PODIATRIC REGISTRATION AND HISTORY

1. PATIENT INFORMATION

Date _____

Patient _____

Address _____

_____

City State Zip

Sex: ☐M ☐F Age ____ Birthdate _____

☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

_____

2. INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐Yes ☐No

Subscriber Name _____

Birthdate _____ SS # _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____ _____

Relationship Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. _____ for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Relationship Date

3. PHONE NUMBERS

Home _____ Work _____ Ext _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone _____ Work Phone _____

4. PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints.)

_____

_____

_____

Have you ever been to a Podiatrist before? ☐Yes ☐No

If yes, please list.

Name _____

Last visit _____

Is there any personal or family history of diabetes? ☐Yes ☐No

Your occupation _____

Cigarette/Tobacco use _____

Years smoked _____

Athletic activities in which you participate (please list and indicate frequency)

_____

_____

Please indicate which foot problems you now have or have had in the past.

Ankle Pain	☐Yes ☐No
Athlete's Foot	☐Yes ☐No
Bunions	☐Yes ☐No
Corns and Calluses	☐Yes ☐No
Cramps or Numbness in Feet or Legs	☐Yes ☐No
Flat Feet	☐Yes ☐No
Foot or Leg Cramps	☐Yes ☐No
Heel Pain	☐Yes ☐No
Ingrown Toenails	☐Yes ☐No
Plantar Warts	☐Yes ☐No
Swelling in Ankles or Feet	☐Yes ☐No
Tired Feet	☐Yes ☐No

5. MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐Yes ☐No	Diabetes	☐Yes ☐No	Psychiatric Care	☐Yes ☐No
Allergies to Anesthetics	☐Yes ☐No	Ear Problems	☐Yes ☐No	Radiation Treatment	☐Yes ☐No
Allergies to Medicine or Drugs	☐Yes ☐No	Epilepsy	☐Yes ☐No	