Mountain Podiatry, PA

# Acknowledgement of Receipt Of Notice of Privacy Practices

Patient Name & Address: _____

_____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Signature Date

For Office Use Only

**We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:**

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason:

  _____
- ❑ Other: _____

  _____

Prepared By _____

Signature _____

Date _____

# PATIENT HEALTH HISTORY

Name _____ Age_____ Height_____ Weight_____ Last Blood Pressure _____/_____

(Following are government mandated questions): Race _____ ☐ do not wish to answer
Ethnicity _____ ☐ do not wish to answer

Family Doctor:_____ Last Visit:_____ Specialist:_____

**Allergies: NONE TAPE (what type) Rubber/Latex Seasonal Food Other_____**

**Medication Allergies:**_____ _____ _____

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

_____ _____

_____ _____

_____ _____

Have you received a flu shot? NO YES

Have you received a pneumonia shot? NO YES

Pharmacy used: _____

Location/Phone #_____

Surgeries- Indicate what type/year:

Hospitalized (not surgeries) Indicate why/year

_____ _____

_____ _____

_____ _____

What specific problem with your foot 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? _____

Circle any of these that you have had:

| | |
|---|---|
| Ankle Pain | Foot Cramps |
| Athlete's Foot | Heel Pain |
| Bunions | Ingrown Toenail |
| Corns | Plantar Warts |
| Calluses | Swollen Feet |
| Flat Feet | Tired Feet |

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 _____ How Long? _____ Have you EVER smoked? NO YES

Do you drink alcohol? NO YES Amount Per Day _____ Beer Wine Liquor How Long? _____

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

Signature of Patient or Legal Guardian_____ Date_____

Name: _____ Date of Birth: _____ Date: _____

## PLEASE CHECK IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING

### HEENT
- ◯ Difficulty Swallowing
- ◯ Glaucoma
- ◯ Cataracts
- ◯ Hearing Problems
- ◯ Thyroid Problems
- ◯ Other:

### CARDIOVASCULAR
- ◯ Chest Pain/Angina
- ◯ Heart Attack
- ◯ Heart Disease
- ◯ High Cholesterol
- ◯ High Blood Pressure
- ◯ Low Blood Pressure
- ◯ Abnormal EKG
- ◯ Swellling of feet/Ankles
- ◯ Abnormal Heart Beat
- ◯ Artificial Heart Valve
- ◯ Pacemaker
- ◯ Blood Clot in Leg
- ◯ Other:

### SKELETAL/MUSCULAR
- ◯ Gout
- ◯ Arthritis
  TYPE: _____
- ◯ Sore that does not heal
- ◯ Limited Joint Motion
- ◯ Back Problems
- ◯ Other:

### LIVER
- ◯ Hepatitis
- ◯ Jaundice
- ◯ Other:

### NEUROLOGICAL
- ◯ Numbness in Legs/Feet
- ◯ Fainting/Dizziness
- ◯ Seizure
- ◯ Epilepsy
- ◯ Stroke
- ◯ Other:

### RESPIRATORY
- ◯ Asthma
- ◯ Lung Disease/COPD
- ◯ Emphysema
- ◯ Abnormal Chest Xray
- ◯ Shortness of Breath
- ◯ Use of Oxygen at Home
- ◯ Tuberculosis
- ◯ Blood Clot in Lung
- ◯ Other:

### GASTROINTESTINAL
- ◯ Abdominal Pain
- ◯ Hiatal Hernia
- ◯ Unexplained Weight Loss
- ◯ Heartburn
- ◯ GERD
- ◯ Stomach Ulcer
- ◯ Other:

### MENTAL HEALTH
- ◯ Depression
- ◯ Panic Attacks
- ◯ OCD
- ◯ Schizophrenia
- ◯ ADD
- ◯ Bipolar
- ◯ Other:

### GENITOURINARY
- ◯ Difficulty Urinating
- ◯ Frequent Infections
- ◯ Prostate Problems
- ◯ Kidney Problems
- ◯ Dialysis
- ◯ Other:

### HEMATOLOGICAL
- ◯ Anemia
- ◯ Bleeding Disorder
- ◯ Hemophilia
- ◯ Sickle Cell Anemia
- ◯ HIV/AIDS
- ◯ Other:

### CANCER
_____ YES _____ NO

**WHAT TYPE:**

**WHEN:**

### ANY OTHER CONDITIONS?

*** **ARE YOU A DIABETIC?** _____ YES _____ NO

*** **Do you need antibiotics before cleanings at the dentist?** _____ YES _____ NO

**PLEASE LIST ANY FAMILY MEMBERS (BLOOD RELATIVES) THAT HAVE ANY OF THE FOLLOWING:**

Diabetes Cancer Gout Heart Disease High Blood Pressure Other

# 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_____

Social Security Number _____

Marital Status: (S) (M) (D) (W) Name of Spouse_____ Phone Number_____

Emergency Contact_____ Phone Number_____

How did you learn of our office? _____

Who is responsible for payment on this account? _____ Relationship to patient_____

Last Name_____ First Name_____ MI____ Date of Birth_____

Street Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Social Security Number _____

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 assigned 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 give the receptionist your insurance card(s) to make copies of.**

## 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 request that payment be made and authorizes release of medical information necessary to pay the claim. If 'other health insurance' is indicated in the item 9 of 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** _____

MountainPodiatry

Scott Hyman, DPM  Bradley Wadington, DPM  Devin Grant, DPM

2315 Asheville Hwy #10
Hendersonville, NC 28791
Phone (828) 697-8686

200 Julian Ln Ste 230
Arden, NC 28704
Fax (828) 697-0960

## 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 have any question, 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, payment for office services are due at the time of service. We accept cash, 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, coinsurance, and/or 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 'non covered,' or you do not have an authorization, you will be responsible for the complete charge. We will always attempt to verify benefits for 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 authorizations 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 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 to this office.
* There is a service charge of $25.00 for all returned checks. Your insurance company does not cover this.
*There is a $20.00 fee for appointments missed without 24 hour notice.

**Signature of patient/responsible party**_____

**Printed name of patient/responsible party** _____ **Date**_____

# Authorization for Release of Information

Name of Patient_____ Date of Birth _____

**MOUNTAIN PODIATRY** is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

**Entity to Receive Information:**
Check each person/entity that you approve to receive information.

May we leave a voice mail? ◯ YES ◯ NO

◯ Spouse _____

◯ Parent _____

◯ Other _____

**Description of information to be released:**
Check which type of information may be given.

◯ Results of lab test/x-rays
◯ Medical as follows: _____
◯ Financial
◯ Other

**Patient Information**

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

*I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.* This authorization shall be in effect until revoked by the patient.

_____ Date_____
Signature of Patient or Representative

Description of Personal Representative's Authority (Attach necessary documentation)

_____