WELCOME

PATIENT INFORMATION

Date _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____ Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Soc. Sec. # _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____ SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

PHONE NUMBERS

Home Phone (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Primary Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to _____
Name of

_____ for any services furnished to me by that provider.
Doctor or Clinic

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____
Signature of Beneficiary, Guardian or Personal Representative

_____
Please print name of Beneficiary, Guardian or Personal Representative

_____ _____
Date Relationship to Beneficiary

PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints.)

_____

_____

_____

Have you ever been to a Podiatrist before ☐ Yes ☐ No

If yes, please list.

Name _____

Last visit _____

Is there any personal or family history of diabetes? ☐ Yes ☐ No

Your occupation _____

Cigarette/Tobacco use _____

Years smoked _____

Athletic activities in which you participate (please list and indicate frequency)

_____

_____

_____

Please indicate which foot problems you now have or have had in the past.

Ankle Pain	☐ Yes	☐ No
Athlete's Foot	☐ Yes	☐ No
Bunions	☐ Yes	☐ No
Corns and Calluses	☐ Yes	☐ No
Cramps or Numbness in Feet or Legs	☐ Yes	☐ No
Flat Feet	☐ Yes	☐ No
Foot or Leg Cramps	☐ Yes	☐ No
Heel Pain	☐ Yes	☐ No
Ingrown Toenails	☐ Yes	☐ No
Plantar Warts	☐ Yes	☐ No
Swelling in Ankles or Feet	☐ Yes	☐ No
Tired Feet	☐ Yes	☐ No

- O V E R -

MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Rash	☐ Yes	☐ No
Allergies to Anesthetics	☐ Yes	☐ No	Eye Problems	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Allergies to Medicine or Drugs	☐ Yes	☐ No	Fainting	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Foot or Leg Cramps	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Sinus Problems	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Artificial Heart Valves or Joints	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Swelling in Ankles, Feet	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hepatitis or Jaundice	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Tired Feet	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Varicose Veins	☐ Yes	☐ No
Chronic Diarrhea	☐ Yes	☐ No	Neuropathy	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Phlebitis	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No			
Ear Problems	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No			

Surgeries you have had _____

_____

_____

Hospitalization other than for the surgeries listed _____

_____

Is the reason for this visit auto accident related? ☐ Yes ☐ No If yes, date of auto accident _____

Family physician _____ Last visit date _____

Are you now, or have you been, under any other doctor's care for any reason over the past two years? ☐ Yes ☐ No

If yes, please explain _____

_____

_____

MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins _____

_____

_____

Pharmacy Name(s) _____

Pharmacy Phone(s) _____

Do you take oral contraceptives? ☐ Yes ☐ No

ALLERGIES

☐ Adhesive/Tape
☐ Anticoagulant Therapy
☐ Aspirin
☐ Codeine
☐ Demerol
☐ Iodine
☐ Local Anesthetics
☐ Novocaine
☐ Penicillin
☐ Seafoods
☐ Sulfa

Other _____

TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

#20590 — ©Medical Arts Press® 1-800-328-2179

West Chester Podiatry

513-779-9673

Name: _____

Race:_____ **Hispanic/Latino** Yes No

Employment Status: Full Time Part Time Retired Unemployed

Occupation (Current or Former:)_____

Do you use tobacco products? Yes No # Per Day:_____

Do you drink caffeinated beverages? Yes No # Per Day:_____

Do you drink alcohol? Yes No # Per Week:_____

SHOE SIZE_____ **HEIGHT**_____ **WEIGHT**_____

Family History

Arthritis:	Mother	Father
Asthma:	Mother	Father
Bunions:	Mother	Father
Cancer:	Mother	Father
Diabetes:	Mother	Father
Heart Disease:	Mother	Father
Kidney Disease:	Mother	Father
Lung Disease:	Mother	Father

West Chester Podiatry, LLC

513-779-9673

Financial and Office Policy

Thank you for choosing West Chester Podiatry as your healthcare provider. We are committed to your treatment being successful and we appreciate your trust in us. Please understand that payment of your bill is considered part of your treatment. We find communication with our patients regarding our policies assists us in providing the best service possible. The following is a statement of our Financial Policy which we require you to read and agree to prior to your treatment.

- As our patient, you are responsible for obtaining all referrals required by your insurance company to seek treatment in this office.
- We are happy to file your insurance claim. In order to work with your insurance company, we must have **complete and current insurance information, a copy of your insurance card and government ID,** and **your signature on file.** You must inform the office of all insurance changes. You will be responsible for any charges that are denied by your insurance company which result from your failure to provide the office with complete and current information.
- Please understand there may be charges for Podiatric Services which your insurance company considers non-covered and may be excluded from your policy. You are responsible for these fees and you authorize West Chester Podiatry to bill you for any appropriate services. This is in accordance with your insurance company contract.
- All co-pays, co-insurance, deductibles, and account balances **are due at time of service.** We accept cash, check, Mastercard, Visa, American Express, and Discover.
- Patients who are self-pay or have no insurance are required to pay the balance in full at the time of service.
- Missed appointments and/or failure to cancel without 24 hour notice will be subject to a $30.00 patient charge. This is an office charge and cannot be billed to your insurance company.
- There is a charge of $40 to complete FMLA and other disability paperwork which is payable prior to these forms being completed. Understand that these forms can be quite complicated and tedious to fill out. Please allow the office 10 business days in which to review your medical record for the information requested, complete it, copy, mail, or fax it.
- Returned checks are subject to a $25.00 fee.
- We do understand special financial needs and offer payment plans in these circumstances. Most balances will be required to be paid off in 4 monthly consecutive payments.
- Past due accounts are subject to collection proceedings. All fees including, but not limited to, delinquent fees, collection fees, and court fees will become your responsibility in addition to the balance due to the office.

Please note the following fee schedule for copies of Medical Records and preparation of any medical paperwork. The following fees (plus actual cost of any postage) apply if request comes from the patient or a patient representative.

- $2.92 per page for the first 10 pages
- $0.61 per page for pages 11-50
- $0.25 per page for pages 51 and higher
- For data other than on paper: $5.00 per disc

The following fees (plus any actual postage) apply if the request comes from an attorney:

- $1.81 per page for the first 10 pages
- $0.61 per page for pages 11-50
- $0.25 per page for pages 51 and higher
- For data other than on paper: $5.00 per disc

The practice requires 5 business days turnaround time for copies of Medical Records and 10 business days for preparation of any medical paperwork or discs. Prices are determined by Ohio Department of Health in accordance with Ohio Revised Code Section 3701.742.

I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE FINANCIAL POLICY

*****Must be signed by patient or person financially responsible*****

SIGNATURE_____ **DATE**_____

PRINTED NAME _____ **RELATIONSHIP TO PATIENT**_____

West Chester Podiatry, LLC

513-779-9673

PATIENT RECORD OF DISCLOSURE

The HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI.) The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner:

Preferred Phone_____ **Detailed Message Yes No**

Email_____ **Detailed Message Yes No**

PHI can be released to the family/friends (please do not include physicians:)

_____

_____

_____

The privacy rule requires health care providers to take reasonable steps to limit the use of disclosure of and/or requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Health care entities must keep records of PHI disclosures. Information provided, if completed properly, will constitute an adequate record.

Note: Uses and disclosures of PHI for treatment, payment or other health care operations may be permitted without prior consent.

Patient Signature:_____

Printed Name:_____

Birthdate:_____

Date:_____