The Foot Doctors
Ankle to Toe, Repair, Recovery, & Relief.
929 E Montclair St. STE 100 Springfield MO 65807
417-883-1881

Patient Info. Form

PATIENT LAST NAME: FIRST NAME: MIDDLE INITIAL:

I PREFER TO BE CALLED: MALE / FEMALE

ADDRESS: CITY:

STATE: ZIP: EMAIL:

PHONE #:

DATE OF BIRTH: AGE: SSN:

MARITAL STATUS: SINGLE / MARRIED / DIVORCED / LIFE PARTNER / WIDOWED / LEGALLY SEPARATED

EMPLOYER: OCCUPATION: WORK #:

PRIMARY CARE PHYSICIAN: PHONE #: DATE LAST SEEN:

SPOUSE'S NAME/PARENT OR GUARDIAN NAME IF A MINOR:

GUARDIAN DOB: GUARDIAN SSN:

GUARDIAN ADDRESS:

Medical Insurance Information: May bring card instead of filling this portion out.

PRIMARY INSURANCE: POLICY HOLDER'S NAME:

DOB: RELATIONSHIP: POLICY HOLDER'S ADDRESS:

POLICY HOLDER'S PHONE #: EMPLOYER'S NAME:

MEMBER ID: GROUP ID: SSN:

SECONDARY INSURANCE: POLICY HOLDER'S NAME:

DOB: RELATIONSHIP: POLICY HOLDER'S ADDRESS:

POLICY HOLDER'S PHONE #: EMPLOYER'S NAME:

MEMBER ID: GROUP ID: SSN:

Emergency Contact Information:

PERSON TO NOTIFY IN CASE OF EMERGENCY: RELATIONSHIP:

HOME #: CELL#: WORK #:

HOW DID FIND US? PHYSICIAN: PATIENT:

ONLINE: TV: INSURANCE COMPANY: OTHER:

(Google, Facebook, Instagram, YouTube, Etc.)

Signature (Or patient responsible party) Date

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Patient Privacy Form

Patients,
To ensure your privacy, please answer the following questions and notify the front office staff whenever this information changes.

1.Do we have permission to leave a message on the phone number(s) you have provided us?

☐ YES ☐ NO

2.What may we discuss with your family & friends?

☐ Any aspect of my healthcare ☐ Health information only ☐ Financial only

Please list the names of people with whom we can discuss your medical care with:

1.NAME:	PHONE:
PATIENT'S RELATIONSHIP TO CONTACT:	
2.NAME:	PHONE:
PATIENT'S RELATIONSHIP TO CONTACT:	
3.NAME:	PHONE:
PATIENT'S RELATIONSHIP TO CONTACT:	

Signature (Or patient responsible party) Date

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Acknowledgement of Receipt of Notice or Privacy Practices

I acknowledge the Notice of Privacy Practices and I have read (or have 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

Summary of Notice of Privacy Practices

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other healthcare providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures based on your authorization: Except as stated in more detail in the Notice of the Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures NOT requiring your authorization:

In the following circumstances, we may disclose your health information without your written authorization:

- To family members or friends who are involved in your healthcare;
- For certain limited research purposes;
- For purposes of public health and safety;
- To government agencies for purposes of their audits, investigations and oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by law.

Patient's Rights:

As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern, or complaint regarding our privacy practices, please inform your doctor.

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Authorization to Release Information, Assignment of Benefits and Consent for Treatment

1. Release of Information: I authorize the disclosure of any or all of the information in my medical record to (a) any person, corporations or agency responsible for all or part of The Foot Doctors, PC services who may be responsible for determining the necessity, appropriateness, payment or other matters related to The Foot Doctors, PC treatment or services; (b) this includes but is not limited to insurance companies, health maintenance organizations, PPO, worker's compensation carriers, welfare funds, the Centers for Medicare and Medicaid Serivces or its intermediaries or carriers; (c) further authorize The Foot Doctors, PC to, at its discretions, to disclose such information to its insurance carrier when so requested by such carrier.
2. Certain health insurances require that you obtain a referral or prior authorization from your primary care provider before visiting a specialist. If your insurance company requires you to have a referral to a specialist, it is your responsibility to obtain one prior to your scheduled appointment and you must maintain a current referral for subsequent visits. Failure to obtain the referral and/or preauthorization may result in a lower or non-payment from your insurance company and the balance will be your responsibility. Alternative payments and/or reschedule of your appointment may be necessary.
3. Assignment of Benefits: I assign The Foot Doctors, PC and/or the Independent Contract Groups named in the Notice of Privacy Practices, the benefits due to me covering The Foot Doctors, PC services under my policy(s), managed care plan, HMO, or the Centers for Medicare and Medicaid Services or its intermediaries or carriers.
4. Medicare Patient: I authorize The Foot Doctors, PC to obtain information from the Social Security Administration regarding mt entitlement and the health insurance claim numbers.
5. Financial obligation for The Foot Doctors, PC, any physician employee of The Foot Doctors, PC and the independent contract groups named in The Notice of Privacy Practices: I agree that I am financially responsible for payment of all amounts for services provided by The Foot Doctors, PC. I am responsible to pay for my services regardless of insurance coverage or other responsible parties. I will not be responsible to pay if my obligation is waived by contractual agreements between The Foot Doctors, PC and my insurer, or if prohibited by state or federal laws or regulations. If my insurance plan is Health Maintenance Organization, I understand that I am financially responsible for non-covered services or deductibles, copay or coinsurance as defined in my policy or plan. I also agree that if the account is placed for collections, I will pay all collections agency costs, and reasonable attorney fees. I agree to waive venue and do agree that any action filed to collect any amounts due for services rendered shall be filed in Greene County, Missouri. This includes patient's account balances and the collection of other expenses related to the patient's account balances such as service fees, court costs and attorney fees.
6. Fees for service, which include unpaid balances, deductibles, co-payment, co-insurances, and non-covered over the counter products are due at the time of service unless previous arrangements have been made with the billing coordinator.
7. The charge for a returned check is $35.00 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check. Unpaid returned check fees and balances will be subject to collection placement.
8. I have read and understand the financial obligations above and agree to the terms stated.

