Podiatry Associates, Inc.
4201 S. Cloverleaf Drive
Saint Peters, MO 63376
Tel: (636)-928-1240 Fax: (636)-928-1242

Please fill out completely or mark areas "n/a" if they do not apply.

Patient Name (Last, First, M.I.)_____

Sex ____M _____F Date of Birth _____/_____/_____ Age _____ Social Security # _____/_____/_____

Martial Status: _____Single _____Married _____Widowed _____Divorced

Race: _____ Ethnicity: □ Hispanic/Latino □ Not Hispanic/Latino Language: _____

Address_____City_____State_____Zip_____

Home Phone_____Work_____Cell/Pager _____

Email: _____

Employer_____ City_____State_____Zip_____ Retired ____

Primary Care Physician's Name_____ Phone: _____

How did you hear about us: _____

In case of emergency, notify_____Phone_____Relation to Patient_____

Address_____City_____State_____Zip_____

Insurance Information

Primary Insurance Company_____Phone_____

Insured's Name_____DOB_____/_____/_____Relation to Patient_____

ID Number _____Group Number_____

Employer Name_____

Secondary Insurance Company_____Phone_____

Insured's Name_____DOB_____/_____/_____Relation to Patient_____

ID Number _____Group Number_____

Employer Name_____

IMPORTANT: If patient is a minor, who is financially responsible? _____
D.O.B _____/_____/_____Relation to Patient_____
Address_____City_____State_____Zip_____

I give my <u>consent</u> for Podiatry Associates Inc., A Professional Corporation, employees or associates to leave messages on my answering machine or voicemail regarding my medical care, test results, appointment confirmation, and payment issue. I also give them permission to discuss these listed issues with the following people:

_____ _____
Name/Relationship/Phone Number Name/Relationship/Phone Number

I certify that the above insurance information is current and accurate; I authorize assignment of insurance benefits to Podiatry Associates Inc. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Podiatry Associates Inc and its representatives may use my health care information and may disclose such information to the above-named Insurance Company(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

I have been given the opportunity to review the HIPAA Disclosure Policy regarding my Protected Health Information and understand the manner in which this office uses my information. I agree with the exception of: _____.

_____ _____
Signature of Patient, Parent, or Guardian Date

_____ _____
Please print name of Patient, Parent or Guardian Relationship to Patient

PODIATRY ASSOCIATES, INC.

MEDICAL HISTORY **□INITIAL VISIT** **□UPDATE**

Name:_____ **Date of Birth:**_____ **Date:**_____

Describe your foot problem and/or symptom:

_____
_____
_____

How long have you had this problem? _____Days _____Weeks _____ Months

_____

Describe any <u>past</u> problems with your feet or ankles:_____
_____

Do you use? (Y or N) Walker:_____Crutches:____Cane:_____Wheel Chair:_____

ALLERGIES to Medicine, OR Food: _____
_____

What medications do you take regularly? (please include dose/schedule; you may attach list if you have one; please tell us about blood thinners, including aspirin)

_____
_____
_____
_____
_____
_____
_____

Who is your primary care physician?_____ Phone:_____
Are you presently under a physician's care? Y N If so, please list the condition being treated and the physician.

Condition: _____ Physician:_____
Condition: _____ Physician:_____

Preferred Pharmacy Name: _____
Pharmacy Phone Number:_____
Pharmacy Address:_____

Do you have or have you had any of the following conditions? **(**check √, and give details)

_____Cancer _____Skin Problems _____Menopause

_____Visual Problems _____Asthma _____Lung Disease

_____Blood Clots _____Edema/Swelling _____Heart Disease

(conditions continued - please check √ and give details)

_____High Blood Pressure _____Peripheral Vascular Disease _____Stroke

_____Varicose Veins _____Stomach Ulcers _____Kidney Disease

_____Dialysis _____Arthritis _____Gout

_____Osteoporosis _____Vitamin D Deficiency _____Neuropathy

_____Seizures _____Psychiatric Condition _____Anemia

List any other serious illness:_____
_____
_____

Do you have Diabetes? Y N **If yes, do you take insulin?** Y N

When diagnosed:_____ Treating physician: _____

Date of last treatment:_____ Last Hemoglobin A1C Number:_____

List any past major surgeries including any foot or ankle procedures and approximate dates:

1.) _____ Date:_____
2.) _____ Date:_____
3.) _____ Date:_____
4.) _____ Date:_____
5.) _____ Date:_____

FAMILY HISTORY:

Mother Living_____Deceased_____Cause of death_____
Father Living_____Deceased_____Cause of death_____

Brother(s) Number_____How many living_____Causes of deaths_____
_____
Sister(s) Number_____How many living_____Causes of deaths_____
_____

Any family history of the following diseases? If so, which family member?

(M-mother **F**-father **B**-brother **S**-sister)

Heart Disease M F B S
Type:_____

Cancer M F B S
Type:_____

Diabetes M F B S
Type:_____

Stroke M F B S

SOCIAL HISTORY:

Marital Status: **S**ingle **M**arried **W**idowed **D**ivorced

Employment status: FT PT Unemployed Retired Student

Smoking Status: □ Current Daily Smoker □ Currently Smoke Some Days
□ Heavy Tobacco Smoker □ Light Tobacco Smoker □ Former Smoker
□ Never Smoked □ Would Like To Discuss Smoking Cessation

Alcohol Use: Y / N Frequency_____ **Drug Use:** Y / N Type_____

Do you exercise? Y / N **If so, describe activities and frequencies:** _____

REVIEW OF SYSTEMS:

Please check any of the following that currently apply to you:

