PATIENT NAME: _____
FIRST MI LAST

HOME ADDRESS: _____APARTMENT#_____

CITY: _____ STATE:_____ ZIP: _____ DATE OF BIRTH: ___/___/____

SOCIAL SECURITY #:_____-_____-_____ AGE: _____ SEX: ☐M ☐ F NICKNAME:_____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED
RACE: ☐ WHITE ☐ AFRICAN AMERICAN ☐ LATINO ☐ ASIAN ☐ OTHER_____
ETHNICITY: ☐ NOT HISPANIC ORIGIN ☐ HISPANIC ☐ OTHER

MAY WE LEAVE A MESSAGE?

HOME PHONE #: (_____) _____-_____ YES NO
WORK PHONE #: (_____)_____-_____ YES NO EMPLOYER:_____
CELL PHONE #: (_____) _____-_____ YES NO OCCUPATION:_____
E-MAIL ADDRESS:_____ YES NO
SPOUSE NAME:_____SPOUSE DOB:_____CELL:(___)_____

*GUARANTOR: _____ RELATIONSHIP TO PATIENT: _____
(PERSON RESPONSIBLE FOR BILLS) ☐ SELF

ADDRESS: _____ CITY:_____

STATE: _____ ZIP: _____ PHONE #: (_____) _____-_____ DATE OF BIRTH:____/____/____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE #: (____) _____-_____
CELL PHONE# (_____)_____-_____

PRIMARY CARE DOCTOR: _____CLINIC :_____

I WAS REFERRED TO THIS OFFICE BY: ☐ PHYSICIAN/NURSE_____☐ FRIEND_____
☐ HEALTH FAIR ☐ YELLOW PAGES/NEWSPAPER ☐ INTERNET ☐ OFFICE WEBSITE ☐ INSURANCE COMPANY

PHARMACY: _____ LOCATION: _____ PHONE #: (____) ____-_____

INSURANCE INFORMATION **** (WE WILL ALSO COPY YOUR CARDS UPON CHECK IN, PLEASE PROVIDE THE INSURED'S DATE OF BIRTH)*

PRIMARY INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) _____-_____

INSURED NAME: _____ INSURED'S DATE OF BIRTH _____ EMPLOYER _____

ID # _____ GROUP # _____ RELATIONSHIP TO SUBSCRIBER:_____

SECONDARY INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) _____-_____

INSURED NAME: _____ INSURED'S DATE OF BIRTH _____ EMPLOYER _____
ID # _____ GROUP # _____ RELATIONSHIP TO SUBSCRIBER:_____

I UNDERSTAND I HAVE BEEN PROVIDED; AND AGREE TO THE TERMS OF THE HIPAA PRIVACY POLICY AND FINANCIAL POLICIES. I AM ULTIMATELY RESPONSIBLE FOR ALL CHARGES RELATING TO MY FOOT & ANKLE CONDITION. I AUTHORIZE MY INSURANCE COMPANY TO BE BILLED AND PAY ASSOCIATED PODIATRISTS DIRECTLY FOR SERVICES RENDERED.

PATIENT SIGNATURE:_____DATE:_____

IF A MINOR, PARENT OR GUARDIAN MUST SIGN

CURRENT FOOT PROBLEM:

PLEASE DESCRIBE YOUR FOOT PROBLEM:_____

HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: ☐ BEGIN ALL OF A SUDDEN ☐ GRADUALLY DEVELOPED OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? ☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING
☐ RADIATING ☐ ITCHING ☐ STABBING ☐ OTHER _____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)
(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 *(WORST PAIN POSSIBLE)*

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: ☐ STAYED THE SAME ☐ BECOME WORSE ☐ IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? ☐ WALKING ☐ STANDING ☐ DAILY ACTIVITIES
☐ RESTING ☐ DRESS SHOES ☐ HIGH HEELS ☐ FLAT SHOES ☐ ANY CLOSED TOE SHOE
☐ RUNNING ☐ OTHER _____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? _____

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? _____

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ NO OR ☐ YES (DESCRIBE) _____

_____IF YES, WAS IT A WORK-RELATED INJURY? ☐ YES ☐ NO

ALLERGIES: ☐ NONE KNOWN ☐ DRUG ALLERGIES_____
☐ ANESTHESIA _____ ☐ ANTIBIOTICS _____
☐ TAPE ☐ LATEX ☐ IODINE ☐ NICKEL (METAL) ☐ FOODS/OTHER_____

CURRENT MEDICATIONS:

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS) ***IF YOU HAVE A LIST, WE WILL COPY IT FOR YOU:

NAME DOSE HOW OFTEN DO YOU TAKE?

