# Welcome to the Community Podiatry Group, P.C.

## PATIENT INFORMATION

Today's Date:_______________________________________

Name:____________________________________________

Address:__________________________________________

City:______________________State:_____Zip:_____________

Birth Date:___________ Social Security #:__________________

Sex: [ ] Male [ ] Female

Marital Status: [ ] Single [ ] Married [ ] Widowed
[ ] Divorced [ ] Separated

Parent's Name(s) if patient is a minor______________________

___________________________________________________

Occupation:________________________________________

Employer:_________________________________________

Employer Address:____________________________________

City:______________________State:_____Zip:_____________

Are you disabled? [ ] Yes [ ] No; Why?___________________

## CONTACT INFORMATION

Please place a check next to the best number to contact you regarding appointments or test results

[ ] Home Phone #:_____________________________________

[ ] Work Phone #:_________________________Ext:_________

[ ] Cell Phone #: _____________________________________

[ ] Other/Email (explain)________________________________

May we leave a message on your answering machine or with someone else in your household? [ ] Yes [ ] No

**In Case of Emergency, Contact:**

Name:____________________________________________

Relationship:________________________________________

Home Phone #:______________________________________

Work Phone #:___________________________Ext:__________

If there is anyone (such as a spouse or caregiver) assisting in your care or treatment to whom you approve releasing your medical information, please list here:

___________________________________________________

Name Relationship

___________________________________________________

Name Relationship

## INSURANCE INFORMATION

Who is responsible for this account?_______________________

Name of Health Insurance Co:___________________________

Subscriber Name:______________________________________

Relationship:_____________ Subscriber Birth Date: __________

Contract #______________ Social Security # _______________

Second Health Insurance Co:____________________________

Subscriber Name:______________________________________

Relationship:_____________ Subscriber Birth Date: __________

Contract #______________Social Security # _______________

Do you have additional insurance? [ ] Yes [ ] No

**ASSIGNMENT AND RELEASE**

I, the undersigned certify that I (or my dependent) have insurance with _________________________and assign directly to the **Community Podiatry Group, P.C.** all insurance benefits, it any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

___________________________________________________

Signature Date

___________________________________________________

Relationship

**MEDICARE AUTHORIZATION**

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the **Community Podiatry Group, P.C.** for any services provided to me by this office and/or physicians in this office. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medication information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

___________________________________________________

Signature Date

# NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I, the undersigned, acknowledge receipt of the Notice of Privacy Practices.

_______________________________________________ / _______________

(Signature, patient or patient representative) (Date)

If Personal Representative's signature appears above, please describe Personal Representative's relationship to patient.

_________________________________________________________________

_________________________________________________________________

*to be filed and retained for a minimum of six (6) years

3/2007

## MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you now have or previously had any of the following conditions:

| Condition | | | Condition | | | Condition | | |
|---|---|---|---|---|---|---|---|---|
| AIDS/HIV | ☐ Yes | ☐ No | Diabetes Type 1 or 2 | ☐ Yes | ☐ No | Psychiatric Problems | ☐ Yes | ☐ No |
| Allergies to Drugs | ☐ Yes | ☐ No | Ear Problems | ☐ Yes | ☐ No | Radiation Treatment | ☐ Yes | ☐ No |
| Anemia | ☐ Yes | ☐ No | Epilepsy/Seizures | ☐ Yes | ☐ No | Rash | ☐ Yes | ☐ No |
| Angina | ☐ Yes | ☐ No | Eye Problems | ☐ Yes | ☐ No | Respiratory Disease | ☐ Yes | ☐ No |
| Arthritis | ☐ Yes | ☐ No | Fainting | ☐ Yes | ☐ No | Rheumatic Fever | ☐ Yes | ☐ No |
| Artificial Heart Valves | ☐ Yes | ☐ No | Foot Ulcer/Sore | ☐ Yes | ☐ No | Shortness of Breath | ☐ Yes | ☐ No |
| Artificial Joints | ☐ Yes | ☐ No | Gout | ☐ Yes | ☐ No | Sinus Problems | ☐ Yes | ☐ No |
| Asthma | ☐ Yes | ☐ No | Headaches | ☐ Yes | ☐ No | Stroke | ☐ Yes | ☐ No |
| Back Problems | ☐ Yes | ☐ No | Heart Problems/Disease | ☐ Yes | ☐ No | Swelling in Ankles/Feet | ☐ Yes | ☐ No |
| Bleeding Disorders | ☐ Yes | ☐ No | Hemophilia | ☐ Yes | ☐ No | Swollen Neck Glands | ☐ Yes | ☐ No |
| Cancer | ☐ Yes | ☐ No | High Blood Pressure | ☐ Yes | ☐ No | Tuberculosis | ☐ Yes | ☐ No |
| Chemical Dependency | ☐ Yes | ☐ No | Kidney Problems | ☐ Yes | ☐ No | Ulcers-Stomach/Intestine | ☐ Yes | ☐ No |
| Chest Pain | ☐ Yes | ☐ No | Liver Disease/Hepatitis | ☐ Yes | ☐ No | Varicose Veins | ☐ Yes | ☐ No |
| Chronic Diarrhea | ☐ Yes | ☐ No | Nervous Problems | ☐ Yes | ☐ No | Venereal Disease | ☐ Yes | ☐ No |
| Circulatory Problems | ☐ Yes | ☐ No | Phlebitis | ☐ Yes | ☐ No | Weight Loss-unexplained | ☐ Yes | ☐ No |