General/Constitutional:
( ) Chills **( )** Weight change **( )** Fever

Integumentary:
( ) Athlete's Foot **( )** Dry Skin **( )** Fungal Nails
( ) Ingrown Nails **( )** Skin Ulcers/Wounds **( )** Thick Scars/Keloids

Head:
( ) Dizziness **( )** Head Injury/Concussion **( )** Loss of Balance

Eyes:
( ) Blurred vision **( )** Cataracts **( )** Glasses/Contacts

Ears:
( ) Earache **( )** Poor hearing **( )** Ringing in Ears

Nose:
( ) Nasal Polyps **( )** Nose bleeds **( )** Sinus Problem

Mouth/Throat:
( ) Dry mouth **( )** Mouth sores **( )** Sore throat

Respiratory:
( ) Cough **( )** Difficulty in Breathing **( )** Other_____

Cardiovascular:
( ) Chest pain **( )** High Cholesterol **( )** Irregular heartbeat
( ) Hypertension **( )** Palpitations **( )** Murmur

Peripheral Vascular:
( ) Cold feet **( )** Non-healing Sores **( )** Varicose veins

Gastrointestinal:

( )	Diarrhea	**( )**	GI Ulcer(s)	**( )**	Nausea/Vomiting

Genito-Urinary:

( )	Hernia	**( )**	Frequency	**( )**	Incontinence

Musculoskeletal:

( )	Arthritis	**( )**	Back Pain	**( )**	Gout

Neurological:

( )	Burning	**( )**	Loss of sensation	**( )**	Numbness/Tingling

Psychological:

( )	Anxiety/Depression	**( )**	Bipolar Disorder	**( )**	Panic Attacks

Endocrine:

( )	Excessive Hunger	**( )**	Excessive Urination	**( )**	Excessive Thirst

Hematic/Lymphatic:

( )	Easy Bleeding	**( )**	Easy Bruising	**( )**	Low Platelet Count

Allergy/Immune:

( )	Hepatitis B	**( )**	Hepatitis C	**( )**	HIV

<u>VITAL SIGNS</u>:

Height: _____ Weight: _____ Shoe Size : _____

Other Pertinent Medical Information:

PODIATRY ASSOCIATES FINANCIAL POLICY

We are glad you have chosen our office to help you in your health care. The doctors and staff strive to prescribe the best up to date treatments possible.

Full payment is expected on the day medical services are provided unless you have health insurance coverage with a plan that we have a written agreement. Our financial policy offers you a number of payment options. We accept cash, checks, and credit cards (Visa, Master Card or Discover). Patients with insurance must pay your (when applicable): **DEDUCTIBLE -** an amount you must pay first out of your own pocket each year before insurance will begin paying for any services, and is due at the time of service; **CO-PAYMENT** - an amount you must pay at each doctor's visit and is payable at the time of service; **CO-INSURANCE -** an amount which is usually a percentage of the doctor's fees, that your insurance company will not pay. Deductibles, co-payment and co-insurance is your responsibility. On occasions where there is a very high deductible or you have services that are not covered by insurance, you may speak with our billing department about possible payment arrangements.

We will need to make a copy of the front and back of your insurance card at your initial visit. We expect you to inform us of any change of address, phone, employment or insurance coverage that may occur and provide us with your insurance card to copy at that time. If you have more than one insurance policy, it is your responsibility to inform us which policy is **Primary** (first) coverage, and which policy is **Secondary** (second) coverage. With each policy we will require the name, date of birth, address, phone number, and employer of the member who carries the policy.

Credit Card Policy: At the time of your initial visit, you will be asked to bring a current credit card. We will keep a copy your credit card on file to cover any services not covered by insurance. We will guard your financial information as carefully as we do your medical information. **Unless other arrangements are made, the balance on your statement will be charged to your credit card on file, in increments of not more than $100 per month, unless we call you first**. If you make an overpayment on your account, we will issue a refund if there are no other outstanding debts on your account.

Initials _____

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-payment or deductible, you must pay that at the time of service. It is the insurance company that will make the final determination of your eligibility. Some insurance plans require a referral and/or prior authorization from your insurance company and/or primary care physician. You are responsible for obtaining the referral and/or preauthorization prior to your appointment or full payment will be expected for the medical services rendered. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. You agree to pay any portion of the charges not covered by insurance. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company and full payment will be expected for the medical services rendered.

Required Payments: Any co-payments or deductible required by an insurance company must be paid at time of service. Because this is an insurance requirement, we **cannot** bill you for these.

Returned Checks: There is a fee (currently $20.00) for any checks returned by the bank.

Past Due Balances: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to an attorney, you agree to pay all attorneys' fees which we incur plus all court costs.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment cost, it is the authorizing parent's responsibility to collect from the other parent.

Transferring of Records: You must request in writing if you want copies of your records sent to another doctor. If you request your records to be sent to an organization, you will be requested to pay a reasonable fee which will be dependent upon the number of pages copied. We will not release original x-rays, but you may obtain copies of x-rays on CD for $5.00 each. You authorize us to include all relevant information, including your payment history. If you are requesting your

Transferring of Records (continued): records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Workers Compensation: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to your personal injury.

Co-Signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent care.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions herein and the agreement will be in full force and effect. I have read the above financial policy and understand it fully.

Print Patient's Name: _____

Print Responsible Party: _____
(if not the patient)

Signature: _____ Date: _____

Co-Signature: _____ Date: _____

Please circle: **VISA** **MASTERCARD** **DISCOVER**

Name on card: _____

Credit Card #: _____

Expiration Date: _____/_____ 3 Digit Security: _____

Billing Address: _____

City, State, Zip: _____

Signature: _____

Phone Number: (_____) _____