_____
_____
_____
_____
_____

☐ DO YOU TAKE BLOOD THINNERS? NAME OF MEDICATION:_____

DO YOU USE INSULIN? ☐ YES OR ☐ NO

YOUR MEDICAL HISTORY:

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y	N		FIBROMYALGIA	Y	N		NEUROPATHY	Y	N
ANEMIA	Y	N		GOUT	Y	N		OPEN SORES	Y	N
ARTHRITIS	Y	N		HEART ATTACK	Y	N		PNEUMONIA	Y	N
ASTHMA	Y	N		HEART DISEASE/FAILURE	Y	N		POLIO	Y	N
BACK TROUBLE	Y	N		HEPATITIS	Y	N		RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N		HIV+/AIDS	Y	N		SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N		HIGH BLOOD PRESSURE	Y	N		SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N		KIDNEY DISEASE	Y	N		SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N		LIVER DISEASE	Y	N		STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N		LOW BLOOD PRESSURE	Y	N		STROKE	Y	N
CANCER TYPE:_____	Y	N		MIGRAINE HEADACHES	Y	N		THYROID DISEASE	Y	N
DIABETES TYPE: I OR II	Y	N		MITRAL VALVE PROLAPSE	Y	N		TUBERCULOSIS	Y	N
EMPHESEMA	Y	N		NEUROLOGICAL DISORDER	Y	N		VASCULAR ISSUES	Y	N

LIST ANY OTHER PAST MEDICAL HISTORY:_____

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE

DO YOU HAVE ANY ARTIFICIAL JOINTS?

☐ KNEE ☐ HIP ☐ OTHER_____

DO YOU HAVE A HEART VALVE REPLACEMENT?

☐ YES ☐ NO

SOCIAL HISTORY

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ ☐ SMOKE ____ PACKS/DAY FOR ____ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ TYPE _____
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

OCCUPATION: _____

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐10% ☐25% ☐50% ☐75% ☐100%

EXERCISE: ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY

TYPES OF EXERCISE: _____

HEIGHT_____ WEIGHT_____ BLOOD PRESSURE_____ SHOE SIZE:_____ WIDTH:_____

FAMILY HISTORY

IS THERE A FAMILY HISTORY OF:

	MOTHER	FATHER	SISTER	BROTHER	MATERNAL GRANDMA	MATERNAL GRANDPA	PATERNAL GRANDMA	PATERNAL GRANDPA
DIABETES								
CANCER TYPE: _____								
HEART DISEASE								
HIGH BLOOD PRESSURE								
STROKE								
CORONARY ARTERY DISEASE								
THYROID DISEASE								
RHEUMATOID ARTHRITIS								

CONSENT:

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS. I REQUEST AND AUTHORIZE ASSOCIATED PODIATRISTS, LLP TO DIAGNOSE AND ADMINISTER TREATMENT FOR MY CONDITION.

PATIENT SIGNATURE:_____DATE:_____

ASSOCIATED PODIATRISTS, LLP
FINANCIAL POLICY

We are glad you have chosen our office to help you in your health care.
The doctors and staff strive to prescribe the best up to date treatments possible.

Full payment is expected on the day medical services are provided unless you have health insurance coverage with a plan that we have a written agreement. Our financial policy offers you a number of payment options such as: cash, checks, Visa, MasterCard, Discover or American Express . Patients with insurance must pay, when applicable: **Deductible-**an amount you must pay first out of your own pocket each year before insurance will pay for any services. **Co-payment-** an amount you must pay upon each visit to a doctor that is due at the time of service; **Co-insurance**- an amount which usually is a percentage of the fee that your insurance company will not pay. Deductibles, co-payment, and co-insurance are patient responsibility. On treatments that involve items that are non-covered by insurance, or custom order items, you will be required to pay 50% down at the time of visit, and the remaining balance when the product is dispensed. Orthotics require a deposit of 20% of the total cost at the time of casting and miscellaneous supplies are to be paid at time dispense.

We will need to make a copy of the front and back of your insurance card at your initial visit and at your first appointment of each year following this initial visit. Existing patients are to inform us of any changes in coverage that may have occurred since your last visit and provide us with insurance card/s at that time. If active insurance cards are not presented at time of appointment, the patient must provide insurance information within seven days due to timely filing purposes. If the new insurance information is not received, you may receive a bill for services rendered. If you have two or more insurance policies, it is your responsibility to inform us which policy is **Primary** (first) coverage, which policy is **Secondary** (second) coverage, and which policy is **Tertiary** (third) coverage. With each policy we will require the name, date of birth, address, phone number, and employer of the member who carries the policy.

Billing Statement: You will be sent a monthly billing statement if you have a balance on your account. We do not send invoices but rather billing statements in the middle of each month.

Payments: Unless other arrangements are approved by us in writing, the balance on your billing statement is due and payable by the last business day of the month the billing statement is issued.

Charges to Account: We have the right to cancel your privilege to make charges against your account at any time. If the patient's account is in a past due status, services must be paid in full prior to any services being rendered. Charges for services will continue to be paid in advance until the past due balance is paid in full by guaranteed payment methods, such as, Cash, Cashier's Check, or Debit Card.

Past Due Account Balances: If your account becomes past due, we may refer the overdue balance to a collection agency or to an attorney. I acknowledge and agree to pay all collection costs, attorney fees, and all court costs.

Cancellation/No Show Fee: A $50.00 no-show fee will be applied to your account for any missed appointment. To avoid this fee, we require at least 48 hours' notice for cancellations. Patients who have three no-show/no-call appointments may be dismissed from the practice.

Returned Checks: A $35.00 fee will be charged for any checks returned by the bank.

Telephone Contact: I give permission to Associated Podiatrists, LLP, and its Affiliates or contractors to contact me for any purpose at the current or any future numbers that are provided for my landline, cellular telephone or any other wireless device including the use of automated dialing equipment, prerecorded voice or text messages.

I acknowledge that I have read and agree with Page 1 of this Financial Policy. _____ ***Initials***

Preferred Provider Agreement Insurances: If we are Preferred Providers with your insurance company, we must follow our signed agreement. If you have a copayment or deductible, you must pay that at the time of service. It is the insurance company's requirement to make the final determination of your eligibility. Some insurance plans require a referral and/or preauthorization from your primary care physician. You are responsible for obtaining the referral and/or pre authorization prior to your appointment or full payment will be expected for the medical services rendered.

Non-Preferred Provider Agreement Insurances: If we are not Preferred Providers with your insurance company, we will bill your insurance company as a courtesy to you. By signing this Policy, you acknowledge and agree to pay any portion of the charges not covered by insurance. Failure to obtain the necessary referral and/or preauthorization is your responsibility prior to your appointment. Failure to obtain the necessary referral and/or pre authorization may result in lower payment from the insurance company, and/or denial of charges. Payment of these denied services will be expected to be paid in full.

Workers Compensation: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Marital Separation: If a couple is separated, but remains legally married, both parties are equally financially liable. If a minor child is the patient, both parties are equally financially liable.

Divorce: In case of divorce, the party, or parties responsible for charges incurred on the account prior to the divorce remains responsible for the account. If a minor child is treated, either pre or post divorce, both parents are jointly and severally responsible for any balances due.

Transferring Records: You will need to provide a completed Associated Podiatrists Medical Record Form if you want to have copies of your records sent to another doctor or organization. The amount charged per page is $.25. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history. X-ray copies are available to be transferred to another physician. Copies for x-rays are $10.00 per disk. We request that you please provide at least 3 days notice, prior to needing copies of your records.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, payment of the bill remains the patient's responsibility. Even if a personal injury claim or lawsuit is pending. See the paragraph that refers to Non-Preferred Provider Insurances above.

Patient Signature: _____Date: _____/_____/_____

Printed Patient Name: _____

Patient Spouse/Parent/Guarantor Signature: _____Date: _____/_____/_____

Printed Spouse/Parent/Guarantor Name: _____

By signing this document I acknowledge and agree to this entire Financial Policy.

Please feel free to ask any questions regarding your insurance and treatment in our office and we will do our best to assist you.

Thank You.

ASSOCIATED PODIATRISTS, LLP