PreventiveFootCare

www.preventivefootcare.com

Phone: (804) 643-8863
505 W Leigh St, Ste. 105A
Richmond, VA 23220

Patient Information

First Name: _____ Last Name:_____ M.I.:_____

Suffix (Jr., Sr., III):_____ SS#:_____ Age:_____ Date of Birth:_____

Marital Status: O Married O Single O Domestic Partner O Divorced O Separated O Widowed O Minor

Gender: O M OF

Address:_____

City:_____ State:_____ Zip Code:_____

Contact Information: Home:( )_____ Cell:( )_____ Business:( )_____

Preferred Contact: O Home O Business O Cell

May we leave detailed messages at this number?:_____

E-mail:_____

Employed: O Yes O No Employer Name:_____ Occupation:_____

Emergency Contact:_____ Relation:_____ Phone#:( )_____

Primary Care Physician:_____ Physician Phone#:( )_____

In Order for us to file a claim on your behalf, this section must be completed in its entirety.

Responsible Party for Account (if different than patient)

Name:_____ Relationship to patient:_____

Address:_____ City:_____ State:_____ Zip Code:_____

Contact Information: Home ( )_____ Cell ( )_____ Business ( )_____

Insurance Information:

Primary Insurance Name:_____ Plan Type: O HMO O PPO Other:_____

Policy#:_____ Group#:_____ Effective Date:_____

Insured Name: :_____ Employer:_____

Date of Birth:_____ SS#:_____ Relationship to patient:_____

Secondary Insurance Name:_____ Plan Type: O HMO O PPO Other:_____

Policy#:_____ Group#:_____ Effective Date:_____

Insured Name:_____ Employer:_____

Date of Birth:_____ SS#:_____ Relationship to patient:_____

How did you hear about Preventive Foot Care?

O Google O Website O Facebook O Other Patient/Friend *Name*:_____

Physician Reference -- *Please complete the following:*

*Referring Physician Name:*_____ *Physician Phone#: ( )* _____

*Other (please specify):*_____

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INITIAL PODIATRIC HISTORY

Description of Symptoms: _____

_____

Onset of pain/disability? _____

_____

Duration of pain/disability? _____

_____

What makes it hurt? _____

_____

What makes it better? _____

_____

Describe the symptoms of pain: _____

_____

Do you have any other problems with your feet or ankles? _____

_____

MEDICAL HISTORY

List all Medical conditions you take medication for: _____

_____

List any serious injuries and the age at which they occurred:_____

_____

List any allergies and type of reaction:_____

_____

List all prior surgeries:_____

_____

List any medications you take on a daily basis – include pills, injectables, and vitamins:_____

_____

_____

_____

_____

_____

_____

Do you use: O Tobacco O Alcohol O Drugs Frequency of use:_____

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IMMUNIZATIONS

O Measles	O Influenza	O Pneumonia	O Mumps
O Typhoid	O TB	O Tetanus	O Chicken Pox
O Polio	O Other		

FAMILY HISTORY Is there a Family History of any of these disorders?

O TB	O Heart	O Migraines	O Cancer
O Kidney	O Spine	O Diabetes	O Gout
O Arthritis	O Hypertension	O Epilepsy	O Mental
O Allergies	O Other		

Height: _____ Weight: _____ Shoe Size: _____ Shoe Width: _____

Are you pregnant? _____ O Yes O No Delivery Date? _____

REVIEW OF SYSTEMS

Gastro-Intestinal	O Poor Appetite	O Excessive hunger	O Difficult chewing	O Hemorrhoids
	O Difficult swallowing	O Excessive thirst	O Nausea	O Liver Trouble
	O Vomiting food	O Abdominal pain	O Diarrhea	O Weight loss
	O Constipation	O Black Stool	O Bloody stool	O Ulcers
	O Weight loss	O Weight gain	O Belching	O Gas
	O Stomach trouble	O Appendicitis	O Indigestion	
	O Gallbladder Trouble	O Other		
Genito-Urinary	O Bladder trouble	O Excessive urination	O Scanty urination	O Difficult Urination
	O Painful urination	O Discolored urine	O Frequent urination	O Paralysis
	O Prostate trouble	O Kidney disease	O Blood in urine	O Headaches
	O Other			
Nervous	O Numbness	O Loss of feeling	O Seizure	O Forgetfulness
	O Dizziness	O Fainting	O Stroke	O Brain disease
	O Muscle jerking	O Convulsions	O Weakness	O Confusion
	O Depression	O Spine disease	O Other	
Eyes	O Eye strain	O Eye inflammation	O Vision problem	O Impaired sight
	O Eye disease	O Eye injury	O Other	
Ears/Nose/Throat	O Ear pain	O Ear noises	O Ear discharge	O Sore Mouth
	O Hearing loss	O Nose pain	O Nose bleeding	O Sore throat
	O Nose discharge	O Breathing difficulty	O Sore gums	O Speech difficulty
	O Sore mouth	O Sore throat	O Hoarseness	O Dental problems
	O Other			
Cardio-Vascular	O Chest Pain	O Pain over Heart	O Leg pain on walking	O Tiredness
	O Heart attack	O High blood pressure	O Rapid heart beat	O Weakness
	O Varicose veins	O Heart problems	O Night sweats	O Hands swell
	O Feet swell	O Other		
Respiratory	O Persistent cough	O Difficult breathing	O Bronchitis	O Coughing
	O Lung problems	O Coughing blood	O Emphysema	O Asthma
	O Wheezing	O Hay fever	O Shortness of breath	O Other
Integument	O Itching	O Psoriasis	O Bruises	O Deformed nails
	O Skin rash	O Abrasions	O Ulcerations	O Birth marks
	O Moles	O Discolorations	O Skin cancers	O Eczema
	O Hives	O Other		
Musculoskeletal	O Arthritis	O Stiffness	O Club foot	O Muscle pain
	O Joint disease	O Bursitis	O Fractures	O Sciatica
	O Sprains	O Other		
Allergies	O Penicillin	O Morphine	O Adhesive tape	O Aspirin
	O Sulfa drugs	O Antibiotics	O Any foods	O Codeine
	O Other drugs	O Any chemicals	O Other	
Hematologic	O Bleeding disorder	O Take Coumadin	O Anemia	O Jaundice
	O Take aspirin	O Other		

