Choice Podiatry Center

Patient Registration Form

Date: _____
Patient:_____

Physical Address:_____ Sex: □ Female □ Male
_____ Birth Date:_____
Billing Address:_____ SS#_____
_____

Cell#:_____ Home #:_____
E-mail _____

Employer:_____ Occupation:_____
Address:_____ Employer's #:_____
_____

Ethnicity:_____ Race:_____
Preferred Language:_____

INSURANCE INFORMATION

Primary Insurance Carrier Name: _____ ID NO: _____
Policy Holder Name: _____ Policy Holder DOB: _____
Relationship to Policy Holder: _____

Secondary Insurance Carrier Name: _____ ID NO: _____
Policy Holder Name: _____ Policy Holder DOB: _____
Relationship to Policy Holder: _____

Marital Status: Single □ Married □ Widowed □ Separated □ Divorced □

Do you currently have a living will/advanced directive/Durable Power of Attorney?

_____**Yes**, please circle all that apply _____**No**, currently do not _____Decline to Disclose

IN CASE OF EMERGENCY CONTACT

Name:_____ Relationship:_____
Home Phone Number:_____ Cell Number:_____

Primary Care Physician Name:_____**Date Last Seen** _____
Telephone Number: _____

Pharmacy Name: _____ Telephone Number: _____

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HOW DID YOU FIND OUT ABOUT US?_____

Is there anyone beside yourself we can discuss your medical information with?

Yes, Please List_____ **No**_____

SMOKING STATUS:

Current Every Day Smoker ☐
Current Some Day Smoker ☐ Frequency_____
Former Smoker ☐ How much_____
Never Smoked ☐
Unknown if Ever Smoked Smoker ☐
Do you drink? Yes ☐ No ☐ If yes, How Much_____
Do You Use Any Recreational Drug? Yes ☐ No ☐

Please place a mark if you or your family member has any of the following condition

Family History Guide

M-Mother F-Father S-Sibling U-Uncle A-Aunt GPA-Grandfather GMA-Grandmother

	Self	Family/Who		Self	Family/Who		Self	Family
AIDS/HIV	☐☐	☐____	Ear Problems	☐☐	☐____	Low Blood Pressure	☐☐	☐____
Anesthetics	☐☐	☐____	Epilepsy	☐☐	☐____	Phlebitis	☐☐	☐____
Anemia	☐☐	☐____	Eye Problem	☐☐	☐____	Psychiatric Care	☐☐	☐____
Angina	☐☐	☐____	Fainting	☐☐	☐____	Radiation Treatment	☐☐	☐____
Asthma	☐☐	☐____	Gout	☐☐	☐____	Respiratory Disease	☐☐	☐____
Back Pain	☐☐	☐____	Hammer Toes	☐☐	☐____	Shortness of Breath	☐☐	☐____
Bleeding	☐☐	☐____	Headaches	☐☐	☐____	Sinus Problems	☐☐	☐____
Disorder	☐☐	☐____	Heart Disease	☐☐	☐____	Skin Condition	☐☐	☐____
Cancer	☐☐	☐____	Hemophilia	☐☐	☐____	Special Diet	☐☐	☐____
Chest Pain	☐	☐____	Hepatitis	☐	☐____	Stroke	☐	☐____
Circulatory			High Cholest	☐☐	☐____	Tuberculosis	☐	☐____
Problems	☐☐	☐____	High Blood Pre	☐	☐____	Ulcers foot/leg/toes	☐☐	☐____
Diabetes	☐☐	☐____	Kidney Proble	☐☐	☐____	Varicose Veins	☐☐	☐____
Diarrhea	☐	☐____	Liver Disease	☐☐	☐____	Weight Loss (unexpl)	☐☐	☐____

None of the above conditions apply to myself _____
None of the above conditions apply to any member of my immediate family_____

PLEASE LIST ANY OTHER MEDICAL HISTORY NOT LISTED ABOVE

_____

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PODIATRIC HISTORY

What is your chief complaint for which you came to be treated? _____

_____

Athletic activities in which you participate:_____

SHOE SIZE:_____

Have you ever been to be a Podiatrist before? Yes ☐ No ☐
If yes please list: Doctor's Name:_____Last Visit:_____

Please indicate which Foot or Leg problems you now have or have had in the past:

Ankle Pain	☐ Yes ☐ No	Ingrown Toenails	☐ Yes ☐ No
Athletes Foot	☐ Yes ☐ No	Swelling in Feet	☐ Yes ☐ No
Bunions	☐ Yes ☐ No	Swelling in Ankle	☐ Yes ☐ No
Corns/Callus	☐ Yes ☐ No	Tired Feet	☐ Yes ☐ No
Flat Feet	☐ Yes ☐ No	Foot or Leg Cramps	☐ Yes ☐ No
Heel Pain	☐ Yes ☐ No	Numbness	☐ Yes ☐ No
Plantar Warts	☐ Yes ☐ No	Fracture	☐ Yes ☐ No

Please list any Hospitalizations/Surgeries you had in the past _____

_____

Are you now, or have you been under any other doctors care for any reason over the past two years ☐ Yes ☐☐No
If yes, please explain:_____

MEDICATIONS: Include Prescription, over the counter and Vitamins:

_____

_____

_____

Pharmacy Name:_____Telephone Number:_____

Do you Consent for us to electronically retrieve your medication history? Yes / No

ALLERGIES:

No Known Allergies	☐Yes ☐	Aspirin	☐Yes ☐No	Anesthetics	☐Yes ☐No
Adhesive Tape	☐Yes ☐No	Demerol	☐Yes ☐No	Iodine	☐Yes ☐No
Penicillin	☐Yes ☐No	Codeine	☐Yes ☐No	sulfa	☐Yes ☐No
Local Anesthetics	☐Yes ☐No	Novocain	☐Yes ☐No	other_____	

_____

CONSENT

I certify that the above information is correct to the best of my knowledge. I give my permission

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to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Name of the person filing out this form if not the patient_____

Patient/Guardian Signature_____ Date: _____

HIPAA Privacy

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By signing this acknowledgement of Receipt of Privacy Practices (the "Notice") I acknowledge and agree that I have received a copy or elected not to receive a copy of this notice of Privacy Practice for review and to keep for my records on the date identified below.

