

PATIENT HEALTH HISTORY

Name _____ Age _____ Height _____ Weight _____

Family Doctor: _____ Last visit _____ Specialist _____

Allergies: NONE Tape(what type) Rubber/latex Seasonal Food Other _____

Allergies to medications: _____ Reaction _____

_____ Reaction _____

List of current medications you are taking: (Continue on back if list is longer than the space available)

Pharmacy used: _____ Location/Phone _____

Surgeries - Indicate what type/year Hospitalized(not surgeries) Indicate why/year

What problem brings you to the Doctor today? _____

Have you ever been to a Podiatrist before? NO YES For what problem? _____

FOOT AND ANKLE

Have you ever broken a bone in your foot or ankle? NO YES

Where _____ When _____

Have you had a problem with this area since that time?

If so, what problem _____

What is your normal shoe size? _____ What type of shoe do you normally wear? _____

Do you go barefooted? (Circle one) Never Rarely Occasionally Often As much as I can

Do you smoke? NO YES Amount per day _____ Cigarettes Cigar Other How long? _____

Do you drink alcohol? NO YES Amount per day _____ Beer Wine Liquor How long? _____

I hereby give permission to Dr Hyman, Dr Wadington, and to whomever they designate to administer treatment and to perform such procedures as we may deem necessary in the diagnosis and/or treatment of the extremity condition.

Signature of Patient or Legal Guardian _____ Date _____

PLEASE CIRCLE ANY OF THE FOLLOWING THAT YOU HAVE HAD

HEENT

Nose bleeds
 Difficulty Swallowing
 Difficulty Chewing
 Visual Problems
 Glaucoma
 Cataracts

CARDIOVASCULAR

Chest pain/Angina
 Heart Attack
 Heart Disease
 High Cholesterol
 Low Blood Pressure
 High Blood Pressure

SKELETAL/MUSCULAR

Rash
 Gout
 Arthritis
 Sore not healing
 Limited joint motion
 Back Problems

LIVER

Hepatitis
 Jaundice/
 Yellow Skin
 Other _____

MENTAL HEALTH

Glasses
 Contact Lenses
 Hearing problems
 Sore in mouth that
 will not heal
 Thyroid problem
 Other _____

Abnormal EKG
 Swelling of Feet
 or ankles
 Abnormal Heartbeat
 Rapid Heart Rate
 Artificial Heart Valve
 Pacemaker
 Blood Clot in leg
 Other _____

Other _____

Depression
 How long? _____
 Medication _____

NEUROLOGICAL

Numbness of the
 arms or legs
 Fainting/Dizziness
 Seizures/Epilepsy
 Stroke
 Headaches
 Migraine Headaches
 Other _____

RESPIRATORY

Asthma
 Lung Disease
 Abnormal Chest X-ray
 Shortness of Breath
 Use Oxygen at home
 Tuberculosis
 Blood clot in lung

GASTROINTESTINAL

Abdominal Pain
 Hiatal Hernia
 Nausea or vomiting
 Constipation
 Diarrhea
 Change in Appetite
 Unexplained weight loss
 Heartburn
 Gall Bladder Problem
 Stomach Ulcer
 Other _____

Anxiety
 Panic Attacks
 Agoraphobia
 Obsessive/
 Compulsive
 Disorder
 Schizophrenia
 Chemical
 Dependency
 Other _____

HEMATOLOGICAL

Anemia
 Bleeding Disorder
 Hemophilia
 Sickle Cell Anemia
 HIV Positive
 Other _____

Chronic cough
 Blood in sputum
 Emphysema
 Other _____

GENITOURINARY

Difficulty Urinating
 Frequent infections
 Prostate problems
 Dialysis-Type
 (Hemo) (Peritoneal)
 Kidney problems
 Abnormal Female
 What? _____
 Bleeding
 Other _____

OTHER DIAGNOSIS

Diabetic YES NO
 When diagnosed _____

Medications _____

Have you been
 exposed to any
 infectious disease
 in the last month?

Cancer
 Where? _____
 When? _____

Are there any other medical conditions the doctor should be aware of? Please mention here: _____

Do any one of your blood relatives have any of the following conditions? (Circle these)

Diabetes Cancer Gout Heart Disease High Blood Pressure Tuberculosis

Mountain Podiatry, P.A.

Welcome New Patient / Insurance Information

Last Name _____	First Name _____	MI _____	Date of Birth _____
Street Address _____	City _____	State _____	ZIP _____
Home Phone _____	Cell Phone _____	How would you like to be addressed? _____	
Employer _____	Occupation _____	Work Phone _____	
Employer Address _____	Social Security # _____		
Name of Spouse _____	How did you learn of our Office? (Please give names) _____		

Who is responsible for payment of this account? _____	Relationship to patient _____		
If other is responsible for account:			
Last Name _____	First Name _____	MI _____	Date of Birth _____
Street Address _____	City _____	State _____	ZIP _____
Home Phone _____	Cell Phone _____	Social Security # _____	
Employer _____	Occupation _____	Work Phone _____	
Employer Address _____			
I, the undersigned, certify that I (or my dependent) have insurance coverage as represented by the cards presented and assign directly to Mountain Podiatry, P.A. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that with or without insurance I am financially responsible for all charges whether or not paid by the insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize this signature in all insurance submissions.			
Responsible party signature _____	Relationship _____	Date _____	
Please make sure to give the receptionist your insurance card(s) to make a copy of them			

FOR OUR MEDICARE PATIENTS

To your knowledge, have you met your deductible this year? ___ Yes ___ No

Medicare Authorization

I request that the payment of authorized Medicare benefits be made on my behalf to Mountain Podiatry, P.A. for any services furnished to me by the physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If 'other health insurance' is indicated in item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurances and deductibles are based upon the charge determination of the Medicare carrier .

Beneficiary Signature: _____ **Date:** _____



Mountain Podiatry, PA

Scott Hyman, DPM, AACFAS
Bradley Wadington, DPM, AACFAS
2315 Asheville Hwy #10 317 Chestnut Street
Hendersonville, NC 28791 Brevard, NC 28712

Patient Financial Policy

Due to the complicated nature of health insurance, your understanding of our financial policies is essential to your care and treatment. If you any questions, please do not hesitate to ask our front office staff.

- ❖ As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- ❖ Unless other arrangements have been made in advance by you, payment for office services are due at the time of service. We accept cash, check, VISA and MasterCard.
- ❖ Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance pay the doctor directly.
- ❖ We have made prior arrangements with most insurers to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.
- ❖ If you have insurance coverage with a plan we do not have a prior agreement, the payment will be sent directly to you, per their protocol. Therefore, we will require payment for services 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 authorization, you will be responsible for the complete charge. **We will always attempt to verify benefits for some specialized services; however, you remain responsible for charges to any services rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered if they have any doubt of coverage.**
- ❖ 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.
- ❖ If you have Medicare and have a secondary insurance, Medicare will send claims to your secondary insurance for free. You need only call once to give them the information of your secondary insurance .
- ❖ Past due accounts are subject to collection proceedings. All fees including, but not limited to collection fees, attorney fees, and court fees shall become your responsibility in addition to the balance due this office.
- ❖ There is a service charge of \$25.00 for all returned checks. Your insurance company does not cover this fee.
- ❖ There is a \$20 fee for appointments missed without 24 hour notification.

Signature of patient/responsible party _____

Printed name of patient/responsible party _____ Date: _____