FOOT ENVY

DR. CRAIG UDALL, DPM

Patient Registration Form

Last Name: _____ First Name:_____ MI:_____

Date of Birth: _____

Phone:_____ Email:_____

☐ **I agree to receive text messages from Foot Envy** (Please see terms below)

Primary care doctor:_____Clinic name:_____

Primary doctor phone #:_____ Last primary doctor visit:_____

Emergency Contact: _____

Name Phone # Relationship

Demographics and insurance information will be obtained during scheduling, and verified online through your insurance company prior to your appointment
If you have medical records, including a medication list or prior imaging, please provide to staff.

How did you hear about us?

☐ Doctor Referral ☐ Family/Friend ☐ Insurance ☐ Online search ☐ Pebble Creek Egroup ☐ Previous patient

SMS text messaging Consent Form

Foot Envy offers appointment reminders and simple general communications via text message. If you wish to receive those messages, we require your consent. Please provide your consent by checking the box above after carefully reviewing the terms and conditions.

I understand that by checking the box:

- I agree to receive text messages.
- I can Reply STOP to opt-out.
- I can Reply HELP for support.
- Message and data rates may apply.
- My consent is not required to purchase services
- Message frequency varies

Text messaging will not be used to share protected or confidential information. Text messaging is only used to share general information about appointments or billing statement reminders with links to make payments.

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Patient Name_____

Why are you seeing the doctor today?

_____

_____

Additional concerns:

_____

_____

Describe your pain

☐ Sharp/stabbing ☐ Dull ☐ Ache
☐ Numbness ☐ Tingling ☐ Burning
☐ no pain

Other _____

Check all that apply to you:

Are you pregnant? ☐ Yes ☐ No ☐ Possibly

Alcohol: ☐ Never ☐ Current ☐ Social

Smoke Tobacco: ☐ Never ☐ Current ☐ Former

Do you have balance problems?

☐ Yes ☐ No

Do you have neuropathy?

☐ Yes ☐ No ☐ Unsure

Check if you take: ☐ Gabapentin ☐ Lyrica

Do you have leg swelling?

☐ Yes ☐ No ☐ Varicose veins?

Do you have concerns about circulation in your leg?

☐ Yes ☐ No

History of blood clot?

☐ Yes ☐ No ☐ DVT ☐ PE when?_____

Do you have any allergies to medications?

☐ No ☐ Yes If yes, to what?_____

Reaction: _____

Type of work:_____

Status : ☐ Full ☐ Part ☐ Retired ☐ Disabled

Exercise/Hobbies:

☐ Golf ☐ Hiking ☐ Pickleball ☐ Tennis ☐ Walking
☐ Running ☐ Other_____

DOB _____

Check if you currently take these medications:

☐ Diabetes medication ☐ Cholesterol medication
☐ Hypertension (Blood Pressure) ☐ Narcotics
☐ Blood thinner ☐ Eliquis ☐ Plavix ☐ Coumadin
☐ Antibiotics
☐ Other_____

Your Medical Condition:

☐ No Issues
☐ Rheumatoid arthritis ☐ HIV
☐ Hypertension ☐ A-Fib ☐ Pacemaker
☐ Heart Attack Year?_____ ☐ stents?
☐ Peripheral Arterial disease ☐ Leg stents?
☐ Stroke Year?_____
☐ Kidney disease Stage _____ ☐ Dialysis
☐ Cancer _____ ☐ Chemo treatment
☐ Other _____

_____

☐ Diabetes ☐ type 1 ☐ type 2
year diagnosed_____
Last A1c level?_____ Date:_____
AM Blood sugar?_____
History of wound or ulcer? ☐ Yes ☐ No
History of amputation? ☐ Yes ☐ No

Details

_____

Previous foot Surgeries? ☐ Yes ☐ No

_____

Is there anything else about your health you would like us to know?

_____

_____

Physician Signature:_____

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Foot Envy Financial Policy

Please carefully read each statement and sign below.

