Foot Specialists
OF BIRMINGHAM

David Linde, D.P.M. | David Campbell, D.P.M.
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 (IF POLICY HOLDER IS NOT THE PATIENT PLEASE COMPLETE)

PRIMARY INSURANCE _____ POLICY HOLDER'S RELATIONSHIP _____

SS# OF POLICY HOLDER _____ DOB OF POLICY HOLDER _____

SECONDARY INSURANCE _____ POLICY HOLDER'S RELATIONSHIP _____

SS# OF POLICY HOLDER _____ DOB OF POLICY HOLDER _____

HOW DID YOU HEAR ABOUT US? _____INTERNET _____PHONE BOOK _____NEWSPAPER _____OTHER

_____PHYSICIAN (name) _____ ____FRIEND/FAMLIY (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 REGULARLY? ___Y ___N IF YES, WHAT TYPE? _____

ALLERGIES

___ADHESIVE TAPE ___ASPIRIN ___CODEINE ___IODINE ___LATEX ___LOCAL ANESTHETICS

___LORTAB ___PENICILLIN ___SEAFOOD ___SULFA ___OTHER (Please List)_____

___NO KNOWN DRUG ALLERGIES

FAMILY HISTORY

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

DIABETES _____ BLEEDING DISORDER _____

HEART DISEASE _____ GOUT _____

CANCER _____ RHEUMATOID ARTHRITIS _____

BLOOD CLOTS _____ OTHER _____

PERIPHERAL VASCULAR DISEASE (PVD)_____ NONE _____

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

___EAR PROBLEMS / HEARING

___EYE PROBLEMS

___FAINTING

___GOUT

___HEADACHES/MIGRAINES

___HEART CONDITION – TYPE _____

___HEPATITIS / JAUNDICE

___HYPERTENSION

___HYPOTENSION

___KIDNEY DISEASE – TYPE _____

___LIVER DISEASE – TYPE _____

___NEUROPATHY

___PSYCHIATRIC CARE

___PERIPHERAL VASCULAR DISEASE (PVD)

___RASH

___SHORTNESS OF BREATH

PAST MEDICAL HISTORY (CONTINUED)

___SINUS PROBLEMS

___STROKE

___STOMACH ULCERS

___OTHER: _____

___SWELLING

___TUBERCULOSIS

___VARICOSE VIENS

___NONE

SURGICAL HISTORY

___APPENDECTOMY

___BACK

___C-SECTION

___EYE

___FOOT/ANKLE

___GALL BLADDER

___HEART – TYPE _____

___HYSTERECTOMY

___KNEE

___THYROIDECTOMY

___TONSILLECTOMY

___OTHER: _____

HEALTH REVIEW

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

GENERAL – FEVER, CHILLS, FATGUE, WEIGHT LOSS, WEIGHT GAIN, N/A

HEAD – HEADACHE, VISUAL PROBLEMS, HEARING PROBLEMS, LIGHT SENSITIVITY, N/A

CARDIOVASCULAR – CHEST PAIN, PALPITATIONS, DIZZINESS, SWELLING OF LEGS, OTHER: _____, N/A

HEMATOLOGY – ANEMIA, ABNORMAL BLEEDING/BRUISING, BLOOD CLOTS, BLEEDING DISORDERS, OTHER: _____, N/A

RESPIRATORY – PERSISTANT COUGH, WHEEZING, SHORTNESS OF BREATH, N/A

GASTROINTESTIONAL – DIFFICULTY SWALLOWING, INDIGESTION / HEARTBURN, ABDOMINAL PAIN, CHANGE IN BOWELS, N/A

URINARY – PAINFUL URINATION, FREQUENT NIGHTTIME URINATION, BLADDER LEAKING, OTHER: _____, N/A

MUSCULOSKELETAL – JOINT PAIN / SWELLING / STIFFNESS, BACK PAIN, MUSCLE WEAKNESS, N/A

SKIN – RASH, SUSPICIOUS LESION, ITCHING, N/A

NEUROLOGICAL – NUMBNESS OF HANDS & FEET, SEIZURES, TREMORS, PARALYSIS, N/A

PSYCHIATRIC – DEPRESSION, ANXIETY, PROBLEMS SLEEPING, MEMORY LOSS, N/A

EDOCRINE – HEAT / COLD INTOLERANCE, HOT FLASHES, CHANGE IN HAIR / SKIN TEXTURES, EXCESSIVE THIRST, EXCESSIVE URINATION, N/A

MEDICATION (PLEASE PRINT)

1. _____ **6. _____**

2. _____ **7. _____**

3. _____ **8. _____**

4. _____ **9. _____**

5. _____ **10. _____**

___ NOT CURRENTLY TAKING MEDICATION

PODIATRIC HISTORY

___BUNIONS ___ATHLETES FOOT ___HEEL / ARCH PAIN

___DIABETIC FOOT ULCER ___INGROWN NAILS ___PLANTAR WART

___ACHILLES TENDON PAIN ___BACK PAIN ___DISCOLORATION OF TOES / FEET

___FEET / TOES NUMB ___DIFFICULTY WALKING OR RUNNING ___ANKLE PAIN

SHOE SIZE _____

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 as well as unsigned forms needed for diagnostic purposes.

_____ _____

Signature of Patient or Personal Representative **Date**

_____

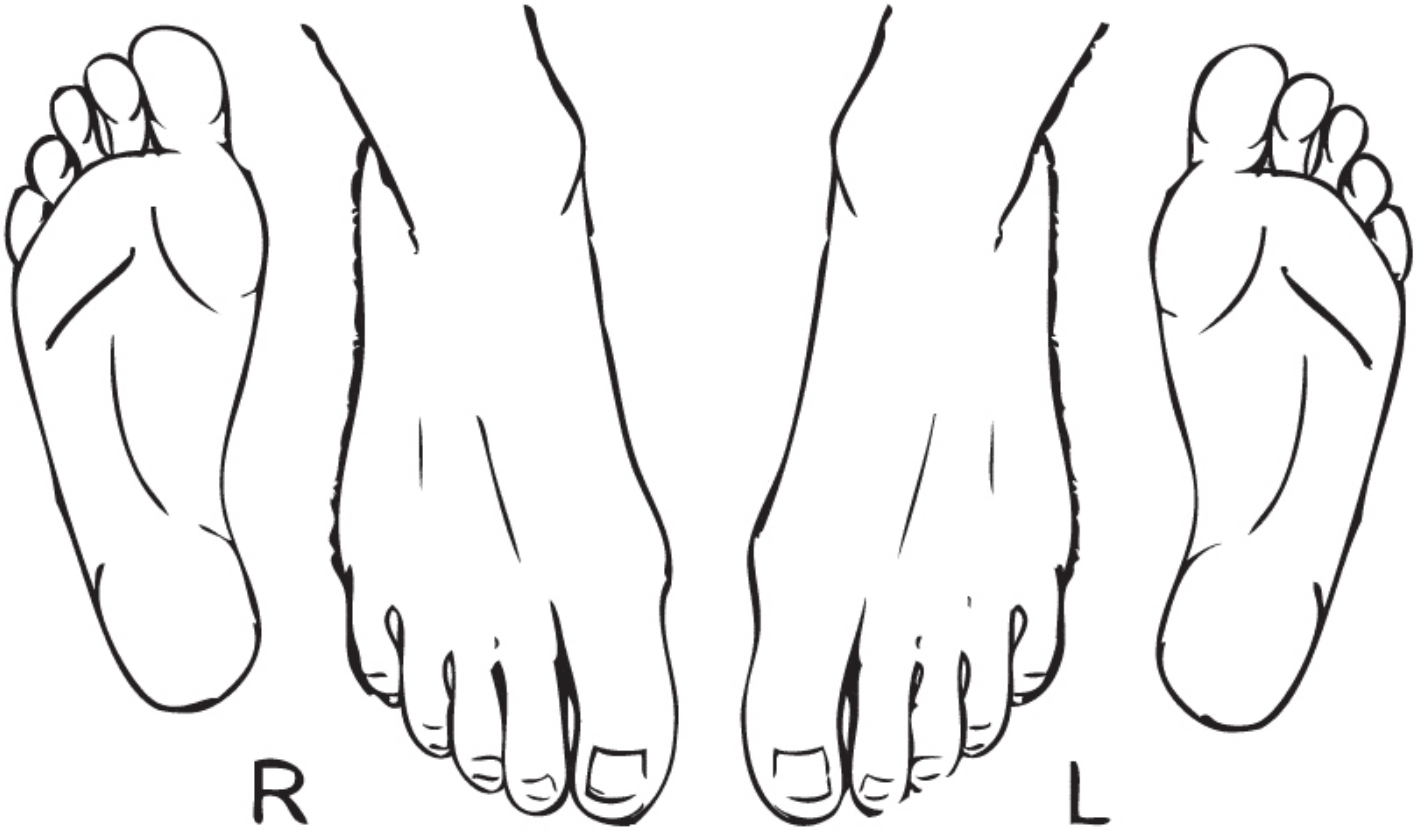
Relationship of Personal Representative to the Patient

_____ _____

Print Patient's Name **Print Personal Representative's Name**

Foot Specialists
OF BIRMINGHAM

PLEASE MARK WHERE YOU ARE EXPERIENCING PAIN / PROBLEMS



INTIAL _____ DATE_____

PERMISSION TO DISCLOSE PROTECTED HEALTH INFORMATION
CONSENT AND ACKNOWLEGEMENT
(PLEASE PRINT)

Patient Name _____ Date of Birth _____

Patient's Address _____ SSN _____

_____

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

- ☐ 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 a message with detailed information
___Leave message with call back number only

☐ **Work Telephone ___(___)_____-_____**
___O.K. to leave a message with detailed information
___Leave message with call back number only

☐ **Written Communication**
___O.K. to mail to my home address or email to personal email
___O.K. to mail to my work / office or email to business email
___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 request 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.

ACKNOWLEDGEMENT:
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 skilled 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 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 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 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 follow payment methods: Cash, Check and VISA/MasterCard.

COLLECTIONS: You agree, in order for us and any third-party collection agency to service your account or to collect any amounts you may owe, we may contact you by telephone at any number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or email, using any email address you provided to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automated dialing device, as applicable.

- **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 non-covered services based on your insurance benefit information at the time of service.**
- **An additional $35 will be added to your statement if the check is returned for insufficient funds (NSF).**

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 request physician to provide continuity of care. I authorize the use of this signature on all insurance submission.

Patient Signature: _____ Date: _____

FINANCIALLY RESPONSIBLE PARTY

Signature: _____ Relationship to Patient: _____ Date: _____