Practice: Podiatry Institute Of The South **Today's Date:**

Name: _____ **DOB:** _____ **Chart Number:** _____

Sex: ☐M ☐F **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced **SS#:** _____

E-mail: _____ **Spouse/Partner Name:** _____

E-mail newsletters, reminders, statements, etc. **Emergency Name:** _____ **Phone:** _____

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

Home #: _____ **Cell #:** _____ **Other #:** _____

Employer: _____ **Phone:** _____

Employer Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Primary Insurance: _____ Are you the insured? ☐Yes ☐No

Insured Information

Subscriber Name: _____ Relationship to insured: ☐Spouse ☐ Child ☐Self ☐ other

Phone #: _____ Sex: ☐Male ☐Female DOB: ___/___/___

Address: _____

Policy ID: _____ Group ID: _____ Employer: _____

Secondary Insurance: _____ Are you the insured? ☐Yes ☐No

Insured Information

Subscriber Name: _____ Relationship to insured: ☐Spouse ☐ Child ☐Self ☐ Other

Phone #: _____ Sex: ☐Male ☐Female DOB: ___/___/___

Address: _____

Policy ID: _____ Group ID: _____ Employer: _____

How did you find out about our practice? ☐ Physician ☐ Internet ☐ Telephone book ☐ Family member ☐ Friend ☐ Other: _____

What is the reason for your visit today? _____

_____ **Result of accident or work injury?** ☐Yes ☐No

How long has this bothered you? 1 2 3 4 5 6 7 ☐ days ☐ weeks ☐ months ☐ years

What treatments have you tried & have they been effective? _____

_____

On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain? ___/10

The pain quality is: ☐burning ☐constant ☐dull ☐sharp ☐shooting ☐throbbing ☐tingling Other:_____

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____ Date: _____

Rev 1/21/2015

History and Physical

Name: _____ **DOB:** _____ **Chart Number:** _____

Medical History:
☐ Alcoholism ☐ Blood disorders ☐ Circulation problems ☐ Musculoskeletal ☐ Breathing issues
☐ Liver ☐ Sleep apnea ☐ Gout ☐ Allergies ☐ Heart disease ☐ Asthma
☐ Heart murmur ☐ Stomach/bowel ☐ Depression ☐ Anxiety disorder ☐ Mental illness ☐ Kidney disease
☐ Blood clot ☐ High cholesterol ☐ High blood pressure ☐ Cancer ☐ Hepatitis
☐ Neuropathy *(specify)* _____ ☐ Thyroid disease *(specify)* _____ ☐ Diabetes (type 1, type 2)
☐ Arthritis *(specify)* _____ ☐ other *(specify)* _____ ☐ HIV ☐ CVA
Are you pregnant? ☐ Yes ☐ No **Are you nursing?** ☐ Yes ☐ No ☐ Skin disorders ☐ Stroke

Surgical History ☐None ☐Appendectomy ☐ C-Section ☐Angioplasty ☐Bypass ☐Cataracts ☐ Cholecystectomy
Have you ever had any surgical procedures on foot/ankle or anywhere else on your body? ☐ Yes ☐ No
If yes, please describe: _____
Do you have any artificial joints? ☐ Yes (where? _____) ☐ No Do you have an artificial heart valve? ☐Yes ☐ No

Social History
Do you smoke? ☐Yes ☐No If yes how many packs per day? ☐1 ☐2 ☐3 ☐4 ☐5 For how long?
Do you drink alcohol? ☐Yes, everyday (5-7 days/week) ☐Yes, occasionally/socially ☐No/Rarely
Substance abuse: ☐Yes, I have a current substance abuse problem. Please specify: _____
☐Yes, I had a past substance abuse problem. Please specify: _____
☐ No, I have never had a substance abuse problem
What is your occupation? _____ Does it involve mostly ☐ standing or ☐sitting
Do you exercise regularly? ☐ No, I do not exercise regularly ☐ Yes, I do the following regular exercise: _____
_____

Family History Is there any family history *(blood relative)* of: *(Please indicate family member)*

☐ Alzheimer's	_____	☐ Depression	_____
☐ Arthritis	_____	☐ Diabetes	_____
☐ Bleeding disorders	_____	☐ Emphysema	_____
☐ Blood clot	_____	☐ Heart disease	_____
☐ Cancer	_____	☐ High Blood Pressure	_____
☐ Cataracts	_____	☐ Neurological	_____
☐ Circulation problems	_____	☐ Strokes	_____
☐ Other (specify):	_____		

Review of Systems *(Please check the box if you currently have any of these symptoms or check "NONE")*

