PATIENT INFORMATION

DATE___/___/____ LAST NAME_____FIRST NAME_____MI___

SS#_____ -_____-_____ MALE___ FEMALE___ BIRTHDATE _____/_____/_____ AGE_____

PATIENT IS MARRIED___DIVORCED___WIDOWED___SINGLE___MINOR____

MAILING ADDRESS_____CITY_____ZIP_____

HOME PHONE ( ) _____-_____CELL PHONE ( ) _____-_____ OTHER ( ) _____-_____

I GIVE MY CONSENT FOR PODIATRY CENTER OF IDAHO STAFF TO LEAVE MESSAGES OR VOICEMAIL RE: MY MEDICAL CARE, TEST RESULTS, APPOINTMENT INFORMATION AND PAYMENT ISSUES. YES _____NO_____ INITIALS_____

EMAIL _____ (PLEASE NOTE: WE DO NOT ADVISE SENDING PHI VIA EMAIL DUE TO CHANCES OF INSECURE EMAIL ACCOUNTS/ADDRESSES. **INITIALS**_____

PATIENT EMPLOYER_____ WORK PHONE ( ) _____-_____

SPOUSE NAME _____SPOUSEPHONE ( ) _____-_____

EMERGENCY CONTACT NAME_____ PHONE ( ) _____-_____

DO YOU AUTHORIZE PODIATRY CENTER OF IDAHO TO DISCLOSE PROTECTED HEALTH INFORMATION (MEDICAL RECORD INFORMATION, ACCOUNT INFORMATION, AND APPOINTMENT INFORMATION) TO YOUR SPOUSE IN WHICH YOU HAVE NAMED? YES_____NO_____ INITIALS_____

PLEASE LIST ANY OTHER PEOPLE WHO YOU WOULD LIKE TO AUTHORIZE (PODIATRY CENTER OF IDAHO / TREASURE VALLEY PODIATRY) PERMISSION TO DISCLOSE PROTECTED HEALTH INFORMATION IF THEY WERE TO CALL ON YOUR BEHALF

NAME: _____RELATIONSHIP_____

NAME: _____RELATIONSHIP_____

ARE YOU CURRENTLY ON HOSPICE? YES_____ NO_____

HOW DID YOU HEAR ABOUT THE PRACTICE? (circle one)

INTERNET/GOOGLE_____ FRIEND/FAMILY_____

DOCTOR REFERRAL (WHO?)_____ INSURANCE COMPANY_____

FACEBOOK_____ OTHER_____

PRIMARY INS: _____ID#_____GRP #_____

POLICY HOLDER NAME_____BIRTHDATE ____/_____/_____ SS#_____-_____-

_____ EMPLOYER NAME_____

SECONDARY INS: _____ID#_____GRP#_____

POLICY HOLDER NAME_____BIRTHDATE_____/_____/_____

SS#_____-_____-_____ EMPLOYER NAME_____

Patients Medical History

Patient Name: _____ **Age**_____ **Male/Female**
Describe your foot problem: _____

_____

Is your problem related to an injury from: ❑ Work ❑ Auto ❑ Home ❑ Other
If this is an accident, please list your date of injury: _____

Medical Doctors Name: _____ Date of last visit: _____
Are you ALLERGIC to any of the following? Please circle all that apply **NO KNOWN ALLERGIES**

Local anesthetic	General anesthetic	Codeine	Aspirin	Tape
Penicillin	Sulfa Drugs	Iodine	Shellfish	Environmental Allergies

List any other allergies you may have: _____

List ALL medications and vitamins: (Name, Dosage, Frequency)

_____
_____
_____
_____
_____
_____
_____

List ALL Surgeries/Hospitalizations: (Operation/Date)

_____
_____
_____
_____
_____
_____
_____

Do you have or have you had any of the following medical conditions?

	Yes	No		Yes	No		Yes	No
Eye Problems/Glaucoma	❑	❑	Blood clots/DVT	❑	❑	Diabetes	❑	❑
Heart Trouble	❑	❑	Lung Disease	❑	❑	Arthritis	❑	❑
Chest Pain	❑	❑	Asthma	❑	❑	Gout	❑	❑
High Blood Pressure	❑	❑	Stomach Ulcers	❑	❑	Depression	❑	❑
Bleeding Disorders	❑	❑	Liver Disease	❑	❑	Stroke	❑	❑
Circulation Problems	❑	❑	Hepatitis	❑	❑	Cancer	❑	❑
Epilepsy/Seizures	❑	❑	Kidney Disease	❑	❑	Sleep Apnea	❑	❑
Anemia	❑	❑	Thyroid Disease	❑	❑	Chronic Pain	❑	❑

