Comprehensive Foot Centers, P.A.

Patient Information

Patient Name: First_____ M.I._____ Last_____

Nickname:_____ **SSN:**_____ **Birthdate:**_____ **Gender:** M or F

Home Address: _____ **City/State/Zip:** _____

Mailing Address: _____ **City/State/Zip:** _____

Phone: (H) _____ (C) _____ (W) _____ **Preferred Phone:** Home Cell Work

Email:_____ **Employer:** _____

Race: American Indian/Alaska Native African American Asian European American Native Hawaiian/Pacific Islander Hispanic White Other

Ethnicity: American Indian/Alaska Native African Asian European Hispanic Native Hawaiian/Pacific Islander Non-Hispanic Other

Preferred Language: _____ **Marital Status:** Divorced Married Separated Single Widow(er)

Primary Care Doctor: _____ **Primary Care Doctor Phone:** _____

Referral Doctor: _____ **Referral Doctor Phone:** _____

Pharmacy: _____ **Location:** _____ **Phone:** _____

Person Responsible for Account: Self Spouse Parent Other **If other than yourself, please fill out the following:**

Name: First_____ M.I._____ Last_____

SSN: _____ **Birthdate:** _____ **Gender:** M or F **Email:** _____

Home Address: _____ **City/State/Zip:** _____

Phone: (H) _____ (C) _____ (W) _____ **Employer:**_____

Insurance Information

Primary Insurance: _____ **Effective Date:** _____ **Specialist Copay:** _____

Policy Holder Name: _____ **Relationship to Patient:**_____ **Policy Holder SSN:**_____

Policy Holder Birthdate:_____ **Policy Holder Phone:** (H) _____ (C) _____ (W) _____

Policy Holder Address:_____ **City/State/Zip:** _____

Secondary Insurance: _____ **Effective Date:** _____ **Specialist Copay:** _____

Policy Holder Name:_____ **Relationship to Patient:**_____ **Policy Holder SSN:**_____

Policy Holder Birthdate:_____ **Policy Holder Phone:** (H) _____ (C) _____ (W) _____

Policy Holder Address:_____ **City/State/Zip:** _____

Tertiary Insurance: _____ **Effective Date:** _____ **Specialist Copay:** _____

Policy Holder Name:_____ **Relationship to Patient:**_____ **Policy Holder SSN:**_____

Policy Holder Birthdate:_____ **Policy Holder Phone:** (H) _____ (C) _____ (W) _____

Policy Holder Address:_____ **City/State/Zip:** _____

Assignment of Insurance Benefits/Release of Medical Information

I hear by authorize treatment deemed necessary by the physicians of Comprehensive Foot Centers, P.A. I also authorize the release of medical records to any insurance company with whom I have health insurance coverage or any company to which I have applied for coverage. I request payment of medical insurance benefits to be made directly to Comprehensive Foot Centers, P.A. on any unpaid bill for services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Signature of Patient/Guardian: _____ **Date:** _____

Comprehensive Foot Centers, P.A.

Patient Medical Information and History Form

Patient Name: First_____ M.I._____ Last_____

Drug Allergies:_____

Other Allergies:_____

Current Medications: _____

_____

_____

Exercise/Activities: _____

Social History

Cigarette/Tobacco Use: Never Smoked Current Smoker Former Smoker How much a day? _____

For how many years? _____ When did you quit? _____ **Do you use recreational drugs?** Yes or No

Do you drink alcohol? Yes or No Number of drinks per week: _____ **Caffeine Intake:** None Coffee Soda Tea Other: _____

Family History

Is there a history of Arthritis, Cancer, Diabetes, Gout, Heart Disease, High blood pressure, or other medical condition in your family? Please list your family member and their medical condition(s): _____

_____

_____

Patient Surgical History

Please list any prior surgeries you have had and the year it was performed:

Procedure: _____ Year: _____ Procedure: _____ Year: _____

Procedure: _____ Year: _____ Procedure: _____ Year: _____

Patient Medical History

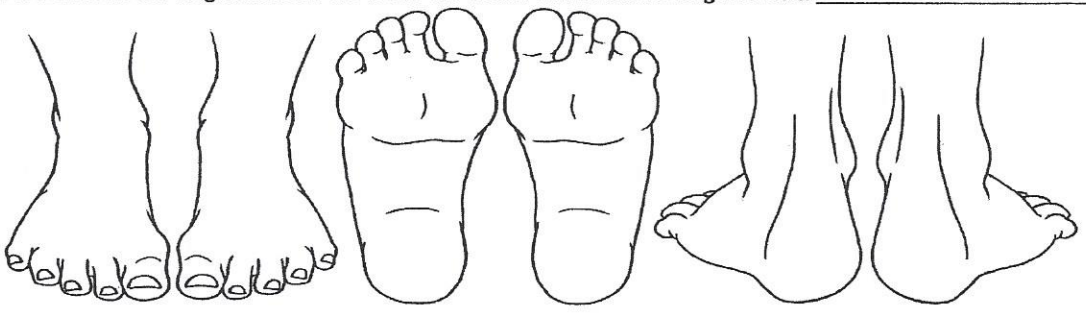
Please circle any of the following conditions if you currently have or previously had them in the past:

