Order My Steps Podiatry

PATIENT INFORMATION FORM

(PLEASE PRINT AND FILL OUT COMPLETELY)

PATIENT NAME: _____ _____ _____

LAST FIRST MI

MAILING ADDRESS: _____ CITY: _____ ZIP: _____

DATE OF BIRTH: ___/___/___ AGE: ___ SEX: [ ] M [ ] F SOCIAL SECURITY #: _____-_____-_____

CONTACT PREFERENCE MAY WE LEAVE A MESSAGE?

[ ] HOME PHONE #: (_____) _____-_____ [ ] YES [ ] NO RACE/ ETHNICITY:

[ ] WORK PHONE #: (_____) _____-_____ [ ] YES [ ] NO [ ] AMERICAN INDIAN [ ] AFRICAN AMERICAN

[ ] CELL PHONE #: (_____) _____-_____ [ ] YES [ ] NO [ ] ASIAN [ ] CAUCASIAN [ ] HISPANIC

E-MAIL: _____ [ ] YES [ ] NO

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? [ ] YES [ ] NO

IF YES, NAME: _____ RELATIONSHIP: _____

BEST PHONE #: (_____) _____-_____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

BEST PHONE #: (_____) _____-_____

PRIMARY CARE DOCTOR: _____ DATE OF YOUR LAST VISIT: _____

PHONE #: (_____) _____-_____

PHARMACY: _____ LOCATION: _____

PHONE #: (_____) _____-_____

(PLEASE GIVE YOUR INSURANCE CARD AND PHOTO ID TO THE RECEPTIONIST)

INSURANCE INFORMATION			
PERSON RESPONSIBLE FOR BILL	DOB	HOME#:	CELL#:
PATIENT'S RELATIONSHIP TO SUBSCRIBER: [ ] SELF [ ]SPOUSE [ ]CHILD [ ]OTHER_____			
PRIMARY INSURANCE	ID/POLICY#	GROUP #	
SECONDARY INSURANCE	ID/POLICY#	GROUP #	

Who may We Thank for the Referral (please check one box):

❑ Direct Mail ❑ Facility ❑ Family ❑ Dr._____

❑ Friend ❑ Radio ❑Hospital ❑ Patient _____

❑ Insurance ❑ Website ❑ Work ❑ Other_____

FAMILY HISTORY

MOTHER (ALIVE / DECEASED): ☐ DIABETES ☐ CANCER ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE

☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ RHEUMATOID ARTHRITIS ☐ THYROID DISEASE

☐ OTHER SYSTEMIC DISEASE: _____

FATHER (ALIVE / DECEASED): ☐ DIABETES ☐ CANCER ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE

☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ RHEUMATOID ARTHRITIS ☐ THYROID DISEASE

☐ OTHER SYSTEMIC DISEASE: _____

PAST MEDICAL HISTORY

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ABNORMAL BLEEDING	Y	N	DEPRESSION	Y	N	KIDNEY DISEASE	Y	N
ACID REFLUX	Y	N	DIABETES -INSULIN OR NO INSULIN (CIRCLE)	Y	N	LIVER DISEASE	Y	N
AMPUTATIONS	Y	N	FIBROMYALGIA	Y	N	MITRAL VALVE PROLAPSE	Y	N
ANEMIA	Y	N	GOUT	Y	N	NEUROPATHY	Y	N
ARTHRITIS	Y	N	HEART ATTACK/HEART DISEASE	Y	N	NON-HEALING WOUND	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	OSTEOPOROSIS	Y	N
BLEEDING DISORDER	Y	N	HIGH BLOOD PRESSURE	Y	N	SICKLE CELL DISEASE	Y	N
BLOOD CLOTS/PHLEBITIS	Y	N	HIGH CHOLESTEROL	Y	N	SKIN DISORDER	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	HIV+/AIDS	Y	N	SLEEP APNEA	Y	N
CANCER(TYPE)_____	Y	N	INFLAMMATORY BOWEL SYNDROME	Y	N	STOMACH ULCERS	Y	N
CONGESTIVE HEART FAILURE	Y	N	JOINT REPLACEMENT	Y	N	STROKE	Y	N
COPD	Y	N	KELOID/THICK SCAR	Y	N	THYROID DISEASE	Y	N
OTHER CONDITIONS:								

PLEASE LIST ALL CURRENT MEDICATIONS (INCLUDE OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME DOSE HOW OFTEN DO YOU TAKE?

