NEUHAUS FOOT & ANKLE

Welcome To Our Office

Patient Information Sheet

NAME

First:_____ **MI:**_____ **Last:**_____

Social Security Number#_____-_____-_____ **Date of Birth**_____

Circle Gender: M / F Race _____ Ethnicity _____ Language _____

Mailing Address:_____

City:_____ **State:**_____ **Zip:**_____

Home Ph #: (_____)_____**Cell Ph #: (**_____)_____

Emergency Contact:_____ Ph #: (____)_____

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Pharmacy Name:_____**Pharmacy Number:**_(____)__ _____

Pharmacy Address/ Street_____

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

Name of Doctor and/or Friend that referred you:_____

E-mail Address:_____

Primary Insurance Company Information:	**Secondary** Insurance Company Information:
Policy Holder Last Name: _____	**Policy Last Name:** _____
Policy Holder First Name: _____	**Policy Holder First Name:** _____
Policy Holders SS# : _____-_____-_____ **Policy Holders Date of Birth:** _____ / _____ / _____	**Policy Holders SS# :** _____-_____-_____ **Policy Holders Date of Birth:** _____ / _____ / _____
Gender: ☐ Male ☐ Female **Relationship to Policy Holder:** ☐Self ☐Spouse ☐Child ☐Other	**Gender:** ☐ Male ☐ Female **Relationship to Policy Holder:** ☐Self ☐Spouse ☐Child ☐Other
Policy Holder's Address: ☐ **Same as patient**	**Policy Holder's Address:** ☐ **Same as patient**
City: _____ **State:**_____ **Zip:** _____	**City:** _____ **State:** _____ **Zip:** _____
Insurance's Name: _____	**Insurance's Name:** _____
Policy ID: _____ **Group #:**_____ **Claim Submission Address:**	**Policy ID:**_____ **Group #:**_____ **Claim Submission Address:**
Effective Date: _____ / _____ / _____ **Referral Required:** ☐ Yes ☐ No	**Effective Date:** _____ / _____ / _____ **Referral Required:** ☐ Yes ☐ No
Do you have a Co-pay? ☐ No ☐ Yes, Amt $ _____	**Do you have a Co-pay?** ☐ No ☐ Yes, Amt $_____

_____ _____

Patient Signature (Parent or Guardian if patient under 18 years old) Date

NEUHAUS FOOT & ANKLE

Patient Name: _____ **Date:** _____

Reason for your visit today: _____

When did problem start? _____

Previous treatment condition? ☐ Y ☐ N

Treatment by: _____ **Date treated:** _____

Check all treatments received for this condition:

☐ Pain Medication	☐ Antibiotics	☐ MRI
☐ Injection	☐ Surgery	☐ CT Scan
☐ X-rays	☐ Bone Scan	☐ Hospitalization
☐ Physical Therapy	☐ Ice/Stretching	☐ Other:_____

►Vitals

Weight: _____Height: _____ Shoe Size:_____

►Patient Medical History

Have you been diagnosed with any of the following? Please circle all that apply. None

- Anemia
- Arthritis
- Back Problems
- Blood Clots
- Depression
- Diabetes
- Emphysema
- Fibromyalgia
- Glaucoma
- Gout
- Heart Attack
- High Blood Pressure
- HIV+/AIDS
- Heart Disease
- High Cholesterol
- Irregular Heartbeat
- Kidney Stones
- Kidney Disease
- Liver Disease (hepatitis)
- Stomach Ulcers/Reflux
- Stroke
- Thyroid Disorder
- Tuberculosis
- Other_____

►Social History

Please answer the following:

- Occupation: _____
- Marital Status? Circle: Single Married Divorced Widowed
- Use of Alcohol? ☐ No ☐ Yes (If yes, how much?)_____
- Use of Tobacco? ☐ No ☐ Yes (If yes, how much?)_____
- Use of Drugs? ☐ No ☐ Yes (If yes, type/frequency)_____

