PATIENT REGISTRATION

PATIENT INFORMATION:

Last Name: _____ First Name: _____

Legal Sex: ☐ Male ☐ Female Date of Birth: _____ Age: _____

Address: _____ Apt# _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Consent to Text? ☐ Yes ☐ No Email: _____

Height: _____ Weight: _____ Shoe Size: _____ Width ☐ M ☐ W ☐ XW

EMERGENCY CONTACT

Full Name: _____ Relationship: _____

Home Phone: _____ Mobile Phone: _____

DEMOGRAPHICS

Race: ☐ Asian ☐ Asian Indian ☐ Black ☐ Black/African American
☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other: _____
☐ I choose not to answer

Ethnicity: ☐ Central American ☐ Cuban ☐ Dominican ☐ Hispanic or Latino/Spanish
☐ Latin American/Latin, Latino ☐ Mexican ☐ Not Hispanic or Latino
☐ Puerto Rican ☐ South American ☐ Spaniard ☐ I choose not to answer

Marital Status: ☐ Single ☐ Married ☐ Divorce ☐ Separated ☐ Widowed ☐ Partnered

Sexual Orientation: ☐ Lesbian, Gay, or Homosexual ☐ Straight or Heterosexual ☐ Bisexual
☐ Something else: _____ ☐ I choose not to answer

Gender Identity: ☐ Male ☐ Female ☐ Gender non-conforming
☐ Transgender Male/Female-to-Male ☐ Transgender Female/Male-to-Female
☐ Other: _____ ☐ I choose not to answer

Assigned Sex at Birth: ☐ Male ☐ Female ☐ I choose not to answer

Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them

EMPLOYMENT

Employer Name: _____ Occupation: _____

Employer Phone: _____

FOOTDRx HANDDRx

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: _____

Address: _____ City: _____ State: _____ Zip: _____

Pharmacy Phone #: _____ Fax#: _____

Are you currently taking any medications? ☐ Yes ☐ No

If yes, please list: _____

INSURANCE / RESPONSIBLE PARTY INFORMATION:

Primary Insurance Name: _____

Member ID #: _____ Group #: _____

Patient's Relationship to Policyholder: ☐ Self ☐ Spouse ☐ Child ☐ Life Partner ☐ Other: _____

Primary Policyholder's Full Name: _____ DOB: _____

Is Policyholder's address different than patient's? ☐ Yes ☐ No

If yes:_____

Secondary Insurance Name: _____

Member ID #: _____ Group #: _____

PRIMARY CARE PHYSICIAN:

(Required for ALL Medicare Plans / Medicare HMO Plans / HMO Referral Plans)

Primary Care Physician (PCP) Name: _____

PCP Address: _____ Suite/Rm/ FL: _____

City: _____ State: _____ Zip Code: _____

PCP Phone: _____ PCP Fax: _____

Approximate Date of Last Appointment with PCP: _____

FOOTDRx

HANDDRx

(FOOT PATIENTS)

REASON FOR TODAY'S VISIT: L = Left R = Right

Current Symptom	L	R	Current Symptom	L	R	Current Symptom	L	R
Ankle Injury			Flat Feet			Metatarsal Fracture		
Ankle Pain			Foot or Leg Cramps			Neuroma		
Ankle Sprain			Foot Injury			Plantar Warts		
Athlete's Foot			Foot Pain			Plantar Fasciitis		
Blister on Foot/Toe			Foot Sprain			Stress Fracture		
Broken Toe			Glass			Swelling in Ankles / Feet		
Broken Nail			Ganglion			Tendon Strain		
Burn			Gangrene			Tired Feet		
Bunion			Gout			Toe Fracture		
Chronic Ankle			Hammer Toes			Toenail Fungus		
Corns / Calluses			Heel Pain					
Diabetic			Ingrown Toenails					

Other: _____

(HAND PATIENTS)

REASON FOR TODAY'S VISIT: L = Left R = Right

Current Symptom	L	R	Current Symptom	L	R	Current Symptom	L	R
Arm Fracture			Ganglion Cyst			Neuroma		
Arm Pain			Gout in Hands			Non-Healing Fracture		
Arthritis			Hand Arthritis			Osteoarthritis		
Brachial Plexus Injury			Hand Deformity			Traumatic Fracture		
Carpal Tunnel Syndrome			Hand Fracture			Triceps Tendinitis		
Clavicle Fracture			Hand Injury			Triceps Tendon Rupture		
Distal Radius Fracture			Hand Pain			Trigger Finger		
Extensor Tendon Injury			Hand Sprain			Wrist Arthritis		
Finger Fracture			Mallet Finger			Wrist Fracture		
Finger Injury			Nailbed Injuries			Wrist Injury		
Finger Pain			Nerve Injury			Wrist Pain		
Frozen Shoulder			Nerve Pain			Wrist Tendinitis		