I understand that the CHOICE PODIATRY CENTER, INC may use and disclose necessary personal information (i.e., name, address, subscribers identification number, podiatry exam information and /or type of products provided) to another in-house employee to permit and perform its administration duties, provide me with podiatry services and products, process my podiatry benefit claims and communicate with me regarding podiatry care services provide by Choice Podiatry Center, Inc (i.e., mailing of exams, reminder information about services/products provided by Choice Podiatry Center, Inc.

I CAN BE ASSURED THAT CHOICE PODIATRY CENTER, INC WILL NOT SELL MY PERSONL INFORMATION OF ANY KIND TO A THIRD PARTY FOR SUCH PARTIES PERSONAL USE.

Choice Podiatry Center is to submit my podiatry benefit claim to my plan sponsor or health plan to receive reimbursement directly for the podiatry services and products that I received.

Please choose one of the following options:

_____ I do not want a copy of Choice Podiatry Centers HIPAA Privacy Practices

_____ I would like to receive a copy of Choice Podiatry Centers HIPAA Privacy Practices.

_____ _____

Patient Signature or Patient's Legal Representative Date

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BILLING POLICY

REGARDING HMO'S, PPO'S and MANAGED CARE PROGRAMS:

We do not participate in some of these programs, so please check with your insurance company to see if we are providers for your particular plan. It is your responsibility to obtain all referral forms required by your insurance company. Please be aware that if you are seen by our doctor under an out of network insurance plan, you assume liability for the difference in coverage benefits. Some HMO/PPO/Managed Care Primary Care Physicians require all x-rays to be taken at their office so please check with your physician before your appointment.

COPAYS:

You will be expected to pay your co-pay at the time of your appointment. If you are unable to pay, you will be required to reschedule your appointment.

REGARDING PATIENTS WITH NO INSURANCE:

Payment is due at the time of service.

REGARDING PATIENTS WITH MEDICARE:

We will file all charges with Medicare and your supplemental insurance if applicable. If you do not have supplemental insurance, you will be billed for the 20% not paid by Medicare, or any deductible that has not been met.

MEDICAID DOES NOT COVER ALL PODIATRY SERVICES FOR INDIVIDUALS.

REGARDING WORKMEN'S COMPENSATION/AUTO/LIABILITY:

Our office requires authorization prior to the initial visit. If authorization has not been received by the time of your visit, you will be responsible for the charges associated with your visit. You will be responsible for all fees until the case has been settled.

MINOR PATIENTS:

Patients under the age of 18 must have a parent and/or guardian accompany them to our office before treatment can be rendered. Arrangements must be made prior to being seen with the parent and/or guardian for any co-pays and payments to be made at the time of treatment.

LAB:

Our office uses an outside laboratory service. In the event that a lab test is performed, you will receive a separate bill for the lab services.

CUSTOM ORTHOTICS:

If your insurance does not cover orthotics or your deductible has not been met, a payment of half the price of the orthotics will be expected prior to ordering. The remaining half is due at the time your orthotics are dispensed.
It is always your responsibility to be sure that your account is settled, regardless of insurance or any other circumstances (such as litigation). The Patient is responsible for costs associated with collecting owed balances including but not limited to, collection agency fees, attorney fees, and court costs.
I hereby authorize the release of any information necessary to file a claim with my insurance company and assign benefits to Choice Podiatry Center.
I acknowledge that I have read the billing policies listed above, agree, and understand my responsibilities as a patient at Choice Podiatry Center. I also understand that if I fail to pay charges, I imply discontinuation of podiatry services.

REFUND POLICY

Thank you for purchasing our products at Choice Podiatry Center, Inc.
We do not offer a refund or exchange for products that are considered to be **"APPAREL",** such as Walking boots, Ankle Braces, Splints, Compression Sleeves/Socks, Thera bands, Toe Spacers, Hammer toe cushions and Bi-plane pads unless there is a manufacturer defect with the product. In the event there is a defect with the purchased items, you must return it back to us within **5 days** of the date of purchase along with the original packaging.

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Products purchased that are not considered to be apparel may be returned to our office for a refund **ONLY**, if the item has not been used and in its original packaging within **5 days** of the date of purchase.

Please sign below that you have read and understand the billing and refund policy for Choice Podiatry Center.

Signature: _____Date: _____

We require that you call at least 24 hours in advance. Appointments that are missed will accrue a fee of $25.00 that will be charged to the patient's account. Thank you in advance for your cooperation.

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AUTHORIZATION OF PATIENT PICTURE, NAME AND AGE TO BE RELEASED FOR THE SOLE PURPOSE OF MARKETING

I_____ give permission to Choice Podiatry Center to use Video and/or pictures in print for marketing and/or educational purposes.

This consent may be withdrawn at any time. Withdrawal of consent must be writing to Choice Podiatry Center physicians or practice manager.

I acknowledge that I have given my permission and understand that Choice Podiatry Center will use my information regarding any surgical procedure and/or medical treatments for the sole purpose of marketing and/ or educational purposes.

Patient Name (print): _____ Date: _____

Patient Signature: _____

Parent or Authorized Representative Signature (if patient is a minor)

Date: _____

☐ Please check the box if you DO NOT wish for your picture, name, or age to be released f for the sole purpose of marketing.

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