Shenandoah Podiatry

New Patient Information Form

**** Please Print Clearly ****

PATIENT INFORMATION:

First Name _____ MI _____ Last Name _____ ○ Male ○ Female

Date of Birth ___/___/_____ Social Security #_____-_____-_____ -OR- Driver's License #_____

Home Address _____ Apt# _____

City _____ State _____ Zip _____-_____

Mailing Address (if different from above) _____

Home Ph (_ _ _) _ _ _ - _ _ _ _ Cell Ph (_ _ _) _ _ _ - _ _ _ _ Work Ph (_ _ _) _ _ _ - _ _ _ _

Email Address _____Employer Name & Address _____

Preferred Contact Method: ○ Home Ph ○ Cell Ph ○ Work Ph ○ Email ○ Text

Preferred Pharmacy (please include cross streets and city, if able) _____

Primary Care Physician _____ Phone# (_ _ _) _ _ _ - _ _ _ _ Date of last visit _____

Race: ○ American Indian/Alaska Native ○ African American/Black ○ Asian ○ Native Hawaiian/Pacific Islander ○ White

Ethnicity: ○ Hispanic ○ Non-Hispanic

Primary Language: _____ *Translation services are available upon request.

Do you have an Advance Directive? ◯ Yes ◯ No If yes, please describe type: _____

EMERGENCY CONTACT INFORMATION:

Emergency Contact Name _____ Phone (_ _ _) _ _ _ - _ _ _ _ Relationship to Patient _____

PAYMENT AND INSURANCE INFORMATION:

○ Check here if no health insurance, or if "Self-Pay"

Primary Insurance _____

Policy Holder _____ Date of Birth _____

Secondary Insurance _____

Policy Holder _____ Date of Birth _____

REFERRAL INFORMATION: How did you hear about our office?

○ Doctor _____ ○ Patient _____ ○ Friend/Family Member _____ ○ Our Sign

○ Our website ○ Insurance Website ○ Google ○ Yelp

By signing below, you are attesting that all of the following are all true statements:

- The information provided on this form is true and correct to the best of my knowledge.
- I request that payments of authorized benefits be made on my behalf for any services furnished by **Shenandoah Podiatry**.
- I authorize any holder of personal health information about me to release any information needed to determine these benefits, or the benefits payable to related services, to the insurance agent.
- I recognize my financial obligation of any coinsurance, copays or deductibles and non-covered services that may be required.
- I hereby give permission to **Shenandoah Podiatry,** and any qualified staff to evaluate, diagnose and treat my foot and/or ankle condition, as may be deemed necessary.

_____ _____

Signature of Patient or Representative (Indicate Relationship Below) Date

○ Self ○ Parent ○ Legal Guardian ○ Representative/Healthcare POA

Shenandoah Podiatry

Privacy Policy

Shenandoah Podiatry will use and disclose your health information for the following purposes: to treat you, to assist other health care providers in treating you, to allow insurance companies to process insurance claims for services rendered to you, to obtain payment for services rendered to you and for certain limited operational activities, such as quality assessment, licensing, accreditation and training of students. We will not use or disclose your health information without your written authorization, except as stated in more detail in the Notice of Privacy Practices. If you have any questions, concern or complaints regarding our privacy practices, please refer to the actual Notice of Privacy Practices provided to you for the person(s) whom you may contact.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (See pages 1-7 in provided folder)

My signature below represents that I have been offered a copy of the Notice of Privacy Practices. I acknowledge that I was provided a copy of the policy and have read (or had the opportunity to read, if I so chose) and understood the Notice.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the above Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below:

Any member of my immediate family ○ **Yes** ○ **No**
Spouse ONLY ○ **Yes** ○ **No**
Other (Please Specify): ○ **Yes** ○ **No** _____

PATIENT PORTAL (PATIENT ACKNOWLEDGMENT AND AGREEMENT) (See page 7, part II, in provided folder)

My signature below represents that I have read and fully understand the consent form regarding the Patient Portal. I comprehend the risks associated with online communications between my physician and me, and consent to the conditions outlined.

