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 _____

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:_____How would you like to be addressed:_____

Employer:_____Occupation:_____Work Phone:_____

Email:_____ Marital Status: (S) (M) (D) (W) Name of Spouse:_____

Primary Insurance:_____Secondary Insurance:_____

Emergency contact:_____ Phone Number:_____

How did you hear about our office?_____

Responsible party for payment other than patient:_____Relationship:_____

Last Name:_____First Name:_____MI_____DOB:_____

Address:_____City_____State_____Zip_____

Home Phone:_____Cell:_____Work:_____

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, PA 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 payments of benefits. I authorize the doctor to release all information necessary to secure payments of benefits. I authorize this signature in all Insurance submissions.

Responsible Party Signature:_____Date_____

Please give the receptionist your insurance card(s) to make copies of. Patients that no show or do not give a 24 hour notice to cancel their appointment may be subject to a $50.00 fee.

Acknowledgment of Receipt of Notice of Privacy Practices

Would you like to receive a copy of the Notice of Privacy Practices? _____Yes ____No

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

_____ _____

Signature Date

Master

NEW 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 is more space is needed)

_____ _____

_____ _____

_____ _____

Have you had a flu shot? NO YES Have you received a pneumonia shot? NO YES

What pharmacy do you wish to use:_____Location:_____

Surgeries – Indicate what type and year: Hospitalized (not surgery) Indicate why/year

_____ _____

_____ _____

_____ _____

What specific problem with your foot brings you to the Doctor today?_____

Have you ever been to a Podiatrist before? Yes No For what problem?_____

Have you ever broken a bone in your foot or ankle? No Yes

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?_____

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

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?_____

*****ARE YOU DIABETIC? _____YES _____NO**

****Do you need antibiotics before cleaning at the dentist? _____Yes _____No**

ALL PATIENTS: I hereby give permission to Drs. Hyman and Wadington and their assistants to exam, administer treatment, and to perform such procedures as they deem necessary for my condition after reviewing a treatment plan.

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 ____Other ____None

CARDIOVASCULAR ____Chest Pain ____Heart Attack ____Heart Disease ____High Cholesterol

____High Bood Pressure ____Abnormal EKG ____Low Blood Pressure ____Swelling Feet/Ankles ____Abnormal Heartbeat

____Artificial Heart Valve ____Pacemaker ____Blood Clot in Leg ____Other ____None

SKELETAL/MUSCULAR ____Gout ____Arthritis ____Sore that does not heal ____Limited Joint Motion

____Back Issues ____Other ____None

LIVER ____Hepatitis (type)_____ ____Jaundice ____None

NEUROLOGICAL ____ Neuropathy ____Numbness ____Stroke ____Drop Foot ____ None

RESPIRATORY: ____Asthma ____COPD ____Emphysema ____Abnormal Chest X-Ray ____use Oxygen

____Blood Clot in Lungs ____Other ____None

GASTROINTESTINAL ____Stomach/GI issues ____Stomach Ulcer ____Reflux ____None

MENTAL HEALTH ____Depression ____Panic Attacks ____OCD ____Schizophrenia ____ADD

____Bipolar ____Other ____None

GENITOURINARY ____Kidney Disease ____Other ____None

HEMATOLOGICAL ____Anemia ____Bleeding Disorder ____HIV/AIDS ____Other ____None

CANCER ____Yes ____No What type_____When_____

ANY OTHER CONDITIONS? _____

PLEASE LIST ANY FAMILY MEMBERS (BLOOD RELATIVES) THAT HAVE ANY OF THE FOLLOWING:
Diabetes Cancer Gout Heart Disease High Blood Pressure Other

MEDICARE PATIENTS: 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 Finance Admin 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 the release of medical information necessary to pay the claim. If "other 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 non-covered services. Coinsurances and deductibles are based upon the Charge determination of the Medicare Carrier.

Beneficiary Signature:_____**Date:**_____

MOUNTAIN PODIATRY

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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 $50 fee for appointments missed without 24 hour notification.

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)

_____