COLLAR CITY PODIATRY

PATIENT INFORMATION FORM

_____Richard Altwerger, DPM _____Timothy Fauler, DPM

Email_____

PATIENT INFORMATION	
Name:	Date of Birth:
Address:	Sex: M F Marital Status:
City: State: Zip:	Home Phone: Cell Phone: Work Phone:
Social Security Number:	Spouse Name:
Employer:	Spouse Employer:
Address:	Emergency Contact:
City: State: Zip:	Home Phone: Work Phone:
Language Preference:	Ethnicity/Race:

Insurance:	ID Number:
Group Number:	Copay:
Workers compensation yes/ no No fault yes/no Legal case yes/no	Name of carrier: Address:_____ _____ _____ claim number:

IF PATIENT IS A MINOR	
Parent/Guardian Name:	Date of Birth: Age:
Address:	Home Phone: Cell Phone: Work Phone:
City: State: Zip:	Employer:
Relation to Patient:	Social Security Number:

Who referred you to the office? __ Doctor __ Ad __Telephone Listening __Friend __ other

Referring Doctor:	Referring Friend:
Address:	Address:
Phone Number: Fax:	

_____ _____

Patient or Authorized Representative Signature Date

COLLAR CITY PODIATRY

GENERAL INFORMATION

Name:_____ Date of Birth: _____ Date: _____

In order to help us diagnose and/or treat your foot, problem, it is important that we have a current medical history in your chart. Please answer all the questions to the best of your ability.

What is your chief foot complaint? _____

_____

How long have you had this concern and how has this been treated? _____

_____

Have you or a family member ever been treated for any of the following conditions? If so, please type the appropriate letter (s) that applies to those conditions in the box next to the condition.

P=Self /Patient M= Mother's side F= Father's side B= Brother S= Sister

	Acid Reflux		Anemia		Arthritis
	Asthma		Bleeding Disorder		Cancer
	Cataracts		Circulation problems		Depression
	Diabetes		Digestive Problems		Dizziness
	Eczema		Epilepsy		Fibromyalgia
	Fractures		Glaucoma		Headaches
	Heart Attack		Heart Disease—What Kind? _____		Hearing Loss
	Hepatitis A__ B__ C___		High Cholesterol		Hypertension
	HIV/AIDS		Hyperthyroidism		Hypothyroidism
	Kidney Disease/Transplant		Liver Disease		Lyme Disease
	Memory Loss		Neuropathy		History of MRSA
	Phlebitis		Peripheral Arterial Disease		Parkinson's Disease
	Poor Circulation		Respiratory Condition		Rheumatic Fever
	Shortness of Breath		Seizure Disorder		Sickle Cell Disease
	Sleep apnea		Stroke		Stomach Ulcers
	TB/Lung Diseases		Thyroid Disorder		Varicose Veins

Are you allergic to anything? **Yes** _____ **No** _____ List Allergies _____

_____

List all medications you are currently taking. Please include dosages and frequency. _____

_____

_____

_____

List all major surgeries, general and orthopedic: _____

_____

_____

Pharmacy: _____ Location of Pharmacy: _____ Telephone: _____

Who is your primary care physician: _____

What other doctors seen for treatments: _____

_____

Shoe Size: _____ Height: _____Weight: _____

Do you smoke? No _____ yes ____ number of years_____ how much daily_____quit _____

Do you drink Alcohol No_____ Yes_____ how many a day _____ how much _____ quit_____

Do your drink caffeine No ____ Yes ____how many a day _____ tea _____ coffee____ decaf _____

Do you use recreation drugs? No _____ yes _____ what type _____ frequency _____

FEMALES ONLY : Are you pregnant yes ___ no____ date of last menstrual period _____

ALL OF THE INFORMATION ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE: _____DATE: _____

Brb 1/18/17 updated

COLLAR CITY PODIATRY

ACKKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I ACKNOWLEDGE THAT I WAS PROVIDED A COPY OF THE NOTICE OF PRIVACY PRACTICES AND THAT I HAVE READ (OF HAD THE OPPORTUNITY TO READ IF I SO CHOSE) AND UNDERSTOOD THE NOTICE.

Please list the names of the people you'd like your medical information shared with:

_____

_____

_____

Do you want your primary care doctor to receive a copy of our note(s)? YES NO

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature

CONSENT FOR PHOTOGRAPHY

Patient's Name: _____ Date of Birth: _____

I give my consent to have a photograph taken of _____ for their electronic medical record. On occasion you may be asked if we can take a picture of your foot condition (ulcer, etc.). I understand and agree that these images may be used by Collar City Podiatry for the purpose outlined below.

_____ charting and medical records

_____comparison to previous photos and product success of wounds

Under no circumstances will your name or picture of your face be utilized for anything other than medical records unless authorized by you the patient.

_____ Date: _____

Signature of patient/ legal representative

If legal representative, relationship to the patient _____ Date: _____

Signature of witness: _____ Date: _____

COLLAR CITY PODIATRY

PATIENT FINANCIAL POLICY

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our office manager or supervisor.

As our patient, you are responsible for all authorization/referrals needed to seek treatment in this office. 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 accept VISA, Mastercard, cash or check. **ANY AND ALL FINANCIAL RESPONSIBILITIES NOT TAKEN CARE OF AT THE TIEM OF SERVICE ARE SUBJECT TO A $15.00 SURCHARGE.**

Your insurance policy is a contact between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign and 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, we will have to look to you for payment. .

We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and you will only be required to pay the **co-pay/co- insurance/ deductible at the time of the service.**

If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. 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.

All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be “not covered” or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.

There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In the event, payment will be due one week prior to the surgery.

Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to collection fees, attorney fees, and court fees shall be your responsibility in addition to the balance due this office.

There is a service fee of $25.00 for all returned checks, plus the bank fees charged to us for processing a returned check. We will no longer accept checks from you if your check is returned for any reason. There is a $50.00 charge for any missed appointments that are not cancelled within a 24 hour notice. Your insurance company does not cover these fees.

Any and all over the counter items purchased through our office are nonrefundable regardless of manufactures policies or rebates. Thank you

Signature of Patient/Responsible Party: _____ Date: _____

Printed Name of Patient/Responsible Party: _____ Date: _____

Witness Signature: _____ Date: _____

Printed Name of Witness: _____ Date: _____

_____Patient initials to indicate copy received.

COLLAR CITY PODIATRY

ASSIGNMENT OF BENEFITS & SIGNATURE ON FILE FORM

We are committed to serving you with high quality, skilled care. The medical services we provide are services you've elected to receive. In order to provide our best care to all patients, we've implemented the following office policies:

Payment policies:
Payment is due at the time of services for all medical services, without exception. We participate in most insurance plans. If you are insured, we will collect co-pays at the time of check-in, deductibles at the time of check out and bill your insurance company. Any balances not paid by your insurance company will be your responsibility. **You are responsible for knowing your insurance coverage.**

We are required by law to make every attempt to collect patients' co-pays and deductibles for insurance plans. Please help us remain in compliance by paying promptly.

_____ (initial) **Financial Responsibility** –all professional services rendered are charged to you and are due at the time of services, unless other arrangements have been made in advance with our office manager. Necessary forms will be completed to help expedite insurance carrier payments. However, YOU ARE responsible for all fees, regardless of insurance coverage: this includes co-pays, co-insurance, deductibles, and/or non-covered services. Your doctor may charge you for services not covered under your health insurance contract, including those services not covered due to non-payment of health insurance premiums.

_____ (initial) **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, Medicaid, private insurance and any other health/medical plan to issue payment check(S) directly to Collar City Podiatry for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance. A photocopy and scan of this Assignment Is to be considered as valid as the original.

_____ (initial) **Authorization to release information—**I hereby authorize Collar City Podiatry to furnish and/or release any information necessary to insurance carriers concerning my illness and treatments, to process my insurance claim acquired in the course of my examination or treatment. This order will remain in effect until revoked by me in writing. A photocopy and scan of this Authorization is to be considered as valid as the original.

_____ (initial) **Authorization &release ---** I have read and fully understand the Assignment of Benefits Form as outlined above. In the event that it is necessary to turn my account over to collection, I will also be responsible for any and all cost of collection. I understand that this Authorization shall apply to all services provided to me, my dependents or any other person for which I have assumed responsibility by signing below, from this date forward until it has been revoked in wiring.

Signature of Patient/Responsible Party: _____ Date: _____

Printed Name of Patient/ Responsible Party: _____ Date: _____

Witness Signature: _____ Print Witness: _____ Date: _____

_____ Patient initials to indicate copy received.