LOWCOUNTRY FAMILY PODIATRY

(PLEASE **PRINT** IN **BLUE** OR **BLACK** INK ONLY)

DATE: _____/_____/_____

PATIENT NAME: _____ _____ _____
LAST FIRST MI

DATE OF BIRTH: _____/_____/_____ SEX: M F SSN: _____-_____-_____

HOME ADDRESS: _____

LOT/APT #: _____CITY/STATE: _____ ZIP: _____

MAY WE LEAVE A MESSAGE?

HOME PHONE #: (_____) _____-_____ YES NO

CELL PHONE #: (_____) _____-_____ YES NO

WORK PHONE #: (_____) _____-_____ YES NO

E-MAIL: _____ YES NO
(NEEDED FOR EASIER SET UP OF ONLINE PATIENT PORTAL AND SO THAT YOU MAY RECEIVE EMAIL NOTIFICATIONS WHEN SOMETHING HAS BEEN UPDATED ON YOUR PORTAL)

PRIMARY LANGUAGE: _____ PREFERRED CONTACT METHOD: _____

RACE: _____ HISPANIC/LATINO: Y N

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

EMERGENCY CONTACT: _____ PHONE #: (_____) _____-_____
RELATIONSHIP: _____

PRIMARY CARE DOCTOR: _____ WHO REFERRED YOU TO US? _____

PHARMACY: _____ PHONE #: (_____) _____-_____

LOCATION: _____

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION? (THIS INCLUDES APPT INFORMATION, ACCOUNT INFORMATION AND PRESCRIPTION/REFILL INFORMATION.)

_____ YES NAME(S) _____

_____ NO

WHO IS RESPONSIBLE FOR PAYMENT? _____ RELATIONSHIP TO PATIENT? _____

ADDRESS: _____

CITY/STATE: _____ ZIP: _____

PHONE #: (_____) _____-_____

FINANCIAL STATEMENTS: ☐ MAIL ☐ PATIENT PORTAL ☐ BOTH
STATEMENTS CAN BE MAILED OR SENT THROUGH THE PATIENT PORTAL OR BOTH. PLEASE CHOOSE AN OPTION ON HOW YOU WOULD LIKE TO RECEIVE YOUR STATEMENTS.

PATIENT NAME: _____
DATE OF BIRTH: ____/____/_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME DOSE HOW OFTEN DO YOU TAKE?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY DATE TYPE OF SURGERY DATE

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

SOCIAL HISTORY

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ ☐ SMOKE ____ PACKS/DAY FOR ____ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ TYPE _____
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

EMPLOYER: _____ OCCUPATION: _____

FAMILY HISTORY (IMMEDIATE FAMILY – MOM, DAD, SISTER, BROTHER, SON, DAUGHTER)

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES ☐ CANCER ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE
☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE ☐ RHEUMATOID ARTHRITIS
☐ EPILEPSY ☐ HIGH CHOLESTEROL ☐ DEGENERATIVE JOINT DISEASE ☐ HISTORY UNAVAILABLE
☐ OTHER _____

YOUR MEDICAL HISTORY

ALLERGIES: ☐ NONE KNOWN ☐ ANESTHESIA _____

☐ MEDICATIONS _____
_____
☐ TAPE ☐ LATEX ☐ IODINE ☐ OTHER _____

PATIENT NAME: _____
DATE OF BIRTH: _____/_____/_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y	N		FIBROMYALGIA	Y	N		NEUROPATHY	Y	N
ANEMIA	Y	N		GOUT	Y	N		SICKLE CELL DISEASE	Y	N
ARTHRITIS	Y	N		HEART ATTACK	Y	N		SKIN DISORDER	Y	N
ASTHMA	Y	N		HEART DISEASE/FAILURE	Y	N		STOMACH ULCERS	Y	N
BACK TROUBLE	Y	N		HEPATITIS	Y	N		STROKE	Y	N
ABNORMAL BLEEDING	Y	N		HIV+/AIDS	Y	N		THYROID DISEASE	Y	N
BLOOD CLOTS	Y	N		HIGH BLOOD PRESSURE	Y	N		TUBERCULOSIS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N		KIDNEY DISEASE	Y	N		DIABETES	Y	N
CANCER	Y	N		LIVER DISEASE	Y	N			Y	N
OTHER CONDITIONS:										

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ YES (DESCRIBE) _____ ☐ NO

IF YES, WAS IT A WORK-RELATED INJURY? ☐ YES ☐ NO

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

_____ _____ _____

PRINT NAME SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE

CONSENT FOR TREATMENT/MEDICAL RELEASE AUTHORIZATION:

I HEREBY AUTHORIZE LOWCOUNTRY FAMILY PODIATRY TO GIVE ME MEDICAL TREATMENT. I UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE ANY PROCEDURE/TREATMENT AT ANY TIME. I UNDERSTAND THAT I HAVE THE RIGHT TO DISCUSS ALL MEDICAL TREATMENTS WITH MY PROVIDER. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION THAT IS NECESSARY TO PROCESS INSURANCE CLAIMS. I UNDERSTAND THAT ONLY THE BARE MINIMUM INFORMATION NEEDED TO PROCESS THE CLAIM WILL BE GIVEN TO THE INSURANCE COMPANY. I AUTHORIZE LOWCOUNTRY FAMILY PODIATRY TO RELEASE MEDICAL INFORMATION TO ANY REFERRING PHYSICIAN FOR THE PURPOSE OF TREATMENT.