Other: _____

FOOTDRx HANDDRx

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

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

Other:_____

ALLERGIES (Check all that apply)

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

☐ No Allergies

☐ Other: _____

_____

SURGERIES/ HOSPITALIZATIONS:

_____

_____

SUBSTANCE USE:

Tobacco Use: ☐ Never ☐ Former Smoker ☐ Current Smoker (daily) ☐ Current Smoker (some days)

Use of other forms of tobacco/nicotine: ☐ Yes ☐ No

Level of Alcohol Consumption: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Use of any illicit or recreational drugs: ☐ Yes ☐ No

Level of Caffeine Consumption: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

PHYSICAL ACTIVITY / EXERCISES

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.

Signature of Beneficiary, Guardian, or Personal Representative

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Please print name of Beneficiary, Guardian, or Personal Representative

_____ _____

Date Relationship to Beneficiary

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 & HANDDRx** 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 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 & HANDDRx** Notice of Privacy Practices.

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

Patient's Name (Print): _____
Signature: _____
Date: _____

PATIENT FINANCIAL RESPONSIBILITY POLICY

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship.

- **INSURANCE COVERAGE** – Your insurance policy is a contract between YOU and YOUR INSURANCE COMPANY. As a courtesy, we will file your insurance claim. However, the patient is required to provide the office with the most correct and updated information about their insurance. It is the responsibility of the patient for any charges incurred if any provided information is not correct or current.
- **APPOINTMENTS** – FOOTDRx & HANDDRx have a 24-hour cancellation policy. Appointments that are not cancelled with more than 24 hour notice may be subject to a cancellation fee of $20.00.
- **REFFERALS** – If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If your plan requires a referral and you do not obtain one, YOU will be responsible for all visit charges at the time of service.
- **OUT-OF-NETWORK PLANS** – You will be responsible for any charges incurred from services rendered that are not covered per their explanation of benefits form. In the case of out-of-network insurance policies, most plans will not provide out-of-network benefit coverage and the patient is responsible for all charges incurred for services, without exception. FOOTDRx & HANDDRx will always send a courtesy bill to any out-of-network carrier on your behalf. However, should they not pay your claim in 90 days, you will be responsible for the full amount due.
- **SELF-PAY PATIENTS** – Full payment is expected at the time of service.
- **MEDICARE** – As a courtesy, we will send claims to Medicare and if you have a secondary insurance we will also submit to them on your behalf. However, should your claims remain unpaid by your insurance company, final responsibility for deductible and 20% coinsurance amounts is that of the patient.
- **DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS** – The parent who consents to the treatment of a minor child is responsible for payment of services rendered. FOOTDRx & HANDDRx will not be involved with separation or divorce disputes.

You are responsible for the timely payment of your account. Should it become necessary for us to use an outside agency to collect payment, you will be held responsible for whatever charges we incur as a result of this.

_____ _____

Patient Signature **Date**

PATIENT FINANCIAL LIABILITY STATEMENT

I understand that I am personally and financially responsible for charges incurred for services rendered at FOOTDRx &/or HANDDRx if any of the following apply:

1. My health benefit plan requires prior authorization or referral by a primary care physician before receiving services at FOOTDRx &/or HANDDRx

2. My health plan coverage has lapsed or expired at the time I receive services at FOOTDRx &/or HANDDRx

3. My health plan is not one that FOOTDRx &/or HANDDRx participates in.

I also understand that I am responsible for all co-payments, co-insurance, and deductible sums under my health plan.

Any account that has a balance for over 90 days runs the risk of being placed in collections. If an account is placed in collections, any and all collection and legal fees associated with the collections of the account will be the patient's responsibility. Patients who do not have their account paid in full will also be unable to schedule future appointments until the account is cleared.

Patient Name (Print): _____
Patient/Responsible Party's Signature: _____

<u>Payment Disclaimer:</u>

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: _____