Cardiovascular	☐leg pain when walking	☐fever	☐ chest pain/pressure	☐leg swelling	☐cold hands/feet
	☐fainting	☐ palpitations	☐vascular disease	☐valve problems	☐**NONE**
Genitourinary	☐blood in urine	☐hesitancy	☐incontinence	☐increased urgency	
	☐decreased frequency	☐excessive urination	☐kidney disease	☐kidney stones	☐**NONE**
Gastrointestinal	☐abdominal pain	☐heartburn	☐blood in stool	☐vomiting	☐ulcers ☐constipation
	☐diarrhea	☐trouble swallowing	☐decrease appetite	☐increase appetite	☐**NONE**
Integumentary	☐athletes foot	☐nail abnormalities	☐keloids	☐itchiness	☐dry, scaly skin ☐**NONE**
Hematologic	☐lower leg ulcers	☐sickle cell disease	☐anemia	☐blood thinners	☐clotting disorder ☐**NONE**
Neurological	☐tingling	☐weakness	☐seizures	☐numbness	☐headaches
	☐tremors	☐paralysis			☐**NONE**
Musculoskeletal	☐back pain	☐joint swelling	☐muscle weakness	☐muscle pain	☐neck pain
	☐sciatica	☐joint stiffness	☐joint pain	☐joint instability	☐arthritis ☐**NONE**
Respiratory	☐chest pain	☐wheezing	☐COPD	☐coughing	☐snoring
	☐shortness of breath	☐emphysema			☐**NONE**

PLEASE READ AND SIGN
The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____ Date: _____

Practice: Podiatry Institute Of The South **Today's Date:**

Name: _____ **Chart #:** _____ **Date of birth:** _____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Declined to specify

Race: ☐Asian ☐American Indian or Alaska Native ☐Black or African American

☐White ☐Native Hawaiian or other Pacific Islander ☐Declined to specify

Preferred Language: _____ ☐Declined to specify

Pharmacy Name: _____ **Pharmacy Phone:** _____

Pharmacy Address: _____ City, State, Zip: _____

Primary Care Physician: _____ Phone: _____ Date Last Seen: _____

Address: _____

Referring Physician: _____ Phone: _____ Date Last Seen: _____

Address: _____

Privacy Information Preferences

Do you want to be exempt from public reporting? ☐Yes ☐No Can we send mail to the address on file? ☐Yes ☐No

Can we call the phone number on file? ☐Yes ☐No Can we leave voicemail on machine? ☐Yes ☐No

Will you allow us to send internet based (e-mail) delivery of reminders and newsletters? ☐Yes ☐No

If yes, please provide your e-mail address: _____

Who can we leave messages with? ☐Wife ☐Husband ☐Daughter ☐Son ☐Other: _____

Name(s): _____

Smoking Status

☐Current Every Day ☐Smoker, Current Status Unknown

☐Current Some Day ☐Heavy Tobacco ☐Unknown If Ever

☐Former ☐Never ☐Light Tobacco ☐ decline to answer

Vital Signs

Blood Pressure: _____ / _____

Height: _____ Weight: _____

Current Medications

☐No Known Medications ☐ I take the following medications:

Name / Dose: _____

Name / Dose: _____

Name / Dose: _____

Name / Dose: _____

Name / Dose: _____

Name / Dose: _____

Name / Dose: _____

Name / Dose: _____

Use the back of this form if more room is needed

Allergies

☐No Known Allergies ☐No Known Drug Allergies

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Last Flu Shot Date: _____ **Did you get a pneumococcal vaccination?** ☐Yes ☐No

Have you fallen in the last 12 months? ☐Yes ☐No **Were you injured from the fall?** ☐Yes ☐No

Advanced Directives: ☐Living Will ☐DNR ☐Durable Power of Attorney ☐Surrogate Appointed ☐None

PLEASE READ AND SIGN: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. *(Assignment of Benefits)*: I authorize payment of medical benefits to the practice named above. *(Release of Information)*: I authorize the release of any medical information necessary to process this claim. *(HIPAA Privacy)*: I acknowledge that I received my HIPAA Privacy Practices Notice. *(Medication History)*: I authorize the Doctor's office to retrieve my medication history.

Patient Signature: _____ Date: _____

Podiatry Institute of the South
Authorization from Patient or Legal Representative

Consent to Treat: The undersigned consents to any initial or follow-up evaluations, examinations, x-rays, laboratory procedures, other tests, medications, medical treatment, surgery, home instructions, orthotics, other durable medical equipment, photographing and/or videotaping and/or other services rendered to the patient. The undersigned agrees that it is their responsibility to contact and/or schedule with our office any follow up visits, other services, prescriptions and items ordered for the patient.

Assignment of Benefits: I hereby irrevocably assign, transfer and convey to the Podiatry Institute of the South , any and all benefits and all interest and rights (including causes of action, the right to enforce payment and the right to appeal an adverse benefit determination) to which I'm entitled under an employee benefit plan sponsored by my employer, all insurance policies, benefits, any third-party reimbursement, or prepaid health care plan for services rendered or products I received from the Podiatry Institute of the South.

Medicare Assignment: I certify that the information given by me in applying for payment under XVIII of the Social Security Act is correct. I authorize the release of information concerning me to the Social Security Administration or its intermediaries as well as any information needed for filing a Medicare claim; I request that payment and authorized benefits be made on my behalf. I assign benefits payable for services to the Podiatry Institute of the South.

