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Patient Name:_______________________________________ Date of Birth:________________

Patient Address:____

Preferred Contact Number: _______________ Email (required for billing): ___________________

Preferred Pharmacy (with street and city):____

Marital Status:____________________ Employer:________________________________

Preferred language:___________________ Race/Ethnicity:__________________________

Parent or Guardian:

Name:___________________________ Contact number:_______________________

Relationship: __________________________

Emergency Contact:

Name: _____________________________ Contact number:___________________

Relationship: _________________________

Authorization for Treatment:

Printed patient name: _____________________ Printed Signee name: ______________________

Signature of patient, parent, or guardian: ____

Relationship to Patient: ________________________________

Patient Name:___________________________

Financial Policy

Cancelled Appointments

This office requires a 24 hour notice if you are unable to keep your scheduled appointment. **There is a 50$ charge for no show appointment or cancellations within 24 hours of appointment date. (Initial_________)**

Insurance

Co-payments are due at the time of each visit and it is your responsibility to inform the office of the amount of your co-payment. If your co-payment is not made, you will be billed. The bill will include a $25.00 billing fee per statement. Billing fee will be nullified if credit card is left on file. In order to file claims for you, it is required that you sign an assignment of benefits form for your insurance. We can set up your account to automatically charge your credit card for patient responsibility payments. You may be required to pay co-insurance, a deductible and a co-payment as determined by the medical coverage you have chosen for surgery, orthotics, and other services. These payments may be collected at the time of service. **(Initial__________)**

CREDIT CARD ON FILE AGREEMENT

At Premier Podiatry and Orthopedics (PPO), we require keeping your credit, HAS card, or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. Due to the constant change insurance payments and requirements, this is utilized for protection of patient and office. **A 5 day notice of any charge will be emailed prior to your card being processed.**

Your credit card information is kept confidential and secure and payment to your card are processed ONLY after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

Athenahealth, our electronic health record, encrypts and stores card information via Elavon, Inc. a secure credit card processor affiliated with U.S. Bank. Office personnel will not have access to your card information. (Initial_________)

Assignment of Benefits Form Patient Name: _________________

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s) including Medicare, private insurance and any other health/medical plans to issue payment check(s) directly to Brian A. McDowell, CORP. for medical services rendered to myself and/or dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount covered by insurance.

Authorization to Release Information

I hereby authorize Premier Podiatry and Orthopedics (PPO) to (1) release any information necessary to insurance carriers regarding my illness and treatment (2) process insurance claims generated in the course of examination or treatment (3) allow a photocopy of my signature to be used to process insurance claims for the period of a lifetime. This order will remain in effect until revoked by me in writing. I have requested medical services from McDowell Orthopedics and Podiatry Group on my behalf and/or the behalf of my dependents and understand that by making this request I become fully financially responsible for any and all charges incurred in the course of treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of the assignment is to be considered as valid as the original.

Acknowledgement of Privacy Practices

I acknowledge that I have been provided with a copy of the *Notice of Privacy Practices* containing a more complete description of the users and disclosures of my personal health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*.

It tells me how the practice will use my personal health information for the purposes of my treatment, payment for me treatment, and healthcare options.

The notice explains in more detail how the practice may use and share my personal health information for other than Treatment, Payment and healthcare Operations.

The practice will also use and share my personal health information as required/permitted by law.

I authorize to disclose my medication history to the practice.

Note: Uses and disclosure for TPO may be permitted with our prior consent in an emergency.
I understand that PPO has the right to change the *Notice of Privacy Practices* and I may contact PPO directly for a current copy of the *Notice of Privacy Practices.*

Disclosure of Personal Health Information

I authorize and give permission to disclose my personal health information to the following person(s) listed below:

____
____
____
____
____

By signing this, I acknowledge the Assignment of Benefits Form, the Financial Policy, the Acknowledgment of Privacy Practices, and the Disclosure of Personal Health Information.

Signature of Patient, Parent, or Guardian__________ ______________________________
Date__________________________________
Relationship to Patient___________________________________ Self

Patient Name:_______________________

Clinic Interview

Reason for visit: ____

Medication Allergies: [ ] yes [ ] no If yes, please list medications and reaction:

____

____

Other allergies (ex: Latex or tape) [ ] yes [ ] no If yes, please list allergy and reaction:

____

____

Medications: Please list all medications that you are currently taking including over the counter, herbal drugs or supplements. Medicine list attached [ ] [ ] not taking any medications

____

____

____

Social History:

	Yes/No	How often and how much?
Tobacco/Smoking		
Alcohol		
Illegal Drugs		Explain:
Other:		Explain
Shoe size		
Height		
Weight		

Surgical History: (Previous orthopedic surgeries or surgeries requiring hospitalization)

Date:	Procedure	Complications (Y/N)

If there was a complication, please explain:

____

Patient Name:___________________

Past Medical History:

No past medical history [ ]

	Yes		Yes
Arthritis		HIV/Aids	
Asthma		High Cholesterol	
Blood clot (previous DVT)		Leg or foot ulcer	
Excessive bleeding		Lung disease (specify in notes)	
Cancer (specific type and status in notes)		Organ transplant (specify in notes)	
Coronary Artery Disease		Osteoporosis	
Diabetes		Pacemaker	
Kidney Failure (dialysis yes[ ] no[ ])		Peripheral Neuropathy	
Fibromyalgia or Chronic pain		Peripheral vascular disease/ Vein disease	
Gout		Stroke (if yes: when______)	
Heart disease/Arrhythmia (ex: A-fib)		Urinary tract infections	
Heart attack (if yes: when________)			
Liver failure (hepatitis)		Other:	
If diabetic: What is most recent A1C:_________			

Notes:

____

____

Have you ever had any testing done to your legs for poor circulation?	☐ Yes	☐ No

RISK FACTORS		
Have you ever been told you have diabetes?	☐ Yes	☐ No
Do you have high blood pressure or are you on blood pressure medication?	☐ Yes	☐ No
Do you have high cholesterol or are you on a medication to lower your cholesterol?	☐ Yes	☐ No
Do you smoke or have you ever smoked?	☐ Yes	☐ No
Have you ever been told that you have had a heart attack or stroke?	☐ Yes	☐ No
Has anyone ever told you that you have poor circulation in your legs, intermittent claudication or peripheral arterial disease?	☐ Yes	☐ No
Have you ever had an angioplasty or stent placed in the heart or leg?	☐ Yes	☐ No

SYMPTOMS OF PAD		
Do you have any infections or sores that are not healing on your legs, feet or toes?	☐ Yes	☐ No
Has your walking pace slowed enough to significantly alter your daily activities?	☐ Yes	☐ No
Do your legs ever feel tired or heavy causing you to stop and rest? Do they get better with rest?	☐ Yes	☐ No
When you walk, do you ever have to stop because you have pain or cramping in your calves, thighs, or buttocks? Does the pain go away with rest?	☐ Yes	☐ No
Do you ever experience cramping, tightness, “Charlie horses” or pain in the legs or feet when lying down that improves when you stand up?	☐ Yes	☐ No
Have you given up things you once enjoyed to do over the last year due to leg fatigue, weakness, or discomfort?	☐ Yes	☐ No
Have you ever had trauma to either of your legs?	☐ Yes	☐ No