Patient, Parent if minor child or guardian Date
(If patient is unable to sign, Representative's name and relationship)

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Authorization for Use and Disclosure of Protect Health Information

Patient Identification:

Printed Name: _____ Date of Birth: _____

Address: _____

Social Security #: _____ Phone: _____

Information to be Released-Covering the Periods of Healthcare:

From (date): _____ To (date): _____

Please check type of information to be released:

- ☐ Complete Health Record
- ☐ Consultation Reports
- ☐ X-ray films/Images
- ☐ Diagnosis & Treatment Codes
- ☐ Progress Notes
- ☐ Photographs/Videos
- ☐ Discharge Summary
- ☐ Lab Results
- ☐ Billing Records
- ☐ History & Physical Exam
- ☐ X-Ray Reports
- ☐ Itemized Bill

Other (please specifiy): _____

Purpose of Request:

☐ Treatment or Consultation ☐ At Request of Patient ☐ Billing or Claims Payment

Who & Where to Send/Release Information:

TO: THE FOOT DOCTORS, PC
929 E. MONTCLAIR ST. STE 100
SPRINGFIELD MO 65807
417-883-1881

FROM: Primary Care Physician/Endocrinologist Information:

_____

_____

_____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release:

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensative information, I agree to it's release. (circle one) YES NO

I understand if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Aquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release. (circle one) YES NO

Time Limit & Right to Revoke Authorization:

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to The Foot Doctors, PC, 929 E Montclair St. STE 100, Springfield MO 65807. Unless revoked, this authorization will expire on the following date [1 year from date signed], or 180 days from date of signature, unless otherwise specified.

Re-Disclosure:

I understand the information disclosed by this authorization may be subjected to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, it's employees, officers and physicians are herby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure:

I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed.

I authorize The Foot Doctors, PC to use and disclose the protected health information specified above.

Signature: _____ Date: _____

Authority to Sign if Not Patient: _____

Identity of Requestor Verified Via (circle one): Photo ID / Matching Signature / Other, specify: _____

Verified by: _____

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Patient Symptom Summary

Patient's Name:_____ Date of Birth:_____

What is your primary foot and/or ankle complaint today?_____

When did this start:____Days____Weeks____Months____Years? Is the problem getting better / worse / unchanged?

Was this a result of a trauma? ☐YES ☐NO
Does this affect your walking? ☐YES ☐NO
Was this a job-related injury? ☐YES ☐NO
Does this affect your ability to exercise? ☐YES ☐NO
Does this affect your daily activity? ☐YES ☐NO
If so, what exact date did injury occur?_____

How would you describe your pain? (circle all that apply)
Generalize / Localized / Throbbing / Radiating / Burning / Numbness / Dull Ache / Sharp Ache / Other:_____

Rank the severity of your pain: 1 2 3 4 5 6 7 8 9 10 (severe)

What treatment have you tried for this problem?_____

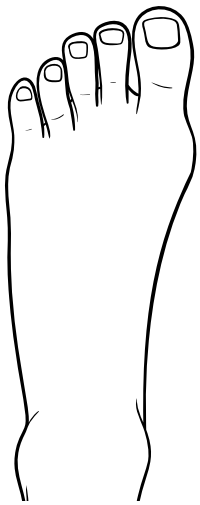
Do you have any other foot and/or ankle problems?_____
Other symptoms:_____
Are you Diabetic? ☐YES ☐NO Do you use insulin? ☐YES ☐NO Date you were diagnosed:_____

What is your average blood sugar reading?_____What was your last A1C reading?_____

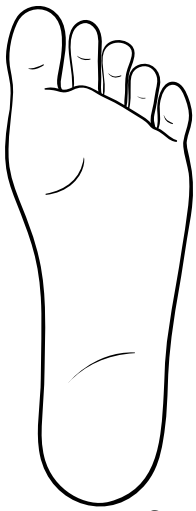
Shoe size:_____Height:_____ Weight:_____

Please circle where on your feet/ankles you are having pain:

LEFT FOOT

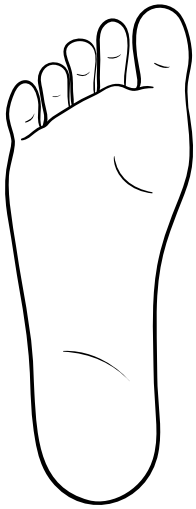


Top of Foot

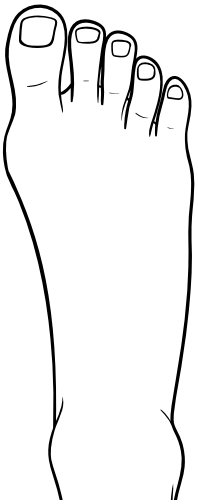


Bottom of Foot

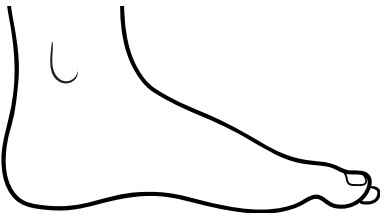
RIGHT FOOT



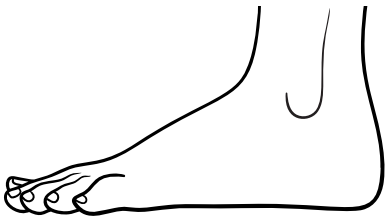
Bottom of Foot



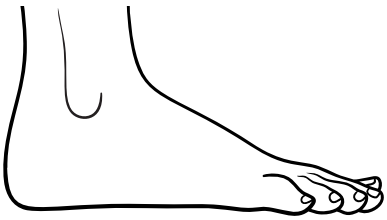
Top of Foot



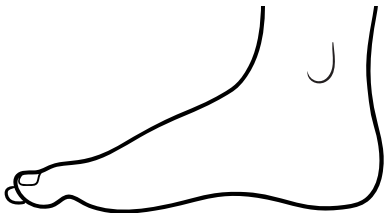
Inside of Foot



Outside of Foot



Outside of Foot



Inside of Foot

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Medical History

Have you ever had any of the following?

- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Abnormalities
- ☐ Cancer/Tumor
- ☐ Circulatory Problems
- ☐ COPD/Emphysema
- ☐ Diabetes
- ☐ Epilepsy/Seizure
- ☐ Heart Disease
- ☐ Hepatitis or Liver Disease
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Kidney Disease/Impaired
- ☐ MRSA
- ☐ Sickle Cell
- ☐ Skin Rash/Hives
- ☐ Skin Ulcer
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Neuropathy
- ☐ Bunion(s)
- ☐ Callus(es)
- ☐ Other: _____

FAMILY HISTORY:

Please note family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE/CONDITION	YES	NO	RELATIONSHIP/LIVING OR DECEASED
Cancer			
COPD/Lung Disease			
Diabetes			
Heart Disease			
Hypertension			
Stroke			
Other (specify)			

SOCIAL HISTORY:

Do you smoke cigarettes: ___Yes___Never smoked ___Former smoker Quit date?_____
Do you use any of these tobacco products: ___Cigars ___Pipes ___Chewing Tobacco ___Snuff ___Vape
Alcohol use:___Never___2-3 times per month___2-3 times per week___2-3 times per day
Do you use recreational drugs? ___Yes ___No If yes, what type(s):_____

ALLERGIES:

Please check all that apply, if yes, please list reaction.

	YES	NO	REACTION
Tape/Adhesives			
Iodine			
Latex			
NSAIDS			
Penicillin			
Morphine/Codeine			
Sulfa Drugs			
Tetanus			
Lidocaine/Novocain/Marcaine			
Other (specify)			

Are you pregnant:____YES____NO *Please note we may take x-rays during your visit, so please inform us if there is a chance you may be pregnant. Also, medications we may prescribe (i.e. antibiotics) could change the effectiveness of birth control medications.

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Medications

Pharmacy Name: **Pharmacy Phone #:**

CURRENT MEDICATIONS: (If you have a list, we can make a copy)
Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements.

NAME OF DRUG	**DOSE** (**strength & # of pills per day**)	**HOW LONG HAVE BE TAKING THIS DRUG?**

Please list all major surgeries you have had, and the dates performed:

I understand the completeness and accuracy of this information is critical to receiving safe and effective medical care and I have completed the form to the best of my ability. I understand that it is my responsibility to inform The Foot Doctors, PC of any changes to my medical status. I hereby consent and authorize The Foot Doctors, PC and staff to perform any service deemed appropriate by attending physician(s) to make a thorough diagnosis. I also authorize The Foot Doctors, PC and staff to perform any procedures, forms of treatment, medication and therapy in connection with my diagnosis and treatment plan.

Patient Name (Please Print) **Date**

Parent or Authorized Representative (if applicable) **Signature**