



Welcome to our office!

Last name: _____ First name: _____ Gender: ___M ___F

Date of birth: _____ Age: _____ Social Security #: _____ - _____ - _____

Address: _____ City _____ State _____ Zip _____

Cell phone: _____ Home phone: _____ Work phone: _____

Email address: _____

Preferred method of contact: ___Cell phone ___Home phone ___Email

Marital status: ___Single ___Married ___Divorced ___Widowed ___Legally Separated

Emergency contact: _____ Phone: _____ Relationship: _____

Employment status: ___Full-time ___Part-time ___Not employed Occupation: _____

Preferred pharmacy: _____ Phone: _____

Reason for visit: _____ Family Doctor: _____

How did you first learn about us? ___Internet search ___Our website ___TV commercials ___Newspaper ad

___Magazine ad ___Billboard ___Facebook ___Instagram ___Referred by Dr. ___Referred by friend/family

___Email ___Event/Expo ___Other: _____

SOCIAL INFORMATION

Do you smoke currently? ___Yes ___No How many packs a day? _____ For how many years? _____

Have you smoked previously? ___Yes ___No When did you quit: _____

History of substance abuse? ___Yes ___No If yes, please list: _____

Amount of alcohol consumed: Per week _____ Per month _____

What is your shoe size? _____

Patient's Past or Current Medical Problems

 Please check yes or no to those that apply to you **now** or **have applied to you in the past**:

| | | | | | |
|----------------------------------|-----------------------------|------------------------------|---------------------------------------|-----------------------------|------------------------------|
| Arthritis | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Gout | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Asthma | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Headache | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Back pain | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Heart Disease | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Blackout/fainting | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Hepatitis | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Bladder/bowel movement | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Hypercholesterolemia | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Bleeding disorder | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Hypertension (high blood pressure) | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Blood transfusion (year: _____) | <input type="checkbox"/> No | <input type="checkbox"/> Yes | HIV or other immune deficiency | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Cancer | <input type="checkbox"/> No | <input type="checkbox"/> Yes | HX of blood clots | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Changes in skin color/texture | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Kidney disease | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Chest pain/palpitation | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Liver disorder | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Deformity | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Muscle/bone/joint pain | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Diabetes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Numbness/tingling | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Dialysis | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Psychiatric problem | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Digestion | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Raynaud's disease | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Dizziness | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Respiratory (lung ___ Cough ___) | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Ears, Nose, Throat | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Stroke | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Epilepsy/seizure disorder | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Swelling discoloration extremity | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Eyes /visual disturbance | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Thyroid disease | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Fever/chills/sweats/fatigue | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Ulcer (leg ___ foot ___) | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Fibromyalgia | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Varicose veins | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Gastritis | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Vascular disease/circulatory problems | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| GI disease (ulcers) | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Weight loss or gain | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

I hereby authorize direct payment of surgical and medical benefits on my behalf to the provider of these services that I would otherwise be payable to me if I did not make this assignment. I understand that I am personally responsible to the physician for charges not covered by my insurance agreement. I permit a copy of this assignment to be used in place of the original for purposes of billing.

I acknowledge that if my insurance requires a paper or electronic referral, I am responsible for getting an up-to-date and valid referral.

The information I provided is accurate to the best of my knowledge. I authorize the release of any previous medical records by fax, mail, or phone by either physician or hospital. Also, I hereby authorize the doctor or his assistants to initiate the diagnosis and treatment of my condition using X-ray examination or photographs as necessary.

I give Physicians Footcare permission to obtain and release medical information to insurance companies and referring physicians. I have read the following and understand and agree with Physicians Footcare's office policy.

 Date

 Signature of patient or legal guardian

If not patient, relation to patient:

___Parent ___ Power of attorney ___Legal guardian ___Other: _____

MEDICATIONS

Please list **all** your **current** medications:

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

ALLERGIES

____ Medications: _____

____ Foods: _____

____ Other: _____

SURGICAL HISTORY

| Surgical procedures / serious injuries / illnesses | Year | Physician | Hospital |
|--|------|-----------|----------|
| | | | |
| | | | |
| | | | |
| | | | |

Has any **family member** had any of the following? Please indicate the relationship:

Cancer: _____ Diabetes: _____

Heart disease: _____ Stroke: _____

Hypertensive disorder: _____ Peripheral vascular disease: _____

Other: _____

NOTICE OF PRIVACY PRACTICES

We are committed to protecting your health information. This notice describes how we use and disclose information about you. It will also explain your rights to access your health information and our legal obligations regarding its control, protection, use, and disclosure in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

We are required by law to:

- Maintain the privacy and security of your information
- Use your information for treatment, research, improvement of quality and patient care, share it with other healthcare professionals who are treating you, and bill for services
- Comply with law enforcement and government agencies, including workers' compensation and the public health department, as required by state and federal laws
- Notify you in the event of a data breach

We will not:

- Sell your personal information for marketing purposes
- Voluntarily disclose any information without a signed release from you

