CURE PODIATRY
& WOUND CARE

DATE

Please bring the following items with you at your initial appointment

- New Patient Forms
- Insurance Cards
- Photo ID
- List of all the Medications you currently taking

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PATIENT INFORMATION FORM

PERSONAL INFORMATION:

Patient Name:		DOB:
Social Security#:	Age:	Sex: ☐ Male ☐ Female
Primary Language:	Race:	Ethnicity:
Home Address:	City/State:	Zip:
Home Phone:	Cell Phone:	
E-mail:	May We call/Text/Email Reminders? ☐ Yes ☐ No	

EMERGENCY INFORMATION:

Emergency Name:	Phone:	Relationship:
Do you have a legal guardian or healthcare power of attorney? ☐ Yes ☐ No		
If Yes, Name:	Relationship:	Phone#:
Is there a family member or other person you would like for us to share your medical information?		
If Yes, Name:	Relationship:	Phone#:

DOCTOR INFORMATION:

Primary Care Doctor:	Phone:

PHARMACY INFORMATION:

Pharmacy:	Location:
Phone#:	How did you hear about us?

INSURANCE INFORMATION:

Primary Insurance Company Name:		
Address:		
City/State:	Zip:	Phone#:
Insured Name:	DOB:	Employer:
Contract#:	Group#:	

Secondary Insurance Company Name:		
Address:		
City/State:	Zip:	Phone#:
Insured Name:	DOB:	Employer:
Contract#:	Group#:	

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PATIENT INFORMATION FORM

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING

(Include prescriptions, over-the-counter meds & herbal supplements):

NAME	DOSE	HOW OFTEN DO YOU TAKE?

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

SOCIAL HISTORY:

Marital Status: ☐ Single	☐ Married	☐ Partnered	☐ Separated	☐ Divorced	☐ Widowed
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
Employer:		Occupation:			

FAMILY HISTORY

Do you have a family history of:

☐ Diabetes: Type 1 or Type 2	☐ Cancer	☐ Heart Disease	☐ High Blood Pressure
☐ High Blood Pressure	☐ Stroke	☐ Coronary Artery Disease	☐ Thyroid Disease
☐ Rheumatoid Arthritis	☐ Other		

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PATIENT INFORMATION FORM

MEDICAL HISTORY:

ALLERGIES
☐ Medications:
☐ Anesthesia: ☐ Foods:
☐ Tape ☐ Latex ☐ Shellfish ☐ Iodine ☐ None Known ☐ Other:

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

HEART DISEASE/FAILURE	*YES*	*NO*
High Cholesterol	☐	☐
Anemia	☐	☐
Arthritis	☐	☐
Asthma	☐	☐
Back Trouble	☐	☐
Bladder Infections	☐	☐
Abnormal Bleeding	☐	☐
Blood Clots	☐	☐
Blood Transfusion	☐	☐
Bronchitis/Emphysema	☐	☐
Cancer	☐	☐
Diabetes: Type 1 or Type 2 (circle)	☐	☐

HEART DISEASE/FAILURE	*YES*	*NO*
Fibromyalgia	☐	☐
Gout	☐	☐
Heart Attack	☐	☐
Heart Disease/Failure	☐	☐
Hepatitis	☐	☐
HIV+/AIDS	☐	☐
High Blood Pressure	☐	☐
Kidney Disease	☐	☐
Liver Disease	☐	☐
Low Blood Pressure	☐	☐
Migraine Headaches	☐	☐
Mitral Valve Prolapse	☐	☐

HEART DISEASE/FAILURE	*YES*	*NO*
Neuropathy	☐	☐
Open Sores	☐	☐
Pneumonia	☐	☐
Polio	☐	☐
Rheumatic Fever	☐	☐
Sickle Cell Disease	☐	☐
Skin Disorder	☐	☐
Sleep Apnea	☐	☐
Stomach Ulcers	☐	☐
Stroke	☐	☐
Thyroid Disease	☐	☐
Tuberculosis	☐	☐

Other Conditions:

CURRENT PROBLEM:

What specific problem brings you to our office today?

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PATIENT INFORMATION FORM

I CERTIFY, 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 HERBY, GIVE PERMISSION TO THE DOCTOR(S) AT CURE PODIATRY & WOUND CARE LLC, TO ADMINISTER AND PERFORM ANY DIAGNOSTIC, THERAPEUTIC AND/OR OPERATIVE PROCEDURES AS MAY BE DEEMED MEDICALLY NECESSARY IN DIAGNOSIS AND/OR TREATMENT OF MY CONDITION.

I AUTHORIZE CURE PODIATRY & WOUND CARE LLC TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS. I HEREBY ASSIGN TO CURE PODIATRY & WOUND CARE LLC ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I AM AWARE THAT IT IS MY OBLIGATION TO KNOW MY INSURANCE COMPANY'S POLICIES AND THAT I AM RESPONSIBLE FOR PAYMENTS IF I HAVE NOT FULFILLED THEIR REQUIRMENTS.