Surgeries (Circle): Heart Bypass Hysterectomy C-section Gallbladder Tonsils/Adenoids Appendix Foot/Ankle

Hospitalizations or other Surgeries:________________________________________

Primary Physician:____________________________Phone:____________ Date of Last Visit__________

Are you now, or have you been within the last two years, under any other doctor's care? ☐ Yes ☐ No

If yes, please explain the reason: ________________________________________

Are you pregnant? ☐ Yes ☐ No

## MEDICATIONS

Include prescriptions, over-the-counter medications, vitamins and supplements:

________________________________________

________________________________________

________________________________________

Pharmacy Name/Phone#:______________________________

## ALLERGIES

- ☐ Adhesive/Tape
- ☐ Anticoagulant Therapy
- ☐ Aspirin
- ☐ Codeine
- ☐ Demerol
- ☐ Local Anesthetics
- ☐ Novocain
- ☐ Penicillin
- ☐ Seafoods
- ☐ Sulfa
- ☐ Latex
- ☐ Other____________________

## PODIATRIC HISTORY

What brings you to our office today?

____________________

____________________

____________________

Have you been treated for this problem before?
☐ Yes ☐ No If yes, please list.

Physician: ____________________

Explain:____________________

____________________

Do you have any personal or family history of **diabetes**? ☐ Yes ☐ No

Do you use alcohol? ☐ Yes ☐ No
How many drinks per week?__________

Do you use cigarettes/tobacco? ☐ Yes ☐ No
_______Packs/day for _______Years
Year Quit:__________

Who referred you to our office?

____________________

Is your condition directly related to employment or an auto accident?
☐ Yes ☐ No
Is the condition related workman's compensation claim?
☐ Yes ☐ No
Athletic activities in which you participate (please list and indicate frequency)

____________________

____________________

____________________

## CONSENT FOR TREATMENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer treatment and/or perform any procedure(s) that are necessary in the diagnosis and/or treatment of my feet. UPDATE________

Patient's signature____________________________Date__________ UPDATE________

Physician Reviewed Information ________________________Date__________UPDATE________

Community PODIATRY Group, P.C.
Foot & Ankle Surgeons

**Financial and Office Policies Agreement**

1. Payment is expected at the time of service for copays, deductibles, and non-covered services. We accept cash, checks, Visa, MasterCard, and Discover. If we are required to send you a statement you will be charged a $5.00 billing fee.
2. A schedule of fees for our services can be given upon request. Please be aware that this is only an estimate. Our office will submit claims to your insurance company as a service to you. It is important to know what your insurance plan covers. If a service we have billed on your behalf is not covered by your insurance, you will be held responsible for payment.
3. All account balances and deductible amounts must be paid in full before any surgical procedures are performed.
4. Please be aware of specific details of your insurance plan's benefits. Do not assume that all services are covered. It is your responsibility to know the limitations of your coverage and to communicate with our office staff prior to your appointment if scheduled services are not covered, or if you've had a change in coverage.
5. We expect 24 hour notice for all cancellations. We reserve the right to charge a $30.00 cancellation or no-show fee for appointments cancelled less than 24 hours in advance.
6. If your insurance is a managed care plan, please review your coverage. Referrals must be authorized by your primary care physician, and may require a visit to their office to obtain one depending on their specific policies. Upon receipt of a referral to a specialist, it is your responsibility to be aware of what has been authorized. Subsequent visits, procedures and surgeries often require additional referrals. Failure to obtain necessary authorizations often leads to out-of-pocket expenses. We are happy to assist you in any way with your managed care plan. Your knowledge of your plan regulations and benefits as well as careful planning will help avoid delays and denied claims. If you do not have a valid referral on the day of service you may pay for services or reschedule appointment after approval has been obtained. We will schedule the ordered referral within 72 hours or give a prescription. The patient will be notified of the date and time by phone and given directions. After the patient's appointment a consult note is received and reviewed within one week.
7. If you cannot provide adequate proof of insurance, you will be responsible for the entire cost of your visit at the time services are rendered. Please make sure to bring your identification and insurance cards to every visit.
8. If you are experiencing financial difficulties, please discuss this with the Billing Department or the Office Manager. You may be asked to supply a credit card number. Accounts over 90 days will be sent to a collection agency and a charge of $25.00 will apply.
9. You may be asked to update your paperwork on a regular basis even if nothing has changed. We must keep all charts up-to date to stay in compliance with healthcare regulations.
10. Sometimes waiting periods may be longer due to unforeseen circumstances. Please be patient with us, we do take pride in giving all our patients the utmost quality care.
11. **A $50.00 cancellation fee will apply for surgical procedures cancelled after boarded**.

I understand and accept the above statements.

**Patient/ Parent**
**Signature:** **Date:**

**David T. Taylor, DPM, FACFAS, Shawn L. Reiser, DPM, FACFAS, Dean W. Singer, DPM, DABLES**
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