List any other medical conditions: _____

_____

Do you smoke? ❑ No ❑ Yes ❑ I Quit. When _____ How many packs a day?_____ How many years? _____

Do you drink alcohol? ❑ No ❑ Yes Type? _____ How much? _____ How often? _____

Have you used recreation drugs? ❑ No ❑ Yes What kind? _____

Do you exercise regularly? ❑ No ❑ Yes What kind? _____ How often? _____

Do you know of any significant medical problems that run in your family? (examples: high blood pressure, diabetes, heart problems, cancers, etc.) Please list family member, their age and the problem.
Father (age) (_____): _____ Mother (age) (_____): _____
Grandparents (_____): _____
Siblings (_____):_____
Children list male or female, ages and any medical problems: _____

_____

Other members of your family with FOOT problems: _____

_____

Is there anything else you feel the doctor needs to know about that we did not ask you on this form?

_____

_____ _____

Signature of Patient or Parent/Guardian if Patient is a Minor ***Date***

POLICIES AND PROCEDURES FOR PODIATRY CENTER OF IDAHO/TREASURE VALLEY PODIATRY

Thank you for choosing us as your healthcare provider. We are committed to quality and caring treatment. The following is a statement of our policies and procedures. Please read the information carefully (subject to change)

Payment is expected at the time of service. All co-pays, co-ins, deductibles, non-covered charges and outstanding balances will be due at the time of your visit. We gladly accept Cash, Check, Visa, MasterCard, Discover and American Express. We will bill participating insurance companies as a courtesy to you. If you do not carry insurance, payment is expected at the time of your visit. ***If you are not financially prepared for your ESTIMATED portion of your visit, we will happily reschedule your appointment.*** (Estimates are based on insurance benefit information provided by your insurance company and based on the description given for the reason for your visit. (Please ask receptionist for estimate) Payment plans may be made on a case by case basis and will be set up for automatic credit card payments. And must be paid in full within 3 months. (ORTHOTICS NOT SUBJECT TO PAYMENT PLAN) **INITIALS_____**

We will take a copy of your photo ID and Insurance cards. We cannot bill your insurance unless you have supplied us with complete policy holder information. If you do not have your insurance card(s) and /or complete policy information you will be responsible for payment in full for your visit. If you provide your insurance information after the date of your visit, you will be refunded after your insurance pays your claim. We participate in many health insurance plans. **All health plans are NOT the same.** Please be aware that **NOT ALL PODIATRY SERVICES ARE COVERED.** We will do our best to inform you if we believe some services may not be covered by your Insurance. Some Insurance plans require a referral prior to seeing a specialist. If you're Insurance plan requires a referral and it is not on file you will be financially responsible for services received. Knowing your Insurance plan is YOUR responsibility. Patients are encouraged to contact their Insurance for clarification of benefits prior to services rendered. If your Insurance plan has not paid your claim(s) within 60 days, the claim balance will be transferred to your responsibility, it is then your responsibility to get them to pay the claim **INITIALS_____**

24 Hours' notice is required for appointment cancellations. Our policy is to charge for missed appointments. $25 for the first missed appointment. $40 for two or more missed appointments and possibly dismissal from this practice. **INITIALS_____**

We accept Workers Comp Insurance with Authorization form the Work Comp carrier. We do not bill any other Third-Party Insurance. A fee will be applied for copies of records, x-rays, or documentation that requires completion by the Physician. Past due balances will be turned over to an outside collection agency. You understand that if your account is submitted to a collection agency, that fact that you received treatment at our office may become a matter of public record. Any returned checks will be charged a $35 return check fee. **INITIALS_____**

AUTHORIZATION AND RELEASE- I CERTIFY THAT THE INSURANCE INFORMATION I PROVIDED IS CURRENT & ACCURATE; I AUTHORIZE ASSIGNMENT OF INSURANCE BENEFITS TO PODIATRY CENTER OF IDAHO/ TREASURE VALLEY PODIATRY. 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. THIS OFFICE MAY DISCLOSE MY HEALTH CARE INFORMATION TO THE INSURANCE COMPANIES I HAVE PROVIDED FOR THE PURPOSE OF OBTAINING PAYMENTS, BENEFITS, OR RELATED SERVICES.

I HAVE BEEN GIVEN THE OPPORTUNITY TO REVIEW AND UNDERSTAND THE HIPAA DISCLOSURE POLICY REGARDING MY PROTECTED HEATLH INFORMATION.

SIGNATURE OF PATIENT OR GUARDIAN_____DATE_____