

DATE: _____

PATIENT NUMBER _____

ALL INFORMATION MUST BE COMPLETED PRIOR TO SEEING PHYSICIAN

P A T I E N T	PATIENT NAME (LAST, FIRST, MIDDLE)				SOCIAL SECURITY NUMBER			
	STREET				HOME PHONE: ()		CELL PHONE: ()	
	CITY			STATE	ZIP	DRIVERS LICENSE NUMBER		
	DATE OF BIRTH	AGE	SEX	CIRCLE ONE MARRIED DIVORCED SINGLE WIDOWED				
	EMAIL ADDRESS:							
	WHOM MAY WE THANK FOR REFERRING YOU? _____ INS. DIRECTORY _____ YELLOW PAGES _____ INTERNET FRIEND _____ DOCTOR _____ OTHER _____							
	WAS PATIENT'S CONDITION(S) RELATED TO: CIRCLE ONE EMPLOYMENT AUTO OTHER DATE OF ACCIDENT: _____							
S P O U S E	PATIENT EMPLOYER OR SCHOOL				WORK PHONE ()			
	EMPLOYER ADDRESS							
	SPOUSE'S/SIGNIFICANT OTHER NAME			DATE OF BIRTH	SOCIAL SECURITY NUMBER			
	SPOUSE'S/SIGNIFICANT OTHER'S EMPLOYER & ADDRESS				WORK PHONE ()			
G U A R A N T O R	NAME OF NEAREST RELATIVE			HOME PHONE ()				
	ADDRESS OF NEAREST RELATIVE			WORK PHONE ()				
	PERSON RESPONSIBLE FOR PAYMENT			DOB	SOCIAL SECURITY NUMBER		RELATIONSHIP	
P A T I E N T	STREET ADDRESS				HOME PHONE ()			
	CITY			STATE	ZIP CODE	DRIVERS LICENSE NUMBER		
	LIST THREE PHONE EMERGENCY CONTACTS							
NAME			PHONE			RELATIONSHIP		
NAME			PHONE			RELATIONSHIP		
NAME			PHONE			RELATIONSHIP		

PATIENT MEDICAL HISTORY

Patient's Name: _____ Age: _____

Height: _____ Weight: _____ Shoe Size: _____

What condition are you being seen for today? _____

Where is it? _____

How long have you had it? _____

What started it or makes it worse? _____

What makes it better _____

What treatment have you had? _____

Goals of Treatment: _____

Have you ever been treated by another podiatrist? _____

If so, who, for what condition and when? _____

MEDICAL HISTORY REVIEW: Do you have a history of any of the following?

- | | | | |
|----------------------------------------------|-----------------------------------------|------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gout | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Asthma | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hepatitis/Liver Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Glaucoma/Eye Problems | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Keloids | <input type="checkbox"/> Last Tetanus Immunization |

Have you had any of the following conditions recently?:

- | | | | |
|----------------------------------------------------------|------------------------------------------------------------------|--------------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Currently Pregnant | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Poor Healing | <input type="checkbox"/> Excessive Fatigue |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Large Weight Change | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Frequent Headaches |
| <input type="checkbox"/> Problems Hearing | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Excessive Coughing |
| <input type="checkbox"/> Frequent Sore Throats | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Frequent Thirst |
| <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Leg Swelling | <input type="checkbox"/> Joint Pain or Stiffness | <input type="checkbox"/> Muscle Weakness |
| <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Leg Cramps | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Skin Rashes |
| <input type="checkbox"/> Swollen Glands | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Immune System Problems | |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Frequent Anxiety or Psychiatric History | | |
| <input type="checkbox"/> Numbness or Neurologic Problems | | | |

Other problems or conditions not listed above: _____

Family doctor and other doctors are you currently seeing?: _____

List all previous significant injuries (broken bones, sprains, etc.) _____

SURGERY

List all previous surgeries: _____

MEDICATIONS: Please list ALL:

<u>MEDICATION</u>	<u>HOW OFTEN TAKEN</u>	<u>STRENGTH</u>	<u>WHY TAKING</u>

ALLERGIES:

___ Novacaine ___ Aspirin ___ Codeine ___ Other Antibiotics _____
___ Penicillin ___ Iodine ___ Metal
___ Tape/Band-Aids ___ Sulfa ___ Other (food, fabric, etc.) _____

SOCIAL HISTORY: (please circle)

Exercise, Sports, or Recreational Activities where you are on your feet _____

Marital Status: Single Married Separated Divorced Widowed

Use of Alcohol: Never Occasional Moderate Daily

Smoking: No Yes, how much? _____

Recreational/Street Drug Use: Never Rare Daily

FAMILY HISTORY:

Please list diseases common to your family including heart disease, diabetes, rheumatoid diseases and arthritis and genetic problems

Grandparents: _____

Father: _____

Mother: _____

Siblings: _____

Children: _____

COMMENTS: _____

SIGNATURE: _____ DATE: _____
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Richard A. Nichols, D.P.M., P.A

OUR OFFICE POLICIES

First and foremost, we want to express our appreciation to you for selecting our practice. We want your experiences with us to be positive and we are committed to your treatment being successful. Healthcare has gone through major changes in the past few years, which means, changes that not only affect you, the patient, but also the physician and his office staff.

This form represents an explanation of our office policies and guidelines concerning financial responsibility. **Please understand, payment of your bill is your responsibility.** We ask that you sign the last page of this form indicating you have read and understood these guidelines. If you have any questions, please consult with a member of our office staff.

Full payment of patient responsibility (co-pays and/or deductibles) is due at the time of service.

All co-pays are collected before a patient is seen.

If you are contracted with an insurance company, all co-insurance and/or co-pays, do apply.

The adult accompanying a minor is responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless appropriate consent has been received and charges have been pre-authorized and payment has been made prior to treatment.

Unless cancelled at least 24-hours in advance, our policy is to charge for missed appointments at the rate of one-half the normal charge for the office visit. We understand circumstances do arise where 24-hour advance notice is not possible and we will take that into consideration.

We require a copy of your current insurance card(s) and drivers license or photo I.D. prior to or at the time of your visit. **If you are unable to present your card before seeing the doctor, the visit may be considered fee for service and full payment may be collected.** If you are an established patient, please verify all information and notify us of any changes. **It is the patient's responsibility to inform us of their insurance coverage and/or insurance changes.**

If we are a participating provider for your insurance, we will file your claim for you. When your insurance processes the claim, we will make the appropriate adjustments. Please note that you will be responsible for any copays or co-insurance amounts as set forth by your insurance company and your contract with them. Your copays are due at the time services are rendered.

Insurance claims filed to a secondary insurance are done so as a courtesy to our patients. If we have no response from your secondary insurance company after a reasonable amount of time, the balance will be placed to the patients' responsibility as well as the responsibility to collect from their secondary insurance.

Some procedures performed in our office are considered "surgical" and as such are subject to co-insurance or deductibles, depending on your individual insurance policy. Please be advised, some and perhaps all of the services provided, may be non-covered services under your insurance plan. They will be your responsibility and payment collected on the day performed or dispensed. **Please be advised, even though your insurance company is our source of information, there is no guarantee of payment by your insurance plan and we will inform you to the best of our ability if a service or supply is not covered.**

As a rule, we try to verify eligibility and benefits prior to your appointment, but in some cases, this is not possible. It is ultimately your responsibility to make sure we are a provider, what your benefits are, that your insurance policy is active, the appropriate referral is obtained, when applicable and we have been provided with that information. In the event of a denial from your insurance company for payment or benefits, you will be responsible for the services rendered and to dispute the claim with your insurance company. We will be happy to assist you with information, but cannot dispute benefit issues with your insurance company.

Under some plans/policies, you are required to obtain a referral from a PCP (Primary Care Physician) before seeing a specialist. If your plan requires a referral, it is your responsibility to insure that our office is in possession of the referral letter or number, prior to your visit. If the referral is not available to us by the time of your visit, you may choose to pay for the visit yourself or reschedule your appointment. If you elect to pay for the visit, you assume responsibility for collection from your insurance company. Please note that most referrals are issued for a specific time period and to a specific doctor and must insist you verify the validity of your referral in relation to each visit.

From time to time, your insurance company may request further information from you before processing a claim. Failure to comply with their request in a timely manner may result in denial of the claim. In the event this happens, you will be held responsible for the full balance of the claim(s).

If you have an indemnity policy, we will file your insurance claims as a courtesy. Please be prepared to pay your portion of the claim at the time services are rendered. You are responsible for the entire balance in the event your insurance company does not pay. We will allow thirty (30) to forty five (45) days for your insurance to process claims, before you become liable for any unpaid balance.

If you are a private pay patient (fee for service), please be prepared to pay at the time services are rendered. If surgery becomes necessary, you will need to contact our billing office to make payment arrangements.

Thirty (30) days after your insurance claim processes, any unpaid balance will become past due and is subject to a 12% finance charge computed monthly on any remaining unpaid balance. In the event your account becomes past due, we will make an every effort to collect, but if necessary, will employ outside services to assist in collections. Please keep your account current, but if not possible, alert the office manager immediately. We are always able to find an amicable solution to any problem.

Please be advised, all medical records and X-rays are the legal property of the practice, however, you have the right to a copy. We do charge for the processing and copying of the records and/or X-rays. X-ray copies are billed per sheet at the rate charged by the copying facility. **Advanced notice and pre-payment is required for X-ray copying**, as we have to send them out for copying and will notify you when completed. All disability papers needing to be completed and signed by the doctor will be charged \$10.00 per form and require at least 7 days prior notification.

There will be no refunds of supplies purchased. Unfortunately, every supply prescribed may not work for all patients, however, we strive to ensure we make every effort to have a satisfactory outcome.

All checks returned by the bank as “NSF” or “insufficient funds” or “account closed”, will be charged with a \$28.00 processing fee and we do require the check to be replaced by cash or Money Order, Visa, Mastercard or Discover. If the check is not replaced within ten (10) business days, after being notified, appropriate action will be taken to collect these funds.

We accept cash, personal checks, Mastercard, Discover and Visa and most debit cards.

I have read and understood the financial policies for Alliance Foot & Ankle Specialists as set forth in the preceding paragraphs. My signature indicates my willingness to comply fully or accept responsibility for payment of any claim denied due to noncompliance. My signature also authorizes this office to file claims for me and assigns all medical rights and benefits due for these services. My signature authorizes this office to release medical records as necessary to my insurance carrier.

Printed name

Signature of patient (parent/guardian, if patient is a minor)

Date