AIDS/HIV	Anemia	Angina	Arthritis	Artificial Heart Valves
Artificial Joints	Asthma	Back Pain	Bleeding Tendency	Cancer
Chest Pain	Chronic Diarrhea	Circulatory Problems	COPD	Diabetes
Foot & Leg Cramps	Glaucoma	Gout	Headaches	Heart Attack
Heart Disease	Hepatitis	High Blood Pressure	High Cholesterol	Jaundice
Seasonal Allergies	Seizures	Shortness of Breath	Sinus Problems	Stroke
Swollen Ankles/Feet	Thyroid Problems	Tired Feet	Ulcers	Varicose Veins

Other: _____

Have you seen a podiatrist before? Yes or No **Who was your last podiatrist?**_____ **Date of last visit with them:** _____

Please describe and indicate on the diagram below the areas the doctor will be addressing this visit: _____



Comprehensive Foot Centers, P.A. – Treatment Agreement

I promise full cooperation with my treating physician whether by surgical or non-surgical means. I understand that if I do not follow my doctor's instructions concerning my care and treatment, including any necessary physical therapy or medications, the outcome of my care and treatment could be put into jeopardy and less than optimal results may occur.

Release of Information

For the purpose of payment, I allow Comprehensive Foot Centers, P.A. to release my Private Health Information to any and all of my insurance carriers, their third party payers, and claim reviewers until the claim is resolved. For the purpose of treatment, I also allow the above listed practice to release my information to or contact any and all of my treating physicians.

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the HIPPA Notice of Privacy Practices, that I have read (or had the opportunity to read if I so chose) and I understand the Notice.

Patient Financial Policy

As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office. You must inform the office of all personal (home address, phone numbers, employment, etc.) and/or insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

Your portion of payment for office services is due at the time of service. We will accept VISA, MasterCard, Discover, American Express, Health Savings cards, cash, or check.

Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you with an assignment of benefits; you are agreeing to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a timely manner, the patient or guardian seeking care for a minor will be responsible for payment of services. You are encouraged to contact our billing department with any questions.

After insurance has paid us, you must pay any remaining balance within 30 days. PAST DUE accounts are subject to collection proceedings, and your credit card on file will be charged. All fees, including but not limited to collection fees, attorney fees, and court costs shall become your responsibility in addition to the balance due to this office.

Please honor our 24-hour reschedule notice as there may be a charge for appointments missed or cancelled without a 24-hour's advance notice. Repetitive missed or cancelled appointments and/or non-compliance may result in the transfer of your care to an alternative practice.

We have made prior arrangements with insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will require you to pay the co-pay/co-insurance/deductible at the time of service. Your upfront portion will be calculated based on your insurance benefits/limits and our negotiated fee agreement with your carrier. If you are seeing any of our doctors on an "Out of Network" basis, you will be subject to those out of network rates.

Not all services are a "covered" benefit in all insurance policies; some plans even impose a waiting period before covering services. In the event your health plan determines a service to be "not covered/pre-existing" 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; however you remain responsible for any charges to any service rendered. Patients are encouraged to contact their insurance plans for clarification of benefits prior to services rendered.

If you possess more than one insurance plan, you MUST give our office staff a copy of all primary/secondary/tertiary insurance cards at the time of service. If a card is not available at the time of service, the patient will be required to pay for the services in full.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. Any payment exceptions will be agreed upon in writing.

Accounts no longer maintaining a financial "Good Faith" status will result in the termination of the Comprehensive Foot Centers' doctor-patient relationship.

There is a service fee of $25.00 for all returned checks. Upon an NSF or CLOSED ACCOUNT occurrence, all future remittances will have to be either in cash or cashier's check.

Authorization of Payment

I hear by assign all Medical Benefits directly to Comprehensive Foot Centers, P.A. for the payment of services rendered. I also authorize the release of medical records necessary to process my health claims. I fully understand that in the event my insurance company does not pay for the services I received, I will be financially responsible for payment.

We are dedicated to providing the best possible care and service to you and regard your complete understanding of our policies as an essential element of your care and treatment. If you have any questions, please feel free to discuss them with our staff.

Patient Name (Print)	Signature of Patient/Guardian	Date

Comprehensive Foot Centers, P.A.

Release of Information

Patient Name: _____ **Birthdate:** _____

Due to patient confidentiality concerns, Comprehensive Foot Centers, P.A. would like to know to whom we have permission to release information regarding your appointments, care, bills, and test results. **This release is for anyone outside of yourself, your insurance company, your primary care physician, and any other doctors involved with your care.** This consent is valid for one calendar year.

I give permission for Comprehensive Foot Centers, P.A. to release my information to:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

If you do not wish to have your information release to anyone other than yourself, mark an "X" here: _____

Please indicate below if you allow permission for Comprehensive Foot Centers, P.A. to leave voice messages on your home answering machine or personal cell phone voicemail box as long as we are sure that it is the correct number. This would include appointment reminder calls. If we cannot reach you by phone, or if you circle "No" below, then test results and other correspondence may be mailed to you.

Yes or **No**

Please indicate below if you allow permission for Comprehensive Foot Centers, P.A. to leave voice messages on your work answering machine or work voicemail box as long as we are sure that it is the correct number.

Yes or **No**

Signature of Patient/Guardian: _____ **Date:** _____

Thank you for choosing us for your foot and ankle needs!

COMPREHENSIVE
FOOT CENTERS, P.A.