PATIENT INFORMATION FORM

DATE: ____________________

PATIENT NAME: ____DATE OF BIRTH: ____________________

AGE: ___ SEX: M F PRIMARY LANGUAGE: _______________________RACE: ___________ ETHNICITY: __________

ADDRESS: ____CITY/STATE: ______________________ZIP: ___________

HOME PHONE: (_______) ________-_________ CELL PHONE: (______) _______-____________

EMAIL ADDRESS: ____

EMPLOYER: ____WORK PHONE: (_______) _______-__________

EMERGENCY CONTACT: __________________________RELATIONSHIP: ____________ PHONE: (_____) _____-_______

PRIMARY CARE DOCTOR: ____DATE LAST SEEN____________________

PHONE: (______) _______-_______ ADDRESS: _______________________________CITY/STATE: __________________

PHARMACY: _______________________LOCATION: ________________________PHONE: (_____) ______-__________

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: ____

ADDRESS: ________________________ CITY/STATE: ________________ ZIP: _______ PHONE: (_____) _____-_______

INSURED NAME: _______________________DATE OF BIRTH _______________ EMPLOYER ______________________

ID # ____ GROUP # ____

SECONDARY INSURANCE COMPANY NAME: ____

ADDRESS: ________________________CITY/STATE: ______________ ZIP: _______ PHONE: (_____) ______-________

INSURED NAME: ___________________________DATE OF BIRTH ___________ EMPLOYER ______________________

ID # ____ GROUP # ____

PATIENT INFORMATION FORM

MEDICATIONS

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

MEDICATION NAME	DOSE	HOW OFTEN DO YOU TAKE?

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE

☐ CURRENT USE - TYPE ______________ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? ________ ☐ SMOKE ___ PACKS/DAY FOR ___ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? ________ TYPE ________________

☐ CURRENT USE - TYPE ____________ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES: TYPE 1 OR TYPE 2 ☐ CANCER ☐ HEART DISEASE

☐ HIGH BLOOD PRESSURE ☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ BLEEDING DISORDER

☐ RHEUMATOID ARTHRITIS ☐ OTHER ____

PATIENT INFORMATION FORM

YOUR MEDICAL HISTORY

ALLERGIES: ☐ MEDICATIONS ____________________

☐ ANESTHESIA ____________ ☐ FOODS ____________

☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER ____________

☐ NONE KNOWN

REACTION: ____________________

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES: TYPE 1 OR TYPE 2 (CIRCLE)	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N
OTHER CONDITIONS:								

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? ____________________

HOW LONG AGO DID THIS PROBLEM FIRST START? ________ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: ☐ BEGIN ALL OF A SUDDEN ☐ GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN OR SYMPTOM?

☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING

☐ RADIATING ☐ ITCHING ☐ STABBING ☐ OTHER ____________________

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: ☐ STAYED THE SAME ☐ BECOME WORSE ☐ IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? ☐ WALKING ☐ STANDING ☐ DAILY ACTIVITIES

☐ RESTING ☐ DRESS SHOES ☐ HIGH HEELS ☐ FLAT SHOES ☐ ANY CLOSED TOE SHOE

☐ RUNNING ☐ OTHER ____________________

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? ____________________

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? ____________________

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ YES ☐ NO (DESCRIBE) ____________________

IF YES, WAS IT A WORK-RELATED INJURY? ☐ YES ☐ NO

COOL SPRINGS
FOOTCARE

Financial Policy Agreement

Your insurance policy is a contract that exists between you and your insurance company. Our relationship is with you, the patient, and not the insurance company. If you have questions about your policy, please call the phone number provided on the back of your insurance card. The patient or responsible party is responsible for their bill being paid in full. Please inform us at every visit of any changes to your insurance coverage.

Please initial each line indicating your understanding of our policies:

___**COPAYMENTS:** It is a requirement of your insurance company that we collect your co-pay. Payment is required before meeting with the doctor.

___**DEDUCTIBLES & CO-INSURANCE:** If you are a new patient and have not met your deductible, we will collect a **$150** deposit to apply toward your deductible and co-insurance. In Lieu of the deposit, you can leave a credit card on file and we will charge the card after we hear back from your insurance. We shall send refunds at the end of every quarter or at the end of your treatment if there is credit after we have heard back from your insurance. Returning patients who have not met their deductible will be subject to a **$75** deposit towards your deductible and co-insurance. Any remaining balance after submission to your insurance company is your responsibility.

___**SELF-PAY PATIENTS:** Full payment is due at the time of service. A down payment will be required before seeing the doctor. **At a minimum, an evaluation and management fee will be charged.** Additional procedures/services may be recommended by the doctor but you will be informed of these charges before proceeding with treatment.

___**CLAIMS SUBMISSION:** We will submit in-network claims ONLY 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.

___**OUT-OF-NETWORK CLAIMS:** We do not submit out-of-network claims. If you choose to use your out-of-network benefits, the insurance charge amount will be due on the date of service.

___**REFERRAL:** If your insurance plan requires a referral from your primary care doctor, this will be required at the time of your visit. Without a referral available, we may need to reschedule your appointment.

___**NO SHOW:** 24 hours notice is required for cancellation of your appointment. If you fail to provide **24 hours notice** of cancellation there will be a $40 fee. More than one NO SHOW will result in dismissal from the practice.

___**SURGERY CANCELLATION:** Failure to provide **5 business days'** notice of cancellation prior to the scheduled surgery date will incur a **$500** fee and you may not be able to re-schedule in the future.

___**BALANCES/COLLECTION FEES:** If the balance is not collected within 30 days from the postmark date of a mailed statement, a **$25** late fee will be added to each additional statement due to an unpaid balance. Accounts due more than 90 days will be turned over to our collection agency and a **$35** administrative fee will be added. We accept cash, checks, and all major credit cards, and for convenience, payments can be made securely through the Patient Portal.

___**FMLA/DISABILITY/MEDICAL RECORDS:** There is a **$40** charge for completion of these forms. There is a **$10** fee to obtain a copy of your medical records. However, your medical records can be obtained for free online via the Patient Portal.

I have read and understand these financial policies.

________________________________	____
PATIENT Name Print	**PATIENT Signature** **DATE**
________________________________	____
PARENT/GUARDIAN Name Print	**PARENT/GUARDIAN Signature** **DATE**

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations. · The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

____

____

This consent was signed by: ____
[PRINT NAME]

Signature: ______________________________________ Date: ____________________

Witness: ____ Date: ____________________

Patient Consent for Medical Photography/Videography

Patient Name: ______________________________ D.O.B_________________ Date:______________

□ Check here if minor or unable to provide consent:

Name of Guardian or legal representative for Minor patient:_____________________________________

I consent for medical photographs or videotaping to be made of my foot/ankle or my child's foot/ankle (or person for whom I am legal guardian). I understand that the information may be used in my medical record, for purposes of medical teaching, publication, or advertisement. By consenting to these medical photographs, I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future, I may contact **COOL SPRINGS FOOT CARE**. I waive the right of prior approval and hereby release **DR. REEVES** and his practice and any associated staff members from any and all claims for damages of any kind based on the use of my photo information contained.

By signing below, I agree and acknowledge that I have read and understood the above Release and agree to all terms described. I am of legal age and freely sign this Release.

1) I consent for these photographs to be used in medical publications, including medical journals, textbooks, and electronic publications. I understand that the image may be seen by members of the general public, in addition to scientists and medical researchers that regularly use these publications in their professional education. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. I also agree for my image to be shown for teaching purposes and to be used for my medical record.

   ___________________________ ___________________________
   PATIENT Signature **WITNESS Signature**

2) I agree for my image to be shown for teaching purposes AND to be used for my medical record but not for medical publication:

   ___________________________ ___________________________
   PATIENT Signature **WITNESS Signature**

3) I agree to use of my image for medical records ONLY:

   ___________________________ ___________________________
   PATIENT Signature **WITNESS Signature**