_____

_____

_____

_____

_____

_____

ALLERGIES: ☐ NO KNOWN DRUGS ☐ MEDICATIONS: _____

_____

☐ NO KNOWN FOOD ☐ SHELLFISH ☐ OTHER FOODS: _____

☐ TAPE ☐ LATEX ☐ IODINE ☐ OTHER ALLERGIES: _____

PAST SURGICAL HISTORY/HOSPITLIZATIONS:

TYPE OF SURGERY/HOSPITALIZATIONS DATE

_____

_____

_____

_____

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

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

TYPES OF EXERCISE: _____

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

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE

☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____

☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

EMPLOYER/SCHOOL: _____ OCCUPATION: _____

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

IS THERE A PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION? [ ] YES (MAX 3) [ ] NO

NAME/PHONE #: 1) _____

2) _____

3) _____

I hereby authorize the Order My Steps Podiatry, PC to apply for benefits on my behalf for covered services rendered by the Doctor(s)/staff and request that payments from my insurance company/carrier be made directly to the practice. To the best of my knowledge, I have answered the questions on this form accurately. I further certify that the information I have reported with regard to my insurance coverage is correct. I understand that providing incorrect information can be dangerous to my health. I also understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status or insurance information. I further authorize the release of any necessary information, including medical information for this or any other related claim to the above patient. This authorization may be revoked by either me or the above named carrier at any time in writing.

_____ _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN PRINT NAME OF PATIENT, PARENT OR GUARDIAN

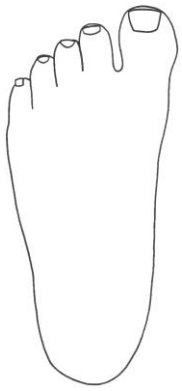
_____ _____

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT DATE

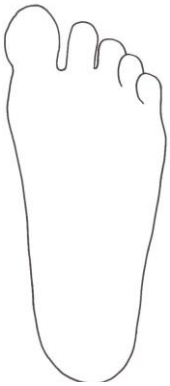
WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

Where is the pain/problem located? Please mark on the pictures below.

LEFT FOOT



TOP OF FOOT

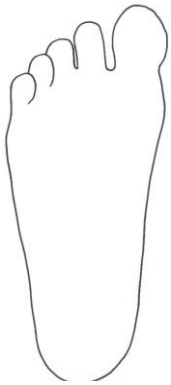


BOTTOM OF FOOT

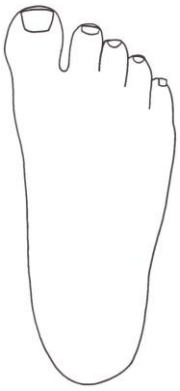
INSIDE OF FOOT

OUTSIDE OF FOOT

RIGHT FOOT

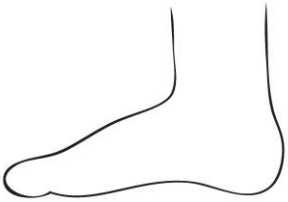


BOTTOM OF FOOT



TOP OF FOOT

OUTSIDE OF FOOT



INSIDE OF FOOT

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

DID YOUR PAIN OR PROBLEM: ☐ BEGIN ALL OF A SUDDEN ☐ GRADUALLY DEVELOPS 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 TRIED FOR THIS PROBLEM? _____

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

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ NO ☐ YES

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

DESCRIBE INJURY _____

_____

Prescription Medication Consent Form

The Providers at Order My Steps Podiatry use an electronic medical record system that allows electronic prescribing of medications. Medications are sent to your pharmacy through a secure electronic prescription connection (Surescripts) which improves the timely and accurate transmission of your medication information.

To optimize the use of this electronic capability, and coordinate you care between us and your Primary Doctor and other Specialists, we ask that patients allow us to access their medication history through Surescripts.

Please check only one of the following:

☐ I consent to allow my provider to access all my medical history.
☐ I consent to allow my provider to access only my medical history for medications prescribed in this office.
☐ I DO NOT consent to my provider accessing any of my medication.

_____ _____

Signature Print Name

_____

Date

Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept American express, Discover, FSA, HSA, MasterCard, VISA, and cash or money order.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.
- There is a charge of $25.00 for missed appointments in the office and a charge of $100 for missed appointments in the operating room; that is, appointments that are not cancelled within 24 hours of the scheduled time. **(To avoid these charges, please call us to reschedule or to cancel your appointment.)**
- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

I have read and acknowledge the above information.

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party: _____ Date: _____

Witness Signature: _____ Date: _____

Printed Name of Witness: _____

HIPAA ACKNOWLEDGEMENT/CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name

_____

Signature

_____

Signature Date

_____

Relationship to Patient (if patient unable to sign)

_____

I_____ have been made aware of the below missed appointment and missed surgery appointment policy.

Due to the financial burden caused by missed appointments **beginning January 20, 2020** there will be a **$50 charge** for patients who miss appointments without a 24hours advanced notice.

There will be a **$150 charge** for patients who miss surgery appointments without a 24hours advanced notice.

ALL CHARGES MUST BE PAID IN FULL BEFORE YOU WILL BE SEEN ON YOUR NEXT SCHEULED VISIT.

In addition, if you are more than **15minutes late** you may be asked to reschedule your appointment.

Date _____ **Patient signature** _____

Patient refused to sign policy agreement, but was made aware verbally, in office signage and practice website ☐

Employee signature _____