**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

Contact Preference





May we leave a message?

 Yes  No

 Yes  No

 Yes  No

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Race/ Ethnicity:

 [ ] American Indian [ ] African American

 [ ] Asian [ ] Caucasian [ ] Hispanic

 Home Phone #: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_

 Cell Phone #: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 #: (\_\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **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 # |

**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 Drug allergies ⬜ Medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ⬜ No Known Food ⬜ Shellfish ⬜ Other Foods: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ⬜ Tape ⬜ Latex ⬜ Iodine ⬜ Other Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Surgical History/Hospitalizations:**

Type of Surgery/Hospitalizations Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Social History**

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

**Prescription Medication Consent Form**

The Provider(s) 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 Practice Manager.

* 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.
* Due to the financial burden caused by missed appointments there will be a **$50 charge** for patients who miss appointments, or who do not reschedule their appointment without a 24hours advance notice.

There will be a **$250 charge** for patients who miss surgery appointments, without a 24hours advance notice.

**ALL CHARGES MUST BE PAID, IN FULL, BEFORE YOU WILL BE SEEN.**

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

* There is a $30.00 NSF fee for all returned checks, and a 6month probation period before another check can be accepted. Your insurance company does not cover this fee.

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 medical status and insurance coverage is correct. I also understand that it is my responsibility to inform doctor and the office staff of any changes in my medical information and insurance information. I understand that providing incorrect information can be dangerous to my health. 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.

***I have read and acknowledge the above information.***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Patient, Responsible party Print name of patient, Responsible party

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If other than patient, relationship to patient Date

**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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient (if patient unable to sign)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_