Authorization to Release Information: I consent and authorize the Podiatry Institute of the South and its agents to release my health information for the purpose of payment, treatment, and healthcare operations to any of the following: insurance company and its affiliates, any practitioner, support staff or facility involved in my plan of care or transfer of care. In addition I understand that the potential uses and disclosures of my Health Information are detailed in the Privacy notice. The HIPAA Notice of Privacy Practices is available in the office. I have read/had the opportunity to read my HIPAA rights.

Designation of Authorized Representative: I designate and appoint the Podiatry Institute of the South (and its agents) as my authorized representative and authorize it to act on my behalf to 1) request and receive a copy of the summary plan description, 2) pursue a benefit claim, 3) appeal an adverse benefit determination, and/or 4) file a legal/equitable action to recover benefits from my employee benefit plan, insurance policy, and any third-party reimbursement or prepaid health care plan. I understand and agree that my authorized representative shall have full authority to act, and receive notices, on my behalf with respect to an initial determination of the claim for health benefits relating to treatment and health care services received by me/my child, any requests for documents relating to this claim and appeal of an adverse determination of the claim.

Financial Agreement: I hereby promise to pay for all products received or services rendered to me/my child to the extent I am legally responsible for such payment. According to the language of the physician's insurance contract, I understand that I am responsible for all health insurance copayments, deductibles, coinsurances, OTC- over the counter convenience items and NCS- non-covered services and any other amounts that apply at the time of service or at the preoperative appointment. Regardless of the assignment of benefits, should the insurance misrepresent their coverage or delay payment of a claim greater than 60 days, as the designated responsible party, I am responsible for all the monies owed to the Podiatry Institute of the South. I also understand that the insurance policy is a contract between me and the insurance company; therefore the policy holder should contact the insurance carrier first when there are questions regarding explanation of benefits.

The undersigned certifies that he/she has read and understands the foregoing statements, and is either the patient, or is duly authorized by the patient as the patient's general agent or the guarantor of the patient to execute the above and accepts its terms. This document shall remain in force until a written revocation by me is delivered to the Podiatry Institute of the South.

Print Name of Patient or Legal Authorized Representative	Signature	Relationship to Patient	Date

Podiatry Institute of the South- Notification of Office Policies and Procedures

Emergency/After Hours: During a medical emergency, patients should call 911 or proceed to the nearest emergency room. The facility will contact our physician for post-operative complications and other urgent situations.
Refills and Medication: Refills and Medication will be completed on the same day **if** received/requested Monday through Thursday before 3:00 p.m. and all others will be handled the next business day except on Fridays.
Payment: Our office accepts Visa, MasterCard, Discover, Cash or Checks.
Returned Checks: A **$35** fee will be charged to the patient on all returned checks. Any NSF or Closed Account will result in future services on a pre-pay cash or credit basis.
Delinquent Accounts: In the event that your account is placed with a Collection Agency, a collection-fee in the amount of **33 1/3%** of the then outstanding balance may be added to your account and shall become a part of the Total Amount Due. You will be responsible for any and all cost of collection including attorney fees and court cost. You agree, that in order for us to service your account or to collect any amounts you may owe, we and our collection agencies may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We and our collection agencies may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.
"No Show" Appointments: A **$25** fee will be charged to the patient for any "No Show" appointments.
Appointment Hold: Repetitive broken appointments, non-compliance, hostile behavior, and/or financially deficient accounts will result in appointment hold and/or the termination of the Doctor/patient relationship. A 30 day notice will be given should the situation result in a transfer of the patient's care.
Over the Counter Convenience Items (OTC): Our office will not submit claims for OTC items (eg. Shoe inserts, Surgical shoe(s), Toe pads/Correctors/Caps, etc…)
Returns: Only unworn and non-custom items are returnable within 14 days of receipt, if no visible signs of wear, tear or odor. Custom items are tailored to meet individual needs; custom items are non-returnable, non-refundable.
Medical Records/FMLA or Short Term Disability Forms: Copies of the patient's medical records will be given to the patient at no charge. A **$5** fee will be charged to the patient if the patient requests copies of their x-rays on a disk. A **$20** fee will be charged to the patient for completing FMLA or Short Term Disability Forms.
Non-Covered Services: I have been informed that the services listed may be denied by any insurance as services not covered by my plan. I agree to be fully responsible for payment of any services provided that are non-covered or excluded from my insurance policy. Examples- Debridement or cutting of nails (routine care), Paring or a lesion (Corns & calluses), Custom orthotics, etc.
Referral: If my insurance plan requires a referral in order to be treated, it is my responsibility to obtain the referral prior to being treated. If a referral is required and I fail to obtain one, I will be financially responsible for any services rendered.

The undersigned certifies that he/she has read and understands the foregoing statements, and is either the patient, or is duly authorized by the patient as the patient's general agent or the guarantor of the patient to execute the above and accepts its terms.

Print Name of Patient or Legal Representative	Signature	Relationship to Patient	Date