(Office Use ONLY: BP _____ P_____)

►Allergies

☐ None or List all known allergies:

_____

_____

_____

►Family History

Has anyone in your family been diagnosed with any of the following? **None**

☐ Arthritis
☐ Cancer
☐ Diabetes
☐ Heart disease
☐ High blood pressure
☐ Stroke

►Current Medications

☐ None or ☐ See Attached List

_____

_____

_____

►Review of Systems

(Please check all conditions and symptoms that you currently have)

General	__Fever	__Chills	__Weight loss/gain	__Appetite loss
Eyes	__Blurry vision	__Double vision	__Poor vision	__Glasses
Ear/Nose/Throat	__Ringing ears	__Sinus congestion	__Hearing Loss	__Sore throat
Heart	__Chest pain	__Irreg. heart beat	__Leg cramps w/ walking	__Murmur
Lungs	__Cough	__Shortness of breath	__Difficulty breathing	__Snoring
Digestive	__Nausea	__Stomach ulcer	__Constipation	__Diarrhea
Urinary	__Burning	__Frequent urination	__Incontinence	__Impotence
Musculoskeletal	__Joint pain	__Muscle weakness	__Joint stiffness	__Deformity
Skin	__Rash	__Sores/Ulcers	__Abnormal scar	__Dry skin
Neurological	__Numbness	__Tingling feet	__Poor balance	__Sciatica
Psychiatric	__Depression	__Mood swings	__Anxiety	__Nervousness
Peripheral Vasc	__Varicose veins	__Leg/foot swelling	__ft pain with sleeping	__Leg cramps
Endocrine	__Hair loss	__Excessive thirst	__Fatigue	__Frequent Urination
Hematological	__Leg swelling	__Bleeding tendency	__Bruise easily	__Slow to heal
OB/GYN	__Pregnant	__Birth control pills	__Hormone therapy	__Menopausal

►Previous Surgeries ☐ None or Please list procedure and date performed:

_____

_____

_____

_____

Patient Signature (Parent or Guardian if patient under 18 years old) **Date:**

Neuhaus Foot & Ankle Financial Agreement

I hereby give Neuhaus Foot and Ankle consent for medical treatment.

Date: _____ Print patient name:_____

Signature: _____

Physicians/Providers at Neuhaus Foot and Ankle are committed to providing you with the best possible medical care. In order to achieve this goal, we need your assistance, and your understanding of our payment policy.

PAYMENTS FOR SERVICE IS DUE AT THE TIME SERVICES ARE RENDERED. We accept cash, personal checks, MasterCard, Visa, Discover and Care Credit. Returned checks are subject to a service charge of $30.00-$40.00 or 5% whichever amount is greater, and you will lose the privilege to write checks in our office.

MEDICARE – Your deductible and 20% of the allowable charges are due at the time of service.

COMMERCIAL INSURANCE – **CO-PAYMENT AND DEDUCTIBLE MUST BE PAID AT THE TIME OF SERVICE.** Because we are under contract with your insurance company, we will file your insurance, provided the information is current and given to our office in a timely manner.

HMO INSURANCE -- It is your responsibility to obtain a referral from you PCP prior to you appointment. If a referral is not obtained, the appointment will be rescheduled.

WORKERS COMPENSATION - It is your responsibility to call your employer to get the visit authorized, we will file your company's insurance. In the event you fail to prosecute the claim for Workers' Compensation for this injury or the condition is determined not the result of a compensable Workers' Compensation case, you agree to pay the usual and customary fees for services rendered to you in this case.

CHILDREN OF DIVORCED PARENTS – **PAYMENT IS DUE AT THE TIME OF SERVICES** no matter who is responsible by order of the divorce decree.