I ACKNOWLEDGE ALL RADIOLOGY IMAGES RECEIVED FROM OTHER FACILITIES MUST BE SEALED WITH OFFICIAL STAMP/SIGNATURE TO PREVENT VIRUSE TRANSMISSION OF PATIENT HEALTH RECORDS.
I AUTHORIZE CURE PODIATRY AND WOUND CARE TO TAKE PHOTOGRAPHS OF WOUNDS AND/OR FOOT DEFORMITY FOR CLINICAL PURPOSES, ADDITIONALLY I CONSENT OF USE OF REMOTE VIRTUAL ASSISTANT SCRIBE.

I ALSO ACKNOWLEDGE THAT I WAS PROVIDED A COPY OF THE NOTICE OF PRIVACY PRACTICES (NPP), AND THAT I HAVE READ, UNDERSTAND, AND AGREE TO THE NOTICE OF PRIVACY PRACTICES (NPP) TERMS.

PRINT NAME OF PATIENT, PARENT OR GUARDIAN

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

SIGNATURE

DATE

CONSENT FOR E-PRESCRIPTION:

I AUTHORIZE CURE PODIATRY & WOUND CARE LLC TO VIEW MY EXTERNAL PRESCRIPTION HISTORY VIA ELECTRONIC E-PRESCRIBING SERVICES. I UNDERSTAND THAT PRESCRIPTION HISTORY FROM MULTIPLE, OTHER UNAFFILIATED, PROVIDERS, INSURANCE COMPANIES, PHARMACIES AND PHARMACY BENEFIT MANAGERS MAY BE VIEWABLE BY THE PROVIDERS AND STAFF OF CURE PODIATRY & WOUND CARE LLC, AND IT MAY INCLUDE PRESCRIPTIONS BACK IN TIME FOR SEVERAL YEARS AND MAY INCLUDE PRESCRIPTIONS TO TREAT HIV, SUBSTANCE ABUSE AND PSYCHIATRIC CONDITIONS. IF APPLICABLE, I UNDERSTAND THAT MY PRESCRIPTION HISTORY WILL BECOME PART OF MY RECORD AT THIS PRACTICE. UNDERSTANDING ALL OF THE ABOVE, I HERBY PROVIDE INFORMED CONSENT TO CURE PODIATRY & WOUND CARE LLC TO ENROLL ME IN THE E-PRESCRIBE PROGRAM. THIS CONSENT WILL REMAIN ENFORCED UNTIL REVOKED OR CHANGED.

PRINT NAME OF PATIENT, PARENT OR GUARDIAN

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

SIGNATURE

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CURE PODIATRY and WOUND CARE FINANCIAL POLICIES

Your insurance policy is a contract that exists between you and your insurance company. **Our relationship is with you, the patient, and not the insurance company**. If you have questions about your policy, please call the phone number provided on the back of your insurance card. The patient or responsibly party is responsible for their bill being paid in full. Upon your initial visit you will be asked to provide a photo ID. Please inform us at every visit of any changes to your insurance coverage and provide us with your most recent insurance card.

PLEASE INITIAL EACH LINE INDICATING YOUR UNDERSTANDING OF OUR POLICIES.

	COPAYMENTS: It is a requirement of your insurance company that we collect your co-pay. Payment is required before meeting with the doctor.
	DEDUCTIBLES & CO-INSURANCE: If you have a high deductible plan, we may collect a deposit to apply towards your deductible and coinsurance. Any remaining balance after submission to your insurance company is your responsibility.
	SELF-PAY: (for non-covered products and services and for patients without insurance coverage): Full payment is due at time of service. Payment for evaluation and management services at minimum will be required before seeing the doctor. Additional procedures/services may be recommended by the doctor. You will be informed of these charges before proceeding with treatment. Any non-covered/ over the counter items are non-returnable and non-refundable.
	REFERRAL: If your insurance plan requires a referral from your primary care doctor, this will be required at the time of your visit. Without a referral available, we will need to reschedule your appointment. Although we may request one on your behalf, it is ultimately your responsibility to make sure you have one if your insurance requires one.
	NO SHOW (failure to present for your appointment): 24 hours business day notice is required for cancellation of your appointment and failure to do so will incur a **$50 fee** for scheduled office visits, laser, nurse and DME pick up appointments. Failure to provide **24 hours' notice** for a scheduled office procedure/diagnostic testing such as padnets will incur a **$65 fee**.
	BALANCES/COLLECTION FEES: If payment of an outstanding balance is not received within 30 days from the postmark date of a mailed statement or e-statement time stamp, a **$10 billing fee** may be added to each additional statement. Patients with balances more than 90 days overdue will be turned over to collection and a **$35 administrative fee** will be applied.
	FMLA/DISABILITY/MEDICAL RECORDS: There is a **$50 charge** for having the doctor complete these forms. There is a $**40 fee** to obtain a copy of medical records (of up to 20 pages, additional fee for additional pages may apply)

I understand I am financially responsible for all charges, whether or not they are covered by insurance or other entities. I have read and understand these financial policies.

PATIENT NAME (PRINT): _____

PATIENT/RESPONSIBLE PARTY SIGNATURE: _____ **DATE:** _____