrier to pay for all or any part of my bill does not constitute a reason for me not to pay. I understand that my insurance policy is a contract between myself and the carrier and that **FOOTDRx** is not responsible for settling disputed claims. **FOOTDRx** will provide the necessary information regarding my treatment in order to facilitate payment of my claim. I also understand and agree that the responsibility for obtaining referrals/authorizations for in-network treatment is solely mine. I understand that I will be seen as an out-of network patient if I do not obtain the appropriate referral for treatment. It will then be my responsibility for all unpaid benefits.

In addition, I have been advised that my failure and/or denial to provide accurate insurance information prior to, or upon my initial visit will mandate that **FOOTDRx** will assign me as a self-paying or uninsured cash patient. This classification will cause me to forfeit any in-network benefits that **FOOTDRx** may accept as a participating provider. I will be reinstated as an insured patient once all documentation and referrals are provided. I also understand that **FOOTDRx** requires 24 hours' notice for any change or cancellation of scheduled appointments and I may be held financially responsible (not my insurance carrier) for late cancellations and missed appointments.

I understand the **FOOTDRx** financial policy and responsibility for my account.

Patient Name (Print): ______________________________

Patient/Responsible Party's Signature: ______________________________

Payment Disclaimer: I request that payment of authorized Medicare and/or private benefits/payments be made either to me or on my behalf to the provider for any services rendered to me by the physician or the supplier.

I authorize any holder of medical information (about me) permission to release same to the health care financing administration and its agents as is required to determine these benefits or any benefits payable for related services. A copy of this signature is as valid as the original.

Patient Signature: ______________________________

Date: ______________________________

CREDIT CARD AUTHORIZATION

In order to facilitate processing of any patient responsibility you may be liable for, **FOOTDRx** enables you to keep your credit card on file in order to cover any expenses involving your medical care. This information will be held securely in your medical record. It allows you to keep your signature on file to authorize payments to be made to **FOOTDRx** for your insurance liabilities as well as payments made via phone, at your appointment, and/or for any balances unpaid after 90 days from treatment date.

This agreement will hold until the balance of all treatment received by the patient is paid in full.

FOOTDRx may keep my credit card on file and charge it for the amount owed for any of the following: deductible, co-insurance, co-pay, or self-pay fees.

I, the undersigned, acknowledge that **FOOTDRx** is hereby authorized to charge my credit card for any of my liability for my medical care without obtaining any additional signatures.

Patient Name (Print): ____

Card Type (Circle One)

□ AMEX □ MASTERCARD □ VISA □ DISCOVER

Card Number:

Expiration Date: ___________ **Security Code:** _________ **Billing Zip Code:** ____________

We can send you a receipt each time we charge your credit card. Please check one of the following:

______ I do not want a receipt sent to me each time my card is charged.

______ I want my receipts emailed to me. EMAIL: ______________________________

______ I want my receipts faxed to me. FAX#: ________________________________

______ I want my receipts mailed to me. Please confirm address at the front desk.

Patient Signature: ____

Date: ______________________