Signature:_____ Date:_____

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OFFICE POLICIES AND PROCEDURES

We would like to take this opportunity to personally thank you for choosing Preventive Foot Care to treat your podiatric needs and concerns. Below is a list of our office policies. Please take a moment of your time to review our policies and please do not hesitate to ask any questions. ***After reviewing the policies below, please initial next to each policy indicating you have read, understand, and will adhere to the written policies. Either typed or hand-written initials will constitute this acknowledgement.***

_____**Patient Treatment**: It is our primary goal to restore and maintain the health of your feet. We strive to provide you with the highest quality podiatric care. If you have any questions regarding your treatment, please feel free to consult with your physician who is providing your care. It is our responsibility to deliver the best health care possible. We highly value your confidence in our practice and we will make a sincere effort to satisfy all your podiatric needs.
Your initials and signature will act as an authorization and consent for treatment.

_____**Appointments**: If you are unable to keep your appointment we require that you contact our office. As a courtesy to other patients who are waiting for an appointment, we request that you call to cancel your appointment within 24 hours. Patients with 3 or more missed appointments without proper notification may be asked to transfer their records to another physician. Also as a courtesy to the doctor and to other patients, we require that you be on time for your appointment. When you are late, you put the doctor behind schedule with their other patients. If you are more than 15 minutes late you will be required to reschedule your appointment.

_____**Release of Records:** If you want your records released to another physician or facility you must sign a Release of Information form indicating who we are releasing records to, as well as, which relevant information you would like us to release. If you wish to receive a copy of your records for your personal files, you must send us a written request. Please allow 7-10 business days to have your records available. Any x-rays taken within our office are our personal property which we are legally responsible to maintain with your records. Therefore we DO NOT release our films. Copies are available upon request.

_____**Referrals:** If your insurance company requires a referral, it is your responsibility for obtaining it. The contract is between you and your insurance carrier. Therefore, we are not responsible to obtain your referral. If you present to the office without your referral you will be required to reschedule your appointment or you may opt to payout of pocket for services rendered. Referrals must be generated from your primary care physician or referring doctor.

_____**Insurance:** Your insurance coverage is a contract between you and your insurance company. We are not a party to this contract. We will bill your insurance company (primary and secondary, if applicable) as a courtesy. Your insurance company does not guarantee payment for services rendered. Your insurance company makes the final determination of benefits and eligibility at the time the claim is reviewed. By signing the line below you hereby agree that you understand you are solely responsible to pay any portion of charges not covered by your insurance carrier.

_____**Verification of Benefits:** You as the policyholder are primarily responsible to know your insurance benefits. We may assist you, if time permits to verify your podiatric coverage available under your policy. The insurance DOES NOT guarantee payment of the benefits quoted and subsequently you will be responsible for any coinsurance or deductibles for services not covered by your insurance carrier. We must have a copy of your insurance card and photo ID in order to process your claim. Therefore, please give your cards to the receptionist. If you are a first- time patient, or if your insurance information has changed, we must be notified. Failure to cooperate will mean that you will be responsible for the charges incurred.

_____**Required Payments:** You be will be responsible to pay any co-payment, deductible, coinsurance, or fees not covered by your insurance carrier at the time services are rendered. We do not accept letters of protection. Any outstanding balances greater than 60 days must be paid prior to being seen by the physician or you will be required to reschedule your appointment. You may choose to pay by cash, check, or Credit Card.

_____**Monthly Statements:** You will receive a statement only if you have an outstanding balance on your account. The statement will reflect any balance pending with your insurance carrier as well as any outstanding balance for services not covered by your insurance company. We request that if you receive a statement, that you make payment within 30 days of receipt. If your balance becomes delinquent past 60 days, your account will be referred to a collection agency.

Signature:_____ Date:_____

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NOTICE OF PRIVACY PRACTICES

This page serves to inform you of the privacy practices of Preventive Foot Care and its representatives. The privacy of your medical information is important to us. We intend to honor your privacy in every way possible. By signing below you will allow us to disclose your personal health information:

I,_____ understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- O A basis for planning my care and treatment
- O A means of communication among the many health professionals who contribute to my care
- O A source of information for applying my diagnosis and evaluation information to my bill
- O A means by which a third-party payer can verify that services billed were actually provided
- O A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I have reviewed and understand the Notice of Information Practices. I understand that I have the right to review the complete policy prior to signing this consent. I understand that the organization reserves the right to change their notice and practices. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

We respect your rights in maintaining the utmost in privacy in regards to your individual health information. We will not release any of your health information to non-medical entities without your prior written permission. Preventive Foot Care maintains physical and electronic safeguards that restrict unauthorized access to your health information. Such safeguards include secured office facilities, locked file cabinets and controlled computer network systems and password accounts.

We will only disclose your medical information to your health plan or other health care professionals or facilities for purposes of diagnosis or treatment of your medical condition. If you prefer that we do not disclose any or all of your medical condition(s), please inform us so that we may take any necessary precautions.

- O No restrictions
- O I request the following restrictions to the use or disclosure of my health information:

_____
_____
_____
_____
_____

_____ _____
Signature of Patient / Legal Representative / Witness Date