InStride Salem Foot Care

Date:_____

Last Name_____ First_____ MI _____ Age_____

Social Security #_____ Sex_____ Date of Birth_____/_____/_____

Home Address _____

Street City State Zip

Home Phone (_____)_____ Marital Status: Single Married Divorced Widow

Cell Phone (_____)_____ Email_____@_____

Preferred Method for Appointment Reminders: _____Text _____Phone

Employer_____ Work Phone (_____)_____

Name of Spouse/ Parent_____

Family Doctor_____ Last Visit_____/_____/_____

Which Pharmacy do you use? Name:_____ City:_____

If insurance is in another's name:

Name_____ Date of Birth_____/_____/_____

Relationship_____

How did you hear about our office? _____

**Our receptionist will make a copy of your insurance cards on the first visit. It is important that we know all of your insurance companies to properly file your claims.

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Patient Medical History

What is your foot problem today?_____
_____
_____

How long have you had this problem?_____

How severe is the discomfort? Minor (1-2) Mild (3-5) Moderate (6-8) Severe (9-10)

Past Medical History: Please Circle All That Apply

Eyes: Diabetic retinopathy
Glaucoma
Macular Degeneration

Cardiovascular: Atrial Fibrillation
Blood Clots in Legs/ DVT
Heart Attack/ MI
Congestive Heart Failure/CHF
Heart Murmur
High Blood Pressure
Leg Bypass or Stent
Swelling of Legs/ edema
Varicose Veins

Respiratory: Asthma
COPD
Emphysema
Blood Clot in Lungs

Dermatologic: Skin Ulcers
Skin Cancer (Type_____)
MRSA Infection
Psoriasis
Thick Scars/ Keloids

Psychiatric: Anxiety
Depression
Bipolar
Dementia
Schizophrenia

Gastrointestinal: GERD/Reflux
Hepatitis (A B C D)
Irritable Bowel Syndrome
Stomach/ GI ulcer
Liver Disease

GU/ Kidney: Kidney Stones
Kidney Disease
Dialysis
Prostate Problems

Musculoskeletal: Gout
Osteoarthritis (Wear & Tear)
Rheumatoid Arthritis
Fibromyalgia
Bulging Discs in Back

Endocrine: Diabetes (Type I or II)
High Cholesterol
Thyroid Problem
Obesity

Hematologic: HIV Infection
Sickle Cell
Anemia (Type_____)

Neurologic: Multiple Sclerosis
Stroke/ CVA
Seizures/ Epilepsy
Parkinson's Disease

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Medical History: Page 2

Please List Any medical problems not circled on first page:_____
_____
_____
_____

Have You Had the Following Surgeries?

Appendectomy
Bunionectomy: Right/ Left
C- section
Cataracts: Right/ Left/ Both
Tubal Ligation
Hysterectomy
Prostate Surgery
Kidney Stones
Tonsillectomy
Gallbladder Surgery

Cardiac Stent
Cardiac Bypass (CABG)
Knee Arthroscopy
Knee Replacement (Right/ Left)
Hip replacement (Right/ Left)
Back Surgery (Disc/ Fusion)
Ankle Fracture/ Surgery
Hammertoe surgery
Heel Spur Surgery

Please list any other surgeries_____
_____

Please list ALL medications you take_____
_____
_____
_____
_____
_____
_____
_____

Weight _____ Height _____

A1C (if diabetic) _____ Date last checked _____

Please list any **drug allergies**: No Known Allergies Penicillin Sulfa Local Anesthetics Iodine Aspirin Morphine Codeine Others:_____

Do you smoke or use tobacco? _____ How much?_____ For how many years?_____

Do you drink alcohol?_____ How often? Rare Social Moderate Heavy

Do you use any recreational drugs?_____What type?_____ How often?_____

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Notice of Privacy Practices

Patient Name: _____ DOB: _____

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

I give permission to the physician of **Salem Foot Care** to administer treatment for my condition. If patient is a minor or incapacitated, guardian or personal representative will sign here to give permission to the physicians for treatment deemed necessary in the diagnosis and treatment of the patient's condition.

