LOWER CAPE PODIATRY

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To help our office ensure the accuracy with your podiatric care, please complete this information.
Please bring your photo ID with you to your appointment.

If your insurance requires a referral, please request it from your PCP prior to your appointment. If you do not obtain the referral by the day of the visit, you will be financially responsible.

Name _____ Gender: ☐ Male ☐ Female
First Name Last Name MI

Date of Birth _____

Primary Insurance _____ Member ID _____

Secondary Insurance _____ Member ID _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner Retired? ☐ Yes ☐ No

Local Address _____
Street City State Zip

Permanent Billing/ Mailing Address _____
Street City State Zip

Home Phone: _____ Other Phone Number: _____

Email Address: _____

Employer _____ Occupation _____ Phone_____

Employer Address _____
Street City State Zip

Emergency Contact _____
Name Phone Number Relationship

Primary Care Physician: _____ Date last seen: _____

RACE

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White
- ☐ Decline

ETHNICITY

- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Latino
- ☐ Black or African American
- ☐ Decline

Preferred Language: _____

PODIATRIC HEALTH

Please describe your present foot problem(s) in detail: _____

_____

_____

How long have you had this problem: _____

What treatments have you tried? Include other doctor visits, over-the-counter products, or prescriptions_____

_____

GENERAL HEALTH

Vital Signs: **Blood Pressure: ____/____** **Height: _____** **Weight: _____**

Please list all surgical operations you have had _____

_____

Do you have, or have you ever had any of the following?

	Yes	No	**Mother Yes**	**Father Yes**		Yes	No	**Mother Yes**	**Father Yes**
Anemia	☐	☐	☐	☐	Parkinson's	☐	☐	☐	☐
Arthritis	☐	☐			Multiple Sclerosis	☐	☐	☐	☐
Back Problems	☐	☐			Kidney Disease	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	Liver Disease	☐	☐	☐	☐
Circulatory Problems	☐	☐	☐	☐	MRSA Infection	☐	☐		
Diabetes	☐	☐	☐	☐	Pacemaker	☐	☐		
Heart Condition/Disease	☐	☐	☐	☐	Thyroid Problems	☐	☐	☐	☐
Hepatitis	☐	☐			Ulcerations	☐	☐		
High Blood Pressure	☐	☐	☐	☐	DVT (blood clots)	☐	☐		
Stroke	☐	☐	☐	☐	Gout	☐	☐	☐	☐

Other conditions/ problems: _____

_____

Please list your current medications **including** any supplements or provide a detailed list:

_____

_____

Your preferred pharmacy: _____ Location: _____

Covid Vaccines, please check if applicable

Type	1st Injection	2nd Injection
Johnson & Johnson		
Moderna		
Pfeizer		

GENERAL HEALTH *(Continued)*

Are you **allergic** to any of the following?

Latex: ☐ Yes ☐ No **Antibiotics:** ☐ Yes ☐ No **Pain Medication:** ☐ Yes ☐ No **Other Medication:** ☐ Yes ☐ No

Please specify what you are allergic to _____

_____

Do you smoke? ☐ **Yes** ☐ **No** How many packs per day: _____ If you have quit, in what year? _____

Do you consume alcohol? ☐ Yes ☐ No Glasses or beers per week: _____

For Patient with Medical Insurance and Medicare

The federal government is requiring all physicians to collect the following information.
This office must comply with this program or be penalized for non-participation.

1. Have you received a **flu vaccination** for the current season? ☐ **Yes** ☐ **No**
   If no, please note the reason: ☐ Patient allergy ☐ Patient declined ☐ Vaccine unavailable

2. Have you received a **Pneumonia vaccination**? ☐ **Yes** ☐ **No**

3. Do you have a **living will** or do you have someone to make decisions on your behalf? ☐ **Yes** ☐ **No**

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was given a copy of the Notice of Privacy Practices and have read (or had the opportunity to read if I so chose) and understood the Notice.

I hereby specifically authorize disclosure of my protected health care information to the person(s) indicated below.
Please circle all that apply and specify their name(s):

Any members of my immediate family _____ YES NO

My spouse only _____ YES NO

Other persons _____ YES NO

_____ _____ _____

Patient Name or Authorized Representative **Date** **Signature**

Lower Cape Podiatry Services Financial Policy

Your Responsibility - You are financially responsible for any services rendered at Lower Cape Podiatry. Many patients have obtained insurance coverage to assist with their medical costs. Your insurance plan is specific and does not guarantee coverage. You should review your plan coverage to determine what you are obligated to pay. It is the patient's responsibility to know their coverage. Lower Cape Podiatry will assist you through the process of insurance coverage whenever possible, but it is important to know the specifics of each individual plan. The patient is responsible for the bill should the insurance company decline payment. As a courtesy, we will file a claim to your primary, secondary and if applicable tertiary insurance plans. Co-payments and charges for non-covered services are due at the time of service**.** Lower Cape Podiatry does not bill for specialty services including but not limited to diagnostic lab tests performed at other facilities or specimens forwarded to another facility.

Patients Without Insurance - Lower Cape Podiatry is pleased to be able to provide services to patients that do not have insurance. However, if you do not have insurance you will be required to pay for services at the time of service unless other arrangements have been made with the billing manager.

Medicare Patients - Lower Cape Podiatry accepts Medicare assignment. We require all patients to set up a crossover between Medicare and your supplementary insurer; if a crossover isn't possible, we will make a single attempt to bill your secondary insurance if provided with the proper insurance information. You are responsible for co-insurance, deductibles and payments for non-covered services.

Private Insurance Patients - Lower Cape Podiatry accepts assignment for many insurances. You will be required to pay applicable co-payments at the time of service and you are responsible for any coinsurance, deductibles and payments for non-covered services.

HMO Patients - If Lower Cape Podiatry participates with your insurance, you will be required to pay the applicable co-payment amount at the time of service. When required, you are responsible for obtaining a primary insurance referral from your primary care physician for your date(s) of service. If you have not obtained the necessary insurance referral, you will be required to sign a referral waiver form which states you are financially responsible for said visit.

Methods of Payments - Lower Cape Podiatry accepts cash, check, Visa, MasterCard, Discover and American Express. We do not accept post-dated checks nor will we hold checks for any length of time.
Payment arrangements can be made as necessary.

Returned Checks - There will be a $25.00 fee assessed for any and all returned checks from the bank for any reason. This is the fee that we are assessed by our bank when your check is returned.

Prior Balance - If you have a prior balance at the time of services are requested, you will be asked to pay the prior balance in full before being seen. If the balance cannot be paid in full, then we may consider monthly payment arrangements.

Collection Procedures - Members of our billing department are always available to help you with questions and or payment arrangements. Once made in writing, agreements are binding. We consider payment by the patient for services rendered to be an important part of the patient's role in the patient/ physician relationship. Prompt payment for services rendered is expected and failure to comply or respond to repeated communications from our office may result in immediate discharge from the practice with 30 day emergency coverage and/ or involvement of an outside collections agency. If we have sent two statements with no payment being received you will incur a $10.00 administration fee with your third statement. Once an account has been referred to an outside agency, prior balances must be resolved before seeing a physician. Any expense incurred as a result of Lower Cape Podiatry's attempt to collect past due balances will become the responsibility of the patient or guarantor, including all collection agency fees.

I have read and understand the terms of this contract.

Patient/ Responsible Party: _____ **Date:** _____