FINANCIAL AGREEMENT - We will gladly discuss your proposed treatment and do our best to answer any questions relating to your insurance. You must realize, however that;

- **Your insurance is a contract between you and your employer, and the insurance company. We are not party to that contract.** *To enable our office to file your insurance, you must provide accurate information at each visit.*
- **Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover (i.e. x-rays, labs, Durable Medical Equipment, elective procedures and pre-existing conditions).**
- **Due to timely filing limits for insurance companies, you must present your current insurance card at the time of check in. If you do not have your insurance card, you can reschedule your appointment or you can choose to pay out of pocket for your visit.**

We must emphasize that as your medical care providers, our relationship and concern is with you and your health, not the insurance company. **ALL CHARGES ARE YOUR RESPONSIBILTY FROM THE DATE SERVICES ARE RENDERED.** On any balance on your account after 90 days, including those that insurance has not paid, collection action will be taken. We realize that emergencies do arise and may affect timely payment of your account. If such cases occur, please contact us promptly for assistance in the management of your account.

- *If it becomes necessary to collect any sum due through a collection company, then the patient agrees to pay all reasonable costs of collection, including collection fees, whether a suit is filed or not.*
- *If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.*

MISSED APPOINTMENTS: THERE WILL BE A $25.00 CHARGE FOR ANY APPOINTMENT NOT CANCELED WITHIN 24 HOURS. THIS $25.00 WILL BE PATIENT RESPONSIBILITY.

Request of Medical Records: There is a $20.00 charge for Medical Records and $5.00 for CD of X-Rays.

FMLA Paperwork and Disability Paperwork: $20.00

I have read and understand the above Financial Policy.

X_____ X_____

Authorization to Treat / Acceptance of Financial Responsibility / HIPAA

I hereby consent to the following treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures / tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees
- Voluntarily and without compensation authorize Neuhaus Foot and Ankle to take and use pictures and/or videos of my foot for educational and advertising purposes which may include office screen saver, websites or other promotional material.

I fully understand that this is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I hereby authorize Neuhaus Foot & Ankle, PC to furnish information to insurance carriers concerning my illness and treatment. I hereby assign to Neuhaus Foot & Ankle, PC all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by my insurance.

I hereby understand that, if I do not have active insurance coverage, that I am being accepted by Neuhaus Foot & Ankle, PC as a Self-Pay patient. I understand that I am financially responsible for all services rendered to my dependents or myself.

In accordance with HIPAA , I have had the opportunity to read and receive a copy of the Privacy practices located in the office of Neuhaus Foot & Ankle, PC. I understand my information will be used for the purposes if treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

NOTE: Original x-rays are the property of this office. Copies may be purchased for $5.00 each.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Patient **Date**

_____ _____

Responsible Party **Date**

DO I NEED A TEST FOR PAD

Peripheral Arterial Disease (PAD) is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain, or kidneys, because narrowed or clogged. It affects over 8 million Americans, most over the age of 50. It may result in leg discomfort with walking, poor healing of leg sores/ulcers, difficult to control blood pressure, or symptoms of stroke. People with PAD are at significantly increased risk for stroke and heart attack. Answers to these questions will determine if you are at risk for PAD and if a vascular seam will help us better assess your vascular health status.

Name_____ Date_____

Circle "YES "or "NO":

Do you have foot, calf, buttock, hip or thigh discomfort (aching, fatigue, tingling, cramping or pain) when you walk which is relieved by rest? **YES NO**

Do you experience any pain at rest in your lower leg(s) or feet? **YES NO**

Do you experience foot or toe pain that often disturbs your sleep? **YES NO**

Are your toes or feet pale, discolored, or bluish? **YES NO**

Do you have skin wounds or ulcers on your feet or toes that are slow to heal (8-12) weeks? **YES NO**

Have you suffered a severe injury to the leg(s) or feet? **YES NO**

Do you have an infection of the leg(s) or feet that may be gangrenous (black skin tissue)

YES NO

Patient Signature_____

Physician Signature_____ Date_____

ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature