

COLLIER PODIATRY, P.A.

WELCOME TO OUR OFFICE

Please Complete the Following:

Today's Date: _____

Name _____

Sex: M F Age _____ Date of Birth _____

Social Security Number: _____

Local Address _____

City & State _____ Zip Code _____

Home Telephone _____ Mobile _____

Permanent Address _____

City, State, Zip _____ Telephone _____

Employer _____ Work Phone _____

Employer Address _____

City, State, Zip _____

Emergency Contact _____

Relationship _____ Telephone _____

Primary Care Physician _____

Physician Address _____

Physician Phone Number _____

How did you hear about us?

_____ Web Site _____ Telephone Book _____ Other

_____ Signage (drove by) _____ Referred (by whom) _____

COLLIER PODIATRY, P.A.

INSURANCE INFORMATION

I have no insurance. I have insurance. I have Medicare.

Your Relationship to Insured: Self Spouse Child Other

Policy Holder Name: _____ D.O.B. _____

Primary Insurance: _____

Secondary Insurance: _____

- Please give the receptionist your insurance cards and driver's license •

-----MEDICAL RELEASE-----

I consent to diagnosis and treatment of my medical condition (or of a minor) by the staff of Collier Podiatry P.A. I authorize release of information necessary to process any claim to my insurance company. I also agree that any balance not covered by my insurance company will be paid for by myself. I agree to notify this office of any changes of my insurance status and/or changes in coverage immediately. I agree that photocopies of this form will be as valid as the original.

-----ASSIGNMENT OF BENEFITS-----

I hereby assign all medical and/or surgical benefits to which I am entitled to due under my insurance policy for the amount to satisfy the fees for services rendered by Collier Podiatry P.A. I understand I am financially responsible for all charges whether or not paid by my insurance company. I also agree that any payments made to me by my insurance company for services rendered by Collier Podiatry P.A. will immediately be forwarded to this office.

Signature of Patient or Legal Guardian

Date

- Should your account be turned over to collections, a \$35.00 fee will be applied. •

COLLIER PODIATRY, P.A.

WELCOME TO OUR OFFICE

Please complete the following: (please print)

Today's Date _____

Name: _____ Date of Birth: _____

Reason for Visit: _____ AGE: _____

HEIGHT _____ WEIGHT _____ SHOE SIZE _____ PREGNANT? _____

MEDICAL HISTORY

• Please Check Those That Apply •

CARDIOVASCULAR:

- ___ high blood pressure
- ___ heart disease/attack
- ___ bypass surgery
- ___ angina
- ___ irregular heart beat
- ___ leg cramps
- ___ high cholesterol
- ___ poor circulation

GASTROINTESTINAL:

- ___ stomach ulcers
- ___ hiatal hernia
- ___ acid reflux
- ___ gall bladder (or removal)
- ___ hepatitis
- ___ colon cancer
- ___ cirrhosis of liver

MUSCULOSKELETAL:

- ___ arthritis
- ___ gout
- ___ back surgery
- ___ hip surgery R L
- ___ knee surgery R L
- ___ foot surgery R L

ALLERGIES:

HEMATOLOGIC:

- ___ anemia
- ___ Blood Transfusions
- ___ taking BLOOD THINNERS
- ___ hemophilia
- ___ AIDS/HIV
- ___ blood clots

RESPIRATORY:

- ___ asthma
- ___ bronchitis
- ___ emphysema
- ___ lung cancer
- ___ pneumonia
- ___ tuberculosis
- ___ other

DERMATOLOGICAL:

- ___ skin cancer
- ___ psoriasis
- ___ other

NEUROLOGICAL:

- ___ stroke
- ___ mini-stroke
- ___ weakness R L
- ___ paralysis R L
- ___ seizures/epilepsy
- ___ depression/anxiety

ENDOCRINE:

- ___ diabetes
- How long? _____
- ___ thyroid disease
- ___ menopause
- ___ osteoporosis
- ___ glaucoma

GENITO-URINARY:

- ___ breast cancer
- ___ kidney disease
- ___ on dialysis
- ___ prostate disease
- ___ hysterectomy

MEDICATIONS: (please list)

COLLIER PODIATRY, P.A.

REVIEW OF SYSTEMS:

• Please circle Yes or NO for each item •

General Symptoms:

Recent Weight Gain > 10 lbs	Yes	No
Recent Weight Loss > 10 lbs	Yes	No
Fever	Yes	No
Chills	Yes	No
Night Sweats	Yes	No
Chronic Fatigue	Yes	No

Eyes:

Wear Glasses/Contacts	Yes	No
Glaucoma	Yes	No
Cataracts	Yes	No
Macular Degeneration	Yes	No

Ears/Nose/Throat:

Hearing Loss	Yes	No
Ear Aches	Yes	No
Chronic Sinus Infection	Yes	No
Recent Sore Throat	Yes	No
Nose Bleeds	Yes	No
Swollen Glands in Neck	Yes	No
Infected Teeth/Gums	Yes	No

Gastrointestinal:

Frequent Heartburn	Yes	No
Frequent Diarrhea	Yes	No
Frequent Constipation	Yes	No
Recent Vomiting	Yes	No
Blood in Stools	Yes	No

Integumentary (Skin):

Rashes or Frequent Itching	Yes	No
Bleeding or Easily Bruised	Yes	No
Psoriasis	Yes	No

Musculoskeletal:

Joint Pain	Yes	No
Joint Stiffness	Yes	No
Weakness in Arms/Legs	Yes	No
Back Pain	Yes	No
Hip Pain	Yes	No
Osteoarthritis	Yes	No
Osteoporosis	Yes	No
Partial/Complete Amputation	Yes	No

Neurological:

Frequent Headaches	Yes	No
Frequent Dizziness	Yes	No
Numbness	Yes	No
Paralysis	Yes	No
Recent Stroke	Yes	No
Sciatica	Yes	No
Memory Loss	Yes	No
Confusion	Yes	No
History of Polio	Yes	No

Cardiovascular:

Chest Pain	Yes	No
Heart Palpitations	Yes	No
Pacemaker	Yes	No
Defibrillator	Yes	No
Swelling in ankles or legs	Yes	No
Leg Pain/Cramps at Night	Yes	No
Leg Cramps when Walking	Yes	No

Respiratory:

Chronic Cough	Yes	No
Shortness of Breath	Yes	No
Difficulty Breathing	Yes	No
Spitting Up Blood	Yes	No
Wheezing	Yes	No
Sleep Apnea	Yes	No

Psychiatric:

Depression	Yes	No
Anxiety	Yes	No
Loss of Sleep	Yes	No
Claustrophobia	Yes	No
Suicidal	Yes	No

Endocrine:

Glandular Problems	Yes	No
Hormonal Problems	Yes	No
Excessive Hair Growth	Yes	No
Excessive Thirst	Yes	No
Frequent Urination	Yes	No
Heat Intolerance	Yes	No
Cold Intolerance	Yes	No

Hematological / Lymphatic:

Lymphedema	Yes	No
Anemia	Yes	No
Slow to Heal Wounds	Yes	No
History of Hepatitis	Yes	No
Liver Transplant	Yes	No
Sickle Cell Disease	Yes	No
Leukemia / Lymphoma	Yes	No

Genitourinary:

Blood in Urine	Yes	No
Incontinence / Dribbling	Yes	No
Pain / Burning with Urination	Yes	No
Bladder Infections	Yes	No
Kidney Infections	Yes	No
Kidney Stones	Yes	No
Kidney Transplant	Yes	No
On Dialysis	Yes	No
Sexually Transmitted Diseases	Yes	No

COLLIER PODIATRY, P.A.

FAMILY HISTORY:

Has any family member died or become seriously ill following anesthesia? NO:___ YES:___

If yes, please provide details:_____.

IMPORTANT: PLEASE BE THOROUGH

	AGE	Living/Deceased	Serious Illness/Cause of Death
Mother	_____	_____	_____
Father	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Has anyone in your family ever been treated for:

	You	Father	Mother	Brother	Sister	Child	Child
Bleeding Disorder							
Cancer							
Diabetes							
Heart Disease							
Stroke							
Kidney Disease							
Neurological Disease							
Foot Conditions							

SOCIAL HISTORY:

Marital Status: ___ Single. ___ Married. ___ Divorced. ___ Separated. ___ Widowed.

Tobacco Use: ___ YES ___ NO # of packs per day _____ Year you Quit: _____.

Alcohol Use: ___ YES ___ NO ___ 1-2 per week ___ 1-2 per day ___ more than 2 per day.

Drug Use: ___ Never. Type & Frequency: _____.

Caffeine Use: ___ Never. Type & Frequency: _____.

WOMEN: # of Children _____. Are you pregnant? ___ NO ___ YES -- Months Pregnant = _____.

Any exposure to dangerous/toxic materials or poisons/pesticides? _____.

Any person, family or job problems that might pertain to your situation or recovery? _____.

_____.

COLLIER PODIATRY, P.A.

OFFICE FINANCIAL POLICY

- We are dedicated to providing the best possible care and service to you, while maintaining our patient's privacy and confidentiality. This requires your complete understanding of our financial policies as an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff. We will assist you in obtaining all of the benefits for which you are eligible for and entitled to.
- We are Medicare participating providers. We will bill Medicare for you. You will be responsible for your annual deductible, co-payment and charges for non-covered services. You will be asked to sign an Advanced Beneficiary Notice form for services **we know** are not covered by Medicare. Medicare does cover surgery, X-rays and other treatments. Medicare **does not cover** routine foot care such as trimming of corns or cutting of toenails. **You will need to pay** for these services at the time they are provided.
- You must inform the office of all insurance changes and authorizations and referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- Unless other arrangements have been made in advance by you or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, 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 if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period (60 days), **you are responsible for payment**. Please assist us in settling your claim by periodically calling your insurance carrier and requesting they pay us in a timely manner.
- We have made prior arrangements with some insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service. We will do our best to inform you of whether we accept or participate with your insurance company. This list changes frequently, so please check your benefits with your insurance company. We handle these claims in accordance with our agreement, if one exists. We will file your insurance as a courtesy. In the event we are not aware of a charge or service that is not covered by your plan, you will be billed after we receive a denial from your insurance company.
- Past due accounts are subject to collection proceedings, including the filing of a Medical Lien. All fees, including but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due this office.
- If you have insurance coverage with a plan in which we do not participate, we will submit the claim for you on an unassigned basis **as a courtesy**. This means your insurer will send the payment directly to you. Therefore, **all charges** for your care and treatment **are due at the time of service**. If the charges exceed \$1000.00, you will be asked to pay 50% of the entire bill with the remaining balance due in 45 days. This gives you time to follow-up with your insurance company. Please understand that since we do not have a contract with your plan, we are not obligated to adjust our charges to your plan's benefit schedule.
- We will not become involved in a dispute between you and your company regarding deductibles, co-payments, secondary insurances, usual and customary charges or medical necessity. We will supply factual information as necessary.
- There is a service fee of 25.00 for all returned checks. Your insurance company does not cover this fee.
- Your signature below signifies that you understand and agree to our financial policy and acknowledge your responsibility regarding charges incurred in this office.

Signature of Patient/Responsible Party

Signature of Witness

Printed Name of Above

Printed Name of Above

Date

Date

_____ Patient initials to indicate copy received.