I agree to be enrolled in the Patient Portal. ○ **Yes** ○ **No**

PRESCRIPTION MONITORING AND ePRESCRIBING

- Shenandoah Podiatry participates in a Prescription Drug Monitoring Program (PDMP), which is a system in which controlled prescription drug data is collected in a database, centralized by each state, and administered by an authorized state agency to promote the appropriate use of controlled substances for legitimate medical purposes while deterring the misuse, abuse, and diversion of controlled substances.
- ePrescribing is defined as a physician's ability to electronically send an accurate, error-free and understandable prescription directly to a pharmacy. The United States Congress has determined that this ability is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety.
- My signature below represents my authorization for Shenandoah Podiatry to view my external prescription history via electronic prescribing services. I understand that this prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies, and pharmacy benefit managers may be viewable by provider(s) and staff at Shenandoah Podiatry and that it may include prescriptions dating back several years and prescriptions to treat HIV, substance abuse, and psychiatric conditions, if applicable. I understand that my prescription history will become part of my Shenandoah Podiatry record.
- I have had the chance to ask questions, and all of my questions have been answered to my satisfaction.

I agree to be enrolled in ePrescribing. ○ **Yes** ○ **No**

_____ _____

Signature of Patient or Representative (Indicate Relationship Below) Date

○ Self ○ Parent ○ Legal Guardian ○ Representative/Healthcare POA

Shenandoah Podiatry

Financial Policy

Thank you for choosing Shenandoah Podiatry as your foot care provider! We are committed to providing you with quality and affordable health care. Your understanding of our Financial Policy is important to our professional relationship. Please read the following policy; feel free to ask us any questions that you may have. Once you accept this policy, kindly sign in the space provided.

1. **INSURANCE** – We participate in most insurance plans, including Medicare. If you are not insured by a plan in which we participate, payment in full is expected at each visit. If you are insured by a plan in which we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. **Please understand it is your full responsibility to know and understand the benefits and details of your insurance policy including, but not limited to, in-network versus out-of-network copays, deductibles, co-insurance and non-covered services. Coverage and benefits you are quoted are done in good faith from what we believe to be true, but is in no way a guarantee of payment or coverage.** Please contact your insurance company with any questions you may have regarding your coverage.
    a. **Proof of Insurance** – All patients much complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the balance of a claim. If required, obtaining the proper referral from your Primary Care Physician is your responsibility. Patients presenting to our office without a valid referral will be asked to pay in full. This payment will be held for 48 hours and will become non-refundable if the proper referral is not obtained by then.
    b. **Copayments and Deductibles** – All copayments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company.
    c. **Coverage Changes** – If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

2. **NON-COVERED SERVICES -** Please be aware that some (and perhaps all) of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit if we know it is non-covered. Sometimes we will not know until your insurance claim has gone through; for these you will be notified and payment will be made through Credit Card on File (CCoF).

3. **NON-PAYMENT -** Invoices are sent out every 30 days. Your prompt payment will assist us in keeping the cost of healthcare down. If your account is over 60 days past due, you will receive a letter requesting immediate payment. A $10.00 rebilling fee will be charged for each additional invoice sent out after 30 days. Partial payments will not be accepted unless otherwise approved by our Billing Office. Please be aware that if a balance remains unpaid, we may refer your account to collections and collection fees incurred will be added to your balance. **Returned Checks/Non-Sufficient Funds fee is $35.**

4. **CLAIMS SUBMISSION -** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is essentially a contract between you and your insurance company.

5. **MISSED APPOINTMENTS -** Our policy is to charge **$50.00** for missed appointments that were not cancelled 24-hours ahead of time, or for an understandable reason. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

I have read the above policy and understand my financial responsibility to Shenandoah Podiatry for medical services provided. I agree to pay any balance due and/or unpaid by my insurance carrier for myself and/or the below-named person. I also agree that in order for my account to be serviced and to collect any amounts owed, I may be contacted by telephone, including wireless numbers, which could result in charges to me. I may also be contacted by text messages or emails, using any email address provided. I understand that methods of contact may include the use of pre-recorded voice messages and/or the use of an automatic dialing device/service, as applicable.

_____ _____

Signature of Patient or Representative (Indicate Relationship Below) Date

○ Self ○ Parent ○ Legal Guardian ○ Representative/Healthcare POA

Shenandoah Podiatry

Authorization for Credit Card on File (CCoF)

In effort to keep our costs at a reasonable level, Shenandoah Podiatry now requires that all patients put a credit card on file to ensure collection of any patient responsibilities after we have received payment from their active insurance plan.