_____ _____

Signature of patient, guardian or personal representative Date

Authorization for Release of Information

Salem Foot Care is authorized to discuss my medical care and may release my confidential protected health information (PHI) to the following:

Entity to receive information. Check each person/entity that you approve	**Description of information to be released.** Check all that apply
☐ Spouse (name & phone number) _____	☐ Any information ☐ Information as follows: _____
☐ Parent (name & phone number) _____	☐ Any information ☐ Information as follows:_____
☐ Other Doctors _____	☐ Any information ☐ Information as follows:_____
☐ Other (name & phone number) _____	☐ Any information ☐ Information as follows:_____

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document by sending written notification to: **Salem Foot Care, 1505 River Street, Wilkesboro, NC 28697**
- Revocations not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- 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 force and will remain in effect until revoked by the patient or representative signing the authorization on behalf of the patient.

_____ _____

Signature of patient, guardian or personal representative Date

*Description of personal representative's authority (attach necessary documentation)

InStride Salem Foot Care

PATIENT PAYMENT POLICY

Thank you for choosing our practice. It is our belief that establishing a written financial policy is mutually beneficial to all parties. It is our goal to avoid any miscommunication or concerns regarding financial matters in order to focus our energies on providing excellent healthcare services to our patients.

We participate with many insurance plans. If you would like a list of these plans, please ask the receptionist. Each insurance plan has different benefits for you as well as financial obligations. Not all insurance policies cover all services. It is ultimately your responsibility to check with your insurance company to determine covered benefits. We do not file claims to any insurance with whom we do not participate.

The following are our guidelines/ policies relative to financial responsibility:

* **Payment is expected at the time services are rendered.** This includes copays, deductibles and co-insurance as well as payment for any non-covered or over the counter items.
* Please present your insurance card(s) at each visit to our office.
* You may be charged a no-show fee of $25.00 for any appointments missed, not cancelled or rescheduled with at least 24 hours notice.
* Prior balances on your account must be paid in full within 60 days unless other arrangements are made in advance in writing with the office manager.
* Accounts may be turned over to a collection agency for any balances past due 60 days or more.
* A service charge of $35.00 will be assessed for returned checks, refiling of insurance due to incomplete or incorrect information given at the time of the appointment or for accounts turned over to collection agencies.
* I understand that I will be legally responsible for all collection costs associated with the collection of this account including court costs, reasonable attorney fees and all other expenses incurred with collection if I default on any unpaid balance.
* A fee of $20.00 will be assessed for the completion of any disability, Family Medical Leave Act (FMLA), attending physician statements (APS) or any other miscellaneous forms.
* Interest in the amount of 1.5% monthly (18% annually) may be added to any balances older than 60 days.
* In the case of services provided to patients under the age of 18, the parent guardian or legal representative who initiates the services for the minor will be responsible for payment. We do not bill another individual or estranged spouse for payment.

I hereby authorize Salem Foot Care to file all medical claims with any and all insurances in which Salem Foot Care participates. I hereby authorize payment of insurance benefits to be made to Salem Foot Care. I further understand that if my insurance company denies any or all medical services as “non-covered”, “coverage terminated”, “pre-existing” or “not a covered member”, I will be responsible for full payment within 30 days of said denial(s), or within 30 days of the first billing statement sent by Salem Foot Care following the receipt of said denial(s). I understand that Salem Foot Care will not file any claims for non-covered or over the counter items. I further understand that Salem Foot Care does not file supplemental, secondary or tertiary claims EXCEPT for the following: 1) Medigap (Medicare supplement) coverages in which Salem Foot Care participates, OR 2) where we participate with BOTH the primary and secondary coverages.

I fully understand the above policies and agree to be financially responsible for any and all incurred charges resulting from medical services rendered.

_____ _____

Signature of patient/ guardian/ responsible party Date