PATIENT INFORMATION FORM

Please Print

Is your visit related to an injury at work? □ No □ Yes

Today's Date: ____________

Name: ____
First Middle Initial Last

Date of Birth: ____/____/______ Age:____ Social Security # : ________-_____-________ Sex: □ Male □ Female
MM DD YYYY

Marital Status: □ Single □ Married □ Widowed □ Divorced If Married, Spouse's Name: ____________

Patient Address: ____________ City: ________ State: ______ Zip: ______

Home Phone: (____)____________ Cell Phone # : (_____)____________

Phone # to use for Confirmation of Appt: (____)____________ E-Mail: ____________

Employer Name: ____________ Phone # : (_____)____________

Employer Address: ____________ City: ________ State: ______ Zip: ______

Primary Care Physician's Name: ____________ Phone # : (_____)____________

Pharmacy Name: ____________ Phone # : (_____)____________

Pharmacy Address: ____________ City: ________ State: ______ Zip: ______

In case of emergency, name & phone number of nearest relative: ____________ (____)____________

Financial / Responsible Party Information – MUST be completed:

Guarantor Name: ____________ Relationship to Patient: □ Self □ Spouse □ Parent
First Middle Initial Last

Date of Birth: ____/____/______ Social security # : ________-_____-________ Sex: □ Male □ Female
MM DD YYYY

Employer Name: ____________ Phone # : (_____)____________

Employer Address: ____________ City: ________ State: ______ Zip: ______

Drivers License # : ____________ State:____________

Insurance Information – MUST be completed:

Primary Insurance:

Insurance Carrier: ____________ Policy / ID # : ____________ Group # : ____________

Policy Holder: ____________ Relationship to Patient: □ Self □ Spouse □ Child

DOB: ____/____/______ Insured SS # : ________-_____-________ Employer: ____________
MM DD YYYY

Secondary Insurance:

Insurance Carrier: ____________ Policy / ID # : ____________ Group # : ____________

Policy Holder: ____________ Relationship to Patient: □ Self □ Spouse □ Child

DOB: ____/____/______ Insured SS # : ________-_____-________ Employer: ____________
MM DD YYYY

Other Insurance:

Insurance Carrier: ____________ Policy / ID # : ____________ Group # : ____________

Policy Holder: ____________ Relationship to Patient: □ Self □ Spouse □ Child

DOB: ____/____/______ Insured SS # : ________-_____-________ Employer: ____________
MM DD YYYY

Signature of Patient / Responsible Party: ____________ **Date:** ________

[Revised 10/2009]

Advanced Podiatric Specialists
Informed Consent

Patient Name: ____________________

- All medical communications carry some level of risk. While the likelihood of risks is low in our secure environment associated with the Portal you need to be conscious of messages you send from public computers.
  - It is easier for online communications to be forwarded, intercepted, or even changed without your knowledge.
  - It is harder to eliminate online communication due to the existence of backup copies. We use a secure network for the Patient Portal. Employers and online services have a right to inspect and keep online communications transmitted through their system.
  - Online communications are also admissible as evidence in court. Online communications may disrupt or damage your computer if a computer virus is attached.

Patient Acknowledgement and Agreement I hereby affirm that I am the patient identified above or legally manage this patients care. I understand that I may be subject to penalties under law for submitting false or misleading information related to this application to access the portal. By using the "Patient Portal" you acknowledge that you have read and fully understand the Terms & Conditions as described above. You understand the procedures and risks associated with online communications with your healthcare team and you consent to the conditions described. If you decide you do not want to use the portal, please notify us to deactivate your account.

Patient or Parent or Guardian Signature ______________________________ Date __________
Relationship to Patient: ____________________

Pharmacy: ______________________________

PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

TODAY'S DATE ___/___/___ PCP DOCTOR ______________________________

NAME ______________________________ DATE OF BIRTH ___/___/___

Were you referred to us by another health care professional? (If yes please state name) ____________________

Occupation: ____________________ Employer ____________________ Is this Work Comp? ________

Medical History **Please list any chronic medical issues or health problems:** Ex: diabetes, heart disease, high blood pressure, etc	POA, living will Age______ Height______ Weight______ Temp______
Please list any past surgeries:	ROS
	New Patient to our Clinic? In the past 3 months, have you experienced or are you currently experiencing any of the following symptoms?
Please list any relevant family medical history (mom/dad/siblings):	**Returning patient?** Since your last visit, have you experienced, or are you currently experiencing any of the following symptoms?
	General: change in weight, nausea, vomiting, chills, or fever, fatigue.
Medications Are you taking any medications? If so, please list:	**Head:** trauma, vertigo, convulsive disorder or syncope.
	Eyes: inflammation, cataracts, or glaucoma.
	Skin: skin conditions, rash, redness.

	Respiratory: Shortness of breath, dyspnea, wheezing, and any history of pneumonia, sore throat.
Allergies **Do you have any medication allergies? (If so, please list)**	**Cardiovascular:** palpitations, tachycardia, heart murmur, irregular rhythm, chest pain, discomfort, leg cramping, swelling, lymph node changes.
	GI: changes in appetite or weight, dysphagia, abdominal pain or ulcerations, blood in stools.
Do you have any METAL allergies? (If so, please list)	**GU:** kidney stones or bloody urine.
Does your skin react to metal jewelry? If so, what is the reaction?	**Hematopoietic:** bleeding disorders or easy bruising, clotting disorder.
Do you have any OTHER allergies? If so, please list:	**Endocrine:** hot or cold sensations. He has never had any symptoms of diabetes.
	Neurological: balance issues, muscle control, neuropathy, sensory, motor or autonomic disturbances, numbness, tingling.
Do you smoke? If so, how much?	**Musculoskeletal:** arthritis, joint pain, aches, coldness, loss of strength, fracture or dislocation, back pain, neck pain, joint swelling.
	Psychiatric: history of mental illness.
Do you drink alcohol? Occasionally Regularly Frequently	Other________ Are you pregnant?

New Patient **Estab pt/New Complaint** **Follow-up**

Chief Complaint:

What is the main reason for your visit today? Right Left Both Body part:______________________	Previous episodes of same issue:
Did your symptoms start: (circle one) GRADUALLY SUDDENLY	Have you noticed any associated symptoms? (In other joints, etc.)
If injured, how did it occur?	Any previous treatment?
How long have your symptoms been present? ______________________ How severe are your symptoms? 1 2 3 4 5 6 7 8 9 10 Mild Severe	What makes your symptoms better? Rest Medication Nothing Elevation Heat Massage Chiropractic Ice Physical therapy
Frequency of symptoms: Constant or Intermittent Progression of symptoms: improving, worsening, remain same	What makes your symptoms worse?
Type of symptoms: circle all that apply Pain Weakness Instability Stiffness Catching Locking Sharp pain Shooting pain Numbness	Related Imaging or tests:

ADVANCED PODIATRIC SPECIALISTS , LLC Financial Policy;

We are committed to providing you with the best care. In order to achieve these goals, we need your assistance and your understanding of our payment policy. Payment for services are required at the time of service; therefore, at the time of your appointment. We accept payments in the form of cash, credit or debit card, or check. If you have insurance coverage in which we do not participate, we will process a claim after you have paid in full any balances due. Returned checks are subject to additional collection fees, including insufficient funds fees.

Balances older than 90 days are forwarded to a collection agency with additional fees.

1. Medicare patients: You are responsible for your annual deductible and 20% of what Medicare allows (coinsurance). We may ask you to sign a Medicare Advantage Beneficiary Form (ABN), which states that if Medicare does not cover a service or medical equipment, you understand that you will be responsible for the payment.

   Medicare patients only initial : _________

2. I agree that if my account falls delinquent, I will be responsible for all collection agency costs.

   Initial : ________

3. I authorize ADVANCED PODIATRIC SPECIALISTS, LLC. to submit all insurance claims on my behalf. I understand that I am responsible for all services not covered by insurance.

   Initial : ________

Medical Records Fee: The cost per page for medical records is $0.65.

No Show Fee: If you missed your appointment and did not call 24 hours ahead of time to cancel or reschedule, you will be subject to a No Show Fee of $30.00.

Check Insufficient Funds: If there are insufficient funds, you will be subject to a $40.00 fee.

Any questions about pricing should be addressed prior to any treatment being rendered.

Signature: ______________________________________ Date: ______________

PARTICIPATING INSURANCES AND MEDICARE ASSIGNMENT: I authorize payment made on my behalf to ADVANCED PODIATRIC SPECIALISTS, LLC for any services performed. I authorize the release of any medical information held by ADVANCED PODIATRIC SPECIALISTS, LLC to the health care financing administration and its agents in order to process my claims.

Signature: ____________________________________ Date: _____________

I, ______________________________, hereby give my permission to ADVANCED PODIATRIC SPECIALISTS, LLC to administer, treat, and to perform such procedures as may be deemed necessary in the diagnosis and/ or treatment of the lower extremity condition. I also hereby assign Ryan J. Donegan, DPM, MS all benefits provided by my insurance company policy or policies for medical or surgical care. I understand that I am financially responsible for any balance due on my account and a collection agency will be employed to enforce such. Furthermore, I have read and signed the financial responsibility form and understand the financial policy of ADVANCED PODIATRIC SPECIALISTS, LLC. I understand this is a lifetime signature.

Federal Trade Commission Red Flag Policy:

One government form of picture identification is required before any treatment can be rendered to a registering new patient. If identification cannot be produced, treatment will be provided on an emergent basis only. In addition, the last five numbers of the patient's social security number and signature will be required before the release of any medical records. If the patient has authorized other individuals to pick up medical information by denoting on the patient registration, their signatures and photo identification will be required before documentation will be released.

Privacy and Information Protection Policy:

Our office utilizes a HIPAA compliant Electronic Medical Record storage system. All data collected on this form is strictly used for insurance claim purposes and never shared with outside sources. All information not stored in the secured electronic storage format are shredded and disposed of properly. By signing below, you are acknowledging that you have either received a copy of our Privacy policy or have been given access to a copy to review. It is understood that all durable medical equipment (DME) and products including, but not limited to creams, lotions, orthotics, arch supports, braces, pads, diabetic, shoes, surgical shoes, crutches, can be purchased via an outside profession vendor. The products and in-office dispensing are for the convenience of the patient: therefore, financial responsibility will be solely on the patient. All payments for such services or devices are due upon receipt of service or item unless other arrangements have been made in advance.

Signature of responsible party: ______________________________ Date: __________

Printed name: _______________