If you choose NOT to put a credit card on file, please DO NOT complete this form. See the receptionist for payment information.

The credit card on file (CCoF) will ONLY be used to pay for deductibles, coinsurances, and non-covered services, once the claim has been processed by insurance. Once the insurance company has paid its portion, the patient will receive an Explanation of Benefits (EOB) which will state any remaining balance that must still be paid by the patient.

PLEASE NOTE:

- Your credit card information is NOT kept on file in this office; it is kept securely offsite, which means that this office does not have any access to the full credit card number once it is entered into the system for the first time.
- Once we receive payment from the insurance company, the CCoF will be charged for the remaining balance.
- If the remaining balance is over $100, you will receive a courtesy call prior to your credit card being charged. At the time of this call, you can agree to pay the balance in full or set up an automatically recurring payment plan for the balance.

By signing below, I authorize **Shenandoah Podiatry** to charge the patient-responsible balances on my account, until further notice. These charges may include old balances, copays, coinsurance, deductibles, and non-covered services. These charges will be authorized to be processed using the following credit card:

Circle One: Visa Mastercard Discover American Express

Last 4 digits of the Credit Card: ____ ____ ____ ____

Exp. Date (mm/yy): ___ ___ / ___ ___

I understand that once my insurance company has paid its portion for my care, I will receive an Explanation of Benefits (EOB) which will state any remaining balance that must be paid by me. I agree that Shenandoah Podiatry may charge my credit card on file for the balance due when they receive a copy of the EOB. If the balance due is more than $100, I will receive a courtesy call prior to my card being charged, at which time I can agree to pay in full or set up a payment plan for the balance.

Signature _____ Date _____

Printed Name _____

Office Use Only:

TSYS ID # _____ Date _____ Initials _____

Shenandoah Podiatry

New Patient Medical History Form

Last Name _____ **First Name** _____ **MI** _____ **DOB** ____/____/_____

Reason for Visit: _____

My condition is… □Work Related □Due to an Auto Accident □Due to a Liability Claim □None of these

Current Treatments: _____

How long has this condition existed? _____ **Pain Scale** (0 = none to 10 = extreme) _____

Current Medications: (Include prescriptions, over-the counter medications, vitamins/herbal supplements) □ **See Attached List**

_____ _____ _____

_____ _____ _____

_____ _____ _____

(Females Only) Are you Currently Pregnant? □ Yes □ No Currently Breastfeeding? □ Yes □No

Do you currently have, or have you ever had, symptoms/diagnosis of:

□ Back/Spine Pain	□ COPD	□ Heart Condition	□ Neurological Disorder
□ Bleeding or Thyroid Disorder	□ Depression	□ High Blood Pressure	□ Neuropathy
□ Blood Clots	□ Diabetes - □ Type I □ Type II	□ High Cholesterol	□ Osteoporosis
□ Bunions	□ Edema	□ Liver Disease	□ Seizure Disorders
□ Cancer - _____	□ Fibromyalgia	□ Mitral Valve Prolapse	□ Stomach Ulcers
□ Congestive Heart Failure	□ Gout	□ MRSA Infection	□ Stroke

□ Other(s):_____

Allergies/Sensitivities: _____

Are you experiencing any of the following symptoms? (Please circle ALL that apply)

Burning (feet toes both)	Fever or Chills	Nausea	Swelling
Chest Pain	GI Upset	Numbness (feet toes both)	Tingling (feet toes both)
Cramping	Itching	Shortness of Breath	

Other _____

Previous Surgeries: _____

Any hospitalizations within the last 12 months? Yes_____ or No_____

If yes, what was the reason: _____

Family History: Please check all that apply, state the member in your family, and if the member is living or deceased:

Condition	**Relative (Living/Deceased)**	**Condition**	**Relative (Living/Deceased)**
□ Bunions	_____	□ Diabetes	_____
□ Cancer	_____	□ Heart Condition	_____
□ Hypertension	_____	□ Stroke	_____
□ Other	_____		

Do you use tobacco products? □Yes □No □Former - How Long Ago _____

If yes, which product? □ Cigarettes □Cigars □Chewing Tobacco **AND** How much/how often? _____

Do you drink alcohol? □Yes □No If yes, how much/how often? _____