As a courtesy to our patients we will file claims to insurance plans who we have a contract with, **Actual benefit payments are determined only when the claim is processed by your insurance company.** This policy has been put in place to ensure that financial payments due are recovered, allowing us to continue to provide quality medical care for our patients. It is important that we work together to assure that payments for services are as simple and straightforward as possible.

- **Co-payments and Deductibles:** Insurance companies require co-payments to be paid in full at time of service. Accounts with deductible amounts remaining, we will collect a portion of the deductible at time of service, the remaining balance after insurance processing will be billed to the patient.

- **No Insurance (Self Pay):** Foot Envy requires payment in full at time of service. The dollar amount will vary per patient due to their health concerns and medical treatment. New patient office visit fee of $150.00 will be collected upon check-in. There may be a balance collected at check-out, depending on treatment with Dr.Udall.

- **Minors:** For all services rendered to a minor patient, the parent, the guardian or responsible party who brings the patient to the appointment is responsible for all charges.

- **Referrals**: If your insurance company requires a referral, it is YOUR responsibility to ensure Foot Envy receives the referral prior to your appointment. Failure to obtain a referral could result in a denial from your insurance company, and would make you fully responsible for the charges.

- **Forms/ Documents:** There is a $50 fee for the completion of all forms including disability forms, work accommodations, and FMLA (Family Medical Leave Act) paperwork, and must be paid prior to the paperwork being completed.

- **Correct information:** It is your responsibility to provide the correct insurance information and notify Foot Envy if there is a change in insurance coverage, residence, or phone number. If you provide incorrect insurance information, including secondary insurance information and the claim is denied due to coordination of benefits, you will be responsible for any and all charges associated with that claim.

- **Financial responsibility:** I understand that I will be financially responsible for any and all treatment(s) received. I understand that in the event my insurance denies any claim, I agree to pay the amount owed in full or arrange for a payment plan to satisfy the balance due.

- **Outstanding balance:** Any account may be turned over to a third-party collections company for further processing and you will be responsible for paying any collection fee incurred by the practice. Any such fees will be added to the outstanding balance owed. No additional appointments will be made for accounts with a large balance until they are brought current.

I certify that I have read and understand the above Financial Policy and I agree to abide by its terms. I also authorize the assignment of insurance benefits to Foot Envy

Patient Signature: _____ Date:_____

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Hipaa Notice of Privacy Practices

This notice describes how Foot Envy may disclose your medical information about you, and how you can access this information. Foot Envy may use or disclose your health information without your authorization for the following purposes:

Treatment: We will use and disclose your health information to provide,coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third-party. For example, we may disclose your health information to your primary care physician, or to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and treat you.

Payment: Your health information will be used or disclosed to obtain payment for your health care services. For example, we may bill your health plan for the cost of the services we provide to you. We may also contact your health plan to determine the amount of your co-payment or to obtain insurance approval.

Patient Photos: I hereby authorize Foot Envy to capture photos of my feet for any medical documentation in my chart, or on the company website.

Required by Law: We are required by federal, state or local law to disclose your health information for reasons including: a serious health threat, or safety concern for you and the public or, if we reasonably believe you are a victim of abuse, neglect or domestic violence.

Our responsibilities

We are required to (i) maintain the privacy of your health information as required by law; (ii) provide you with notice of our legal duties and privacy practices with respect to your health information, and to abide by the terms of such notice; and (iii) notify you following a breach of your health information that is not secured in accordance with certain security standards.

We reserve the right to change the terms of this Notice and to make the provisions of the new Notice effective for all health information that we maintain. If we change the terms of this Notice, the revised Notice will be made available upon request and posted in our practice locations.

I, _____ acknowledge receipt and have read and understand the Notice of Privacy Practice. I also authorize Foot Envy to discuss my protected health information to the person(s) listed below. If none, please write N/A.

Name	Relationship	Phone Number
Name	Relationship	Phone Number

Patient Signature: _____ Date:_____