When it comes to your health information, you have certain rights.**Your rights:**

- Copies of your records within 30 days of making such a request. Records are subject to our Medical Record Charges as determined by state law
- Ask us to correct your health information. You will receive an answer to your request within 60 days
- Request confidential communications
- Ask us to limit what we share
- Ask us for a list of how your health information has been disclosed
- Receive a paper copy of this notice
- Choose someone to act on your behalf (durable power of attorney, legal guardian, etc.)
- File a complaint if you feel your rights are violated (we will not retaliate against you for filing a complaint)

Any use or disclosure of your protected health information (PHI) not mentioned in this notice will be made only with your written authorization. We will request that you sign a separate form entitled "Privacy Policy/Benefits Assignment/Release of Information," acknowledging that you have read a copy of this notice. The acknowledgment will be filed with your records.



PRIVACY POLICY

I have read the Physicians Footcare Notice of Privacy Practices and understand that my protected health information (PHI) may be released to other healthcare providers, hospitals, insurance companies, etc., as outlined in the policy, according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). A paper copy of the policy is available to me under my rights.

BENEFITS ASSIGNMENT

I hereby authorize my insurance carrier to pay Physicians Footcare directly for any charges incurred for medical treatment at the facility where care is rendered.

RELEASE OF INFORMATION

I also authorize the Physicians Footcare doctors and staff to talk to and release information to the following individuals regarding my healthcare. I understand that this release will remain in effect until I revoke it in writing, which I may do at any time.

Spouse/partner: _____

Child/children: _____

Other: _____ Relationship: _____

Other: _____ Relationship: _____

By signing below, I certify that I have read and agree.

Printed Name: _____

Signature: _____ Date: _____

FINANCIAL POLICY

At Physicians Footcare, we are dedicated to providing top-quality care and assisting you in maximizing your insurance benefits. To facilitate this, please note our payment policy:

- Payment Due: Unless prior arrangements are made, payment is due at the time of service.
- Late Fees: Balances over 30 days old incur additional collection fees and 1.5% monthly interest.

Key Points:

1. Insurance: Your policy is a contract between you and your insurer. Most insurance companies typically cover our fees up to the maximum allowance.
2. Coverage: Not all services may be covered. We have no control over this.
3. Medicare Patients: You are responsible for the yearly deductible of 20% co-insurance and any unpaid co-insurance amounts.
4. Claims: We file insurance claims as a courtesy, but you are responsible for all charges. Contact us if you encounter financial difficulties.

Please ask us if you have any questions or need clarification.

PFC Laboratories: We are affiliated with PFC Laboratories for specimen preparation. If we collect specimens for pathology (take biopsies), we will send them to PFC Laboratories unless you instruct us otherwise. PFC Laboratories will bill your insurance company for any charges incurred, and you will receive a bill directly from PFC. Please contact PFC Laboratories at 833-732-3668 with specific questions regarding lab charges. Your insurance company may have an agreement with a specific laboratory. You must notify us at check-in if you prefer a lab other than PFC Laboratories.

Stride Pharmacy: We are affiliated with Stride Pharmacy for prescription or compounded medications. If we send prescription or compound medications, we will send them to Stride Pharmacy unless you instruct us otherwise. Stride Pharmacy will bill your insurance company for any charges incurred, and you will receive a bill directly from Stride Pharmacy. Please contact Stride Pharmacy at 843-531-5187 with specific questions regarding prescription charges.

Radiology Services: We are affiliated with PFC Radiology for X-ray, MRI, and CT services. If we order radiology services (X-ray, MRI, CT), we will send them to PFC Radiology unless you instruct us otherwise. PFC will bill your insurance company for any charges incurred, and you will receive a bill directly from PFC. Please contact PFC at 833-732-3668 with specific questions regarding radiology charges.

By signing below, I acknowledge that I have received this notice and understand these policies:

Printed Name: _____ Date of Birth: _____

Signature: _____ Date: _____

24 HOUR CANCELLATION & “NO SHOW” FEE POLICY

Recognizing that everyone’s time is valuable and that appointment time is limited, we ask that you provide 24-hour advance notice if you cannot keep your appointment. Each time a patient misses an appointment without proper notice, another patient is prevented from receiving care. Therefore, Physicians Footcare reserves the right to charge a fee of \$25.00 for each missed (“no show”) appointment that is not canceled within 24-hour advance notice. “No-show” fees will be billed to the patient. Insurance does not cover this fee and must be paid before your next appointment. Multiple “No-shows” in any 12 months can result in termination from our practice. Thank you for your anticipated cooperation.

By signing below, I acknowledge that I have received this notice and understand these policies:

Signature: _____ Date: _____

INSURANCE and MEDICARE ASSIGNMENT AGREEMENT

I authorize the payment of MEDICAL BENEFITS to be made on my behalf to Physicians Footcare for any services provided to me. I authorize the release of any medical information held by Physicians Footcare to the healthcare financing administration and its agents to process my claims.

Signature: _____ Date: _____