_____ _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE

ASSIGNMENT OF BENEFITS:

I HEREBY ASSIGN TO LOWCOUNTRY FAMILY PODIATRY ANY INSURANCE OR THIRD-PARTY BENEFITS AVAILABLE FOR HEALTH CARE SERVICES PROVIDED TO ME. IF THESE BENEFITS ARE NO ASSIGNED TO LOWCOUNTRY FAMILY PODIATRY, I AGREE TO FORWARD TO LOWCOUNTRY FAMILY PODIATRY ALL HEALTH INSURANCE AND THIRD-PARTY PAYMENTS THAT I RECEIVE FOR SERVICES RENDERED TO ME IMMEDIATELY UPON RECEIPT.

_____ _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE

MEDICARE INSURANCE:

I REQUEST PAYMENT OF MEDICARE BENEFITS BE PAID TO LOWCOUNTRY FAMILY PODIATRY FOR ANY SERVICES RENDERED TO ME BY THIS PROVIDER. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION THAT IS NECESSARY TO PAY THE CLAIM TO THE HEALTH CARE FINANCING ADMINISTRATION. IF I HAVE OTHER HEALTH INSURANCE IN ADDITION TO MEDICARE, I AUTHORIZE THE RELEASE OF MEDICAL AND CLAIMS INFORMATION TO THIS INSURANCE AS WELL. I AUTHORIZE HEALTH CARE FINANCING ADMINISTRATION TO RELEASE INFORMATION TO PROCESS CLAIMS FOR MEDIGAP OR SECONDARY INSURANCE.

_____ _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE

LOWCOUNTRY FAMILY PODIATRY

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, HEREBY ACKNOWLEDGE THAT I HAVE REVIEWED OR RECEIVED A COPY OF LOWCOUNTRY FAMILY PODIATRY'S PRIVACY PRACTICES.

_____ _____

SIGNATURE DATE

E-PRESCRIBING CONSENT

EPRESCRIBING IS DEFINED AS A PHYSICIAN'S ABILITY TO ELECTRONICALLY SEND AN ACCURATE, ERROR FREE AND UNDERSTANDABLE PRESCRIPTION DIRECTLY TO A PHARMACY FROM THE POINT OF CARE. EPRESCRIBING GREATLY REDUCES MEDICATION ERRORS AND ENHANCES PATIENT SAFETY. THE MEDICARE MODERNIZATION ACT (MMA) OF 2003 LISTED STANDARDS THAT HAVE TO BE INCLUDED IN AN EPRESCRIBE PROGRAM. THESE INCLUDE:

- FORMULARY AND BENEFIT TRANSACTIONS – GIVES THE PRESCRIBER INFORMATION ABOUT WHICH DRUGS ARE COVERED BY THE DRUG BENEFIT PLAN.
- MEDICATION HISTORY TRANSACTIONS – PROVIDES THE PHYSICIAN WITH INFORMATION ABOUT MEDICATIONS THE PATIENT IS ALREADY TAKING TO MINIMIZE THE NUMBER OF ADVERSE DRUG EVENTS.

BY SIGNING THIS CONSENT FORM YOU ARE AGREEING THAT LOWCOUNTRY FAMILY PODIATRY CAN REQUEST AND USE YOUR PRESCRIPTION MEDICATION HISTORY FROM YOUR PHARMACY AND EPRESCRIBE YOUR PRESCRIPTIONS TO THE PHARMACY OF YOUR CHOICE.

_____ _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE

FINANCIAL POLICY

PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. WE ACCEPT VISA, MASTERCARD, DISCOVER, CASH OR CHECK. THERE IS A $30.00 FEE FOR ANY RETURNED CHECK. THERE IS A $10.00 SERVICE FEE ADDED TO ACCOUNTS THAT ARE NOT PAID ON THE DATE OF SERVICE.

AS A COURTESY, LOWCOUNTRY FAMILY PODIATRY VERIFIES YOUR BENEFITS WITH YOUR INSURANCE COMPANY. A QUOTE OF BENEFITS IS NOT A GUARANTEE OF PAYMENT. YOUR CLAIM WITH PROCESS ACCORDING TO YOUR PLAN. IF YOUR CLAIM PROCESSES DIFFERENTLY FROM THE BENEFITS WE WERE QUOTED, YOUR INSURANCE COMPANY WILL SIDE WITH THE PLAN AND NOT THE BENEFITS QUOTED.

WE DO REQUIRE PRE-PAYMENT FOR OUTPATIENT SURGERIES AND YOU WILL BE NOTIFIED OF THE AMOUNT ONCE WE PRECERT IT WITH YOUR INSURANCE COMPANY.

IT IS YOUR RESPONSIBILITY TO KEEP US INFORMED OF ANY CHANGES TO YOUR INFORMATION, ESPECIALLY INSURANCE CHANGES. YOU ARE RESPONSIBLE FOR PAYMENT IF YOU FAIL TO PROVIDE US WITH THE CORRECT INFORMATION.

PAST DUE ACCOUNTS ARE SUBJECT TO COLLECTION PROCEEDINGS. ALL COSTS INCURRED DURING THE COLLECTION PROCESS WILL BE YOUR RESPONSIBILITY INCLUDING ATTORNEY AND COURT FEES.

WE REQUIRE AT LEAST 24 HOURS NOTICE WHEN CANCELLING APPOINTMENTS. THERE IS A $40.00 FEE FOR MISSED/NO-SHOW APPOINTMENTS.

_____ _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE