FOOT SPECIALISTS OF BIRMINGHAM

MEDICAL AND SURGICAL CARE OF THE FOOT

Birmingham: One Independence Plaza Suite 530 | Homewood, AL 35209 | Phone: 205-445-0661 | Fax: 205-445-0664
Alabaster: 122 7th Ave. N.E., Suite B | Alabaster, AL 35007 | Phone: 205-663-9450 | Fax: 205-663-9430
www.bhamfoot.com

PATIENT INFORMATION

DATE: ______________ SS#: ____________________

PATIENT NAME: ________________________________ BIRTH DATE: ____________________

ADDRESS: ____

HOME PHONE: ____________________ WORK PHONE: __________________ CELL PHONE: ____________________

EMAIL: ________________________________ MARITAL STATUS: ___M ___S ___W ___D ___O

RACE: ___ASIAN ___BLACK ___HISPANIC ___NATIVE AMERICAN ___WHITE ___N/A

PRIMARY LANGUAGE: ____________________ PARENT'S NAME (IF MINOR): ______________________

EMPLOYER: ____________________________ PHONE: ______________________

FAMILY PHYSICIAN: ______________________ PHONE: ______________________

PHARMACY: ____________________________ PHONE: ______________________

EMERGENCY CONTACT: _____________________ PHONE: ______________________

INSURANCE

PRIMARY INSURANCE: ____________________ POLICY HOLDER'S RELATIONSHIP: _____________

SS# OF POLICY HOLDER: __________________ D.O.B. OF POLICY HOLDER: _______________

SECONDARY INSURANCE: __________________ POLICY HOLDER'S RELATIONSHIP: _____________

SS# OF POLICY HOLDER: __________________ D.O.B. OF POLICY HOLDER: _______________

HOW DID YOU HEAR ABOUT US?

___INTERNET ___PHONE BOOK ___NEWSPAPER ___OTHER

___PHYSICIAN (name): ______________________ ___FRIEND/FAMILY (name): ____________________

SOCIAL HISTORY

DO YOU SMOKE? ___EVERYDAY ___SOCIAL ___FORMER ___NEVER
IF YES, HOW MUCH AND FOR HOW LONG? ____

DO YOU DRINK ALCOHOL? ___Y ___N
IF YES, HOW MUCH AND HOW OFTEN? _________________________

DO YOU USE RECREATIONAL DRUGS? ___Y ___N

DO YOU EXERCISE REGUARLY? ___Y ___N
IF YES, WHAT TYPE? ____

ALLERGIES				
____ADHESIVE TAPE	____ASPIRIN	_____CODEINE	_____IODINE	____LATEX
____LOCAL ANESTHETICS	____LORTAB	____PENICILLIN	____SEAFOOD	____SULFA
____OTHER	_____NO KNOWN DRUG ALLERGIES			

FAMILY HISTORY

HAS AN IMMEDIATE FAMILY MEMBER HAD ANY OF THE FOLLOWING (PLEASE INDICATE RELATIONSHIP) (I.E. MOTHER, FATHER, GRANDPARENTS, SIBLINGS, OR CHILDREN)

DIABETES____________________ BLEEDING DISORDER________________

HEART DISEASE________________ GOUT______________________

CANCER_____________________ RHEUMATOID ARTHRITIS____________

PERIPHERAL VASCULAR DISEASE (PVD)____________________________

BLOOD CLOTS__________________OTHER________________________

PAST MEDICAL HISTORY

____AIDS/HIV

____ANEMIA

____ARTHRITIS-TYPE_____________

____ASTHMA

____ARTIFICIAL HEART VALVES/JOINTS-TYPE__________

____BACK PROBLEMS

____BLEEDING DISORDERS/HEMOPHILIA

____CANCER - TYPE______________

____CIRCULATORY PROBLEMS-TYPE___________

____DIABETES

____DVT (BLOOD CLOTS)

____EPILEPSY

____FAINTING

____GOUT

____HEART CONDITION-TYPE___________

____HYPOTENSION

____HYPERTENSION

____HEADACHES/MIGRAINES

____HEPATITIS/JAUNDICE

____ KIDNEY DISEASE- TYPE______________

____LIVER DISEASE- TYPE________________

____NEUROPATHY

____ PSYCHIATRIC CARE

____PERIPHERAL VASCULAR DISEASE (PVD)

PAST MEDICAL HISTORY CONTINUED:

____EAR PROBLEMS/HEARING

____EYE PROBLEMS

_____SINUS PROBLEMS

_____STROKE

_____STOMACH ULCERS

____RASH

____SHORTNESS OF BREATH

_____SWELLING

_____TUBERCULOSIS

_____VARICOSE VEINS

HEALTH REVIEW

PLEASE CIRCLE ANY SYMPTOMS YOU HAVE HAD IN THE PAST 3 MONTHS

GENERAL- FEVER, CHILLS, FATIGUE, WEIGHT LOSS, WEIGHT GAIN

HEAD- HEADACHE, VISUAL PROBLEMS, HEARING PROBLEMS, LIGHT SENSITIVITY

CARDIOVASCULAR- CHEST PAIN, PALPITATIONS, DIZZINESS, SWELLING OF LEGS, OTHER____________

HEMATOLOGY- ANEMIA, ABNORMAL BLEEDING/BRUISING, BLOOD CLOTS, OTHER BLOOD DISORDERS________________

RESPIRATORY- PERSISITANT COUGH, WHEEZING, SHORTNESS OF BREATH

GASTROINTESTIONAL- DIFFICULTY SWALLOWING, INDIGESTION/HEARTBURN, ABDOMINAL PAIN, CHANGE IN BOWELS

URINARY- PAINFUL URINATION, FREQUENT NIGHTTIME URINATION, BLADDER LEAKING, OTHER:____________

MUSCOLOSKELETAL- JOINT PAIN/SWELLING/STIFFNESS, BACK PAIN, MUSCLE WEAKNESS

SKIN- RASH, SUSPICIOUS LESIONS, ITCHING

NEUROLOGICAL- NUMBNESS OF HANDS & FEET, SEIZURES, TREMORS, PARALYSIS

PSYCHIATRIC- DEPRESSION, ANXIETY, PROBLEMS SLEEPING, MEMORY LOSS

ENDOCRINE- HEAT/COLD INTOLERANCE, HOT FLASHES, CHANGE IN HAIR/SKIN TEXTURES, EXCESSIVE THIRST, EXCESSIVE URINATION

SURGICAL HISTORY

___APPENDECTOMY

___BACK

___C-SECTION

___EYE

___FOOT/ANKLE

___GALL BLADDER

___HEART

___HYSTERECTOMY

___KNEE

___THYROIDECTOMY

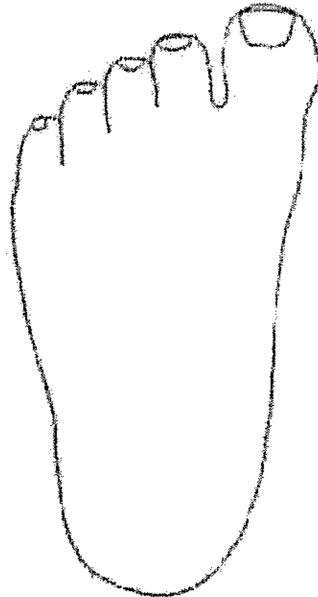
___TONSILLECTOMY

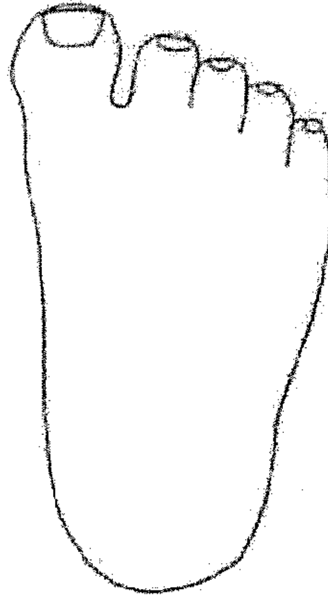
___OTHER: ____

Foot Specialists of Birmingham, P.C.

PLEASE MARK WHERE YOU ARE EXPERIENCING PAIN

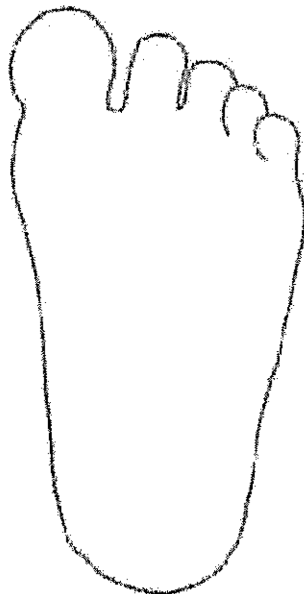
Left Foot (top)

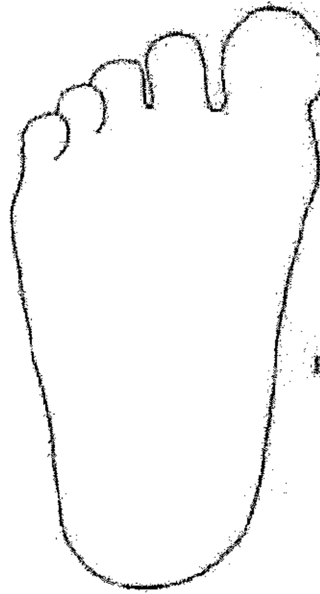




Right Foot (top)

Left Foot (bottom)





Right Foot (bottom)

INITIAL ____________________ DATE ____________________

MEDICATIONS

1.______________________________ 5.______________________________

2.______________________________ 6.______________________________

3.______________________________ 7.______________________________

4.______________________________ 8.______________________________

5.______________________________ 9.______________________________

6.______________________________ 10.______________________________

PODIATRIC HISTORY

____BUNIONS ____ANKLE PAIN ___ATHLETES FOOT ____HEEL/ARCH PAIN

____DIABETIC FOOT ULCER ____INGROWN NAILS _____PLANTAR WART

____ACHILLES TENDON PAIN _____BACK PAIN _____DISCOLORATION OF TOES/FOOT

___FEET/ TOES NUMB ____DIFFICULTY WALKING OR RUNNING

AUTHORIZATION

I have reviewed the information on the questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate treatment. If there are any changes in my medical condition I will inform the doctor. I also authorize my insurance company to pay the doctor or medical group for all insurance benefits, otherwise benefits are payable by me for services rendered. I authorized use of this signature on all insurance submissions.

SIGNATURE: ______________________________

DATE: ____________________

PRINT NAME: ______________________________

PERMISSION TO DISCLOSE PROTECTED HEALTH INFORMATION CONSENT AND ACKNOWLEDGEMENT

(PLEASE PRINT)

Patient Name ______________________________ Date of Birth: ____________

Patient Address ______________________________ SSN: ________________

____

I give Foot Specialists of Birmingham, P.C. permission to release medical information to the follow persons:

☐ None

☐ Parents ______________________________ ☐ Spouse ______________________________

☐ Father (only) ______________________________ ☐ Mother (only) ______________________________

☐ Other ______________________________ ☐ Guardian ______________________________

I wish to be contacted in the following manner by Foot Specialists of Birmingham, P.C. (check all that apply):

☐ **Home Telephone** ______________________
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call back number only

☐ **Work Telephone** ______________________
- ☐ O.K. to leave with detailed information
- ☐ Leave message with call back number only

☐ **Written Communication**
- ☐ O.K. to mail or Email to my home address
- ☐ O.K. to mail or Email to my work/office
- ☐ O.K. to fax to this number ____________
- ☐ Other (Email address)

The Privacy Act generally requires healthcare providers to take responsible steps to limit the use of disclosure of and requests for protected health information to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of protected health information disclosures. Information provided below, if completed properly, will constitute an adequate record.

CONSENT:
I consent to the use and disclosure of protected health information about me by my physician and my physician's practice for purposes of treatment, payment, health care operations, protection of others and disclosures required by law, including information about notifiable diseases, sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), and human immunodeficiency virus (HIV).

NOTE: Uses and disclosures for protected health information may be permitted without consent in an emergency.

ACKNOWLEDGEMENTS:

I acknowledge that I have received Foot Specialists of Birmingham, P.C. Notice of Privacy Practices.

______________________________ ______________________________
Signature of Patient or Personal Representative Date

______________________________ ______________________________
Relationship of Personal Representative to the Patient Signature of Witness

____
Print personal Representative's Name

FINANCIAL POLICY

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

INSURANCE: We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we do 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. *Knowing your insurance benefits is your responsibility*. Please contact your insurance company with any questions you may have regarding your coverage.

MEDICARE: We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. However, that does not mean that all services are covered. *Patients are responsible for paying their annual deductible if it has not yet been met*. You are also responsible for any co-payments, which are usually 20% of the allowed amount for an item or service.

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance (if any except for Medicaid, because Medicaid does not pay for podiatry in the State of Alabama) after payment and/or explanation of benefits (EOB) is received from your primary insurance company.

CO-PAYMENTS, CO-INSURANCE, DEDUCTIBLES: All co-payments, co-insurance and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company.

SELF-PAY ACCOUNTS: Payment in full is due at the time of service if you do not have health insurance.

NON-COVERED SERVICES: Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payments of these services.

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan which mandates that when you visit a specialist such as ours, you must have a referral from your primary care physician prior to seeking specialty care. Therefore, you are financially responsible for services received, unless your referral is presented at the time of the visit.

CLAIM 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 a contract between you and your insurance company.**

PATIENT BILLING: Occasionally after payment and/or explanation of benefits (EOB) are received from your insurance company/companies there is a co-insurance or deductible that we were not aware of at the time of service. You will be sent ***three (3)*** notices of your financial responsibility. After the third and final notice, your account may be forwarded to collections. All cost incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due to the office. Please let the billing office know if you have any difficulties resolving your bill. Payment arrangements can be made on a case by case basis. We accept the following payments methods: Cash, Check, and VISA/MasterCard.

An additional $20 fee will be added to your account if we have to bill you for fees due at the time of service. This includes co-pay, deductible, co-insurance and any non-covered services based your insurance benefit information at the time of service.

An additional $30.00 will be added to your statement if the check is returned for insufficient funds.

I have read the above policy regarding my *financial responsibility* to Foot Specialists of Birmingham, P.C. for medical services provided. I agree to pay Foot Specialists of Birmingham, P.C. any balance unpaid by my insurance carrier for myself or the below named person.

ASSIGNMENT OF BENEFITS:

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to **Foot Specialists of Birmingham, P.C.** all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, co-insurances, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

Patient Signature:______________________________ Date: ___________________________

FINANCIALLY RESPONSIBLE PARTY:

Signature: __________________________ Relationship to Patient: __________________ Date: ________________________