Columbus Podiatry & Surgery Inc.

New Patient Welcome Forms

Today's Date: _____

Name: _____ Date of Birth: _____ Age: _____

Address:

_____

Street Apt. # City State Zip

SSN: _____-_____-_____ Sex: M F Email: _____

Phone: Home ( )_____ Cell ( )_____

Marital Status: _____

Preferred Pharmacy Name and Location: _____

Pharmacy Phone Number: ( )_____

Primary Care Physician (Family Dr): _____Date of Last Visit: _____

Emergency Contact Information

Name: _____ Relationship: _____

Phone: Home ( )_____ Cell ( )_____

Insurance Responsible Party (if not self)

Name: _____ Date of Birth: _____ Relationship:_____

Address: _____

Street Apt. # City State Zip

SSN: _____-____-_____ Sex: MALE or FEMALE

Phone: Home ( )_____ Cell ( )_____

Demographic Update

1. Are you Hispanic or Latino? (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race)

Please circle one: YES or NO

2. Please select the racial category or categories with which you most closely identify by placing an "X" in the appropriate box. Check all that apply.

___ American Indian or Alaskan Native
___ Asian
___ Black or African American
___ Native Hawaiian or other Pacific Islander
___ White or Caucasian
___ I wish to decline answering questions 1 and 2 regarding race and ethnicity

3. What is your primary language?___ English ___ Other, please specify_____

4. (Regardless of your answer to question 3) Do you need an interpreter? YES NO

HIPAA Compliance

May we leave appointment reminders and procedure dates on your home answering machine, cell phone, or other voice communication device voicemail?

Please Circle One: YES or NO

If the patient is unavailable, do you authorize us to share health information with anyone else?
Please Circle One: YES or NO

Please list authorized personnel: Name: _____ Relationship: _____

Cell _____ E-Mail _____

AUTHORIZATION FOR TREATMENT AND ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I consent to and authorize all treatments and care as deemed reasonable and necessary by Columbus Podiatry & Surgery Inc. and agree to be responsible for decisions relating to such.
I also acknowledge that I was provided the Notice of Privacy Practices and that I have read (or had the opportunity to read if I chose) and understood the Notice and agree to its terms.**

**** HIPAA Privacy notification packets are available at the front desk.**

Patient Name: _____

Patient or Guardian Signature: _____ Date: _____

Patient Name _____Today's Date: _____

Reason for Visiting:

Describe your foot/ankle problem. (Example: right ankle pain)

_____

When did the problem start? (Please give a date or rough estimate. Example: one week ago)

_____

Shortly describe how the pain started. (Example: twisted ankle while hiking)

_____

How painful is your condition? (Scale: 0 = no pain 10 = extremely painful)
Please circle one: 1 2 3 4 5 6 7 8 9 10

Please check all that apply:

Type of pain: __Burning __Tingling __Sharp __Dull Ache
__Shooting __Stabbing __Numbness __Throbbing

When does the pain occur?
__Standing __During walking __After walking
__During sports __Worse with activity __Better as activity continues
__With shoes __Without shoes __A.M. __P.M. __Always

What makes the pain/condition better (Example: rest, icing, medications, etc.)?

_____

Have you received medical treatment for this problem?
If yes, please describe the treatment: _____

Medical and Social History

Patient Height: ____ft _____in Patient Weight: _____lbs
Blood Pressure: _____ / _____ Shoe Size: _____

1. Do you smoke tobacco? ___Yes ___No
   If Yes: #packs per day?_____ #cigarettes per day?_____ #of years?_____
   If No: Did you ever smoke? ____Yes ____No
2. Do you consume alcohol? ____Yes ____No

If yes, how much?: ____Socially/Rarely ____Occassionally ____Daily ____Recovering

3. Are you employed? ___Yes ___No Employer:_____
4. **Surgical History**

Procedure	Year	Any Complications?

Patient Name_____

Medication	Dosage	Medication	Dosage

Have you had an allergic reaction to any of these immunizations or medications?

__ none
__ penicillin
__ sulfa
__ iodine
__ shell fish
__ aspirin
__ anesthetics
__ latex
__ codeine
__ adhesives
__ cortisone
__ streptomycin
__ rotavirus
__ polymyxin
_pneumococcal
__ neomycin
__ IPV
__ influenza
__ Hep B
__ Hep A
__ HiB
__ DTaP
__ Baker's yeast
other_____
_____
_____
_____

Family History

*Please check	Father	Mother	Brother	Sister
Diabetes				
Heart Disease				
High Blood Pressure				
Stroke/Heart Attack				
Rheumatic Conditions				
Bleeding Disorders				
Cancer (List Type)				
Other:				

Health History

_____Diabetes: Please cirlce your type: Type 1 or Type 2 What was your last A1c reading?_____
Who is managing your diabetes? Are you on dialysis? Yes or No
Doctor's Name:_____ Phone: ( )_____

__Anemia __Deep Vein Thrombosis __Epilepsy __Nerve Conditions
__Heart Disease __Arthritis __Tuberculosis (TB) __High Blood Pressure
__Osteoarthritis __Stomach Ulcers __Skin Disorder
__Venous Stasis __Aids (HIV) __Lung Disorder __Kidney Disorder
__Stroke __Hepatitis __Osteoporosis
__Colitis/Chron's __Poor Circulation __Gout __Asthma/COPD
__Joint Pain __Thyroid Disorder __Rheumatic Fever __Acid Relux/GERD
__High Cholesterol __Coronary Artery Disease __Mitral Valve Prolapse
__Recurrent Infections __Eczema __Muscle Weakness __Broken Bones
__Speech Difficulties __Deaf/Hearing Loss __Neuropathy
__Prostate Disorder __Chest Pains __Congestive Heart Failure
__Leg Pains __Rheumatic Conditions __Swelling of feet/ankles
__Shortness of Breath __Ataxia (Loss of Balance) __Multiple Sclerosis (MS)
__Peripheral Arterial Disease __Peripheral Vascular Disease
__Psychiatric Disorder:_____ __Cancer:_____
History of bleeding_____ Are you taking any blood thinners?_____

Have you received a flu vaccination for the current season? _____Y N

If NO, the reason is-------Allergy Declined Vaccine-unavailable

Financial Policy and Responsibility

We participate with most insurance plans. Your insurance policy is a contract that exists between you and your insurance company. If you have questions about your insurance policy and benefits, please contact the phone number on the back of your insurance card.
If we do not participate with your insurance plan, or you do not have your insurance policy information at your visit, payment in full will be required at the time of service. If you do not have your insurance card, you may pay in full and provide the information to our practice within 30 days. We will then issue any necessary credit on the account only after the claim has processed through insurance and explanation of benefits (EOB) is received by our office.
We accept cash, check, credit card (Visa, Mastercard, Discover), Carecredit, and Scratchpay. A $50 fee will be added to your account in the event that a check is returned for insufficient funds.

COPAYS ARE DUE AT THE TIME OF SERVICE.

Medicare: We are a participating Medicare provider. There is no guarantee of service coverage. You are responsible for paying any deductibles, coinsurance, and copayments.

Secondary insurance: Your medical claim will be forwarded to your secondary insurance (if any) after payment and EOB is received from your primary insurance. Please make sure to provide any secondary insurance cards to the front desk at the time of service.

Non-covered services: Please be aware that some of the services available at our practice may not be covered by your insurance. Your insurance company may also deem some medical services unnecessary. It is your responsibility to confirm coverage for services. If you choose to receive these services, you will be responsible for payment.

Self-pay: If you do not have health insurance, payment in full will be due at the time of service**.**

Copayments, deductibles, and coinsurance: All specialist copayments will be collected prior to seeing the doctor. You will be responsible for any deductible and coinsurance amounts. Your insurance company sets these amounts, and failure to collect these amounts is a violation of our contract with them and can be considered fraud.

Referrals: If your insurance plan requires a referral to see a specialist from your primary care provider, it is your responsibility to obtain the referral. Without a referral available, we may need to reschedule your appointment, as your insurance company may not pay the claims.
Billing and Collections: 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 to them. It is your responsibility to comply with your insurance company's request. The balance of your claim is your responsibility whether your insurance company pays the claim or not. Your insurance coverage is a contract between you and your insurance company. We will send up to 3 notices for your financial responsibility after the EOB is received from the insurance. After the third notice, your account will be forwarded to a collection agency along with an administrative fee of $50.
Cancellations: A $50 cancellation fee will be added to your account if notice is not provided of the cancellation of your appointment 24-hours in advance and will need to be paid before rescheduling any future appointments.
Surgery Cancellations: Failure to provide 5 business days notice of a cancellation of a surgery scheduled at a hospital or surgery center will incur a $200 fee.
Forms: We charge a $50 fee for the completion of FMLA and disability or similar forms, for each form needing filled.
Privacy Statement: Any information disclosed in your records will remain confidential and will not be used for any reason outside of providing you quality care and treatment. Your information may be used to prior-authorize services or submit claims to your insurance company.

I certify that I (or my dependent) have coverage with my insurance as presented and assign directly to Columbus Podiatry & Surgery, Inc. all insurance benefits, payable to me for services rendered. I have read and agree to the above policies regarding my financial responsibility for services rendered by Columbus Podiatry & Surgery, Inc. and agree to pay any balances unpaid by my insurance plan.

Patient Name_____

Patient or Guardian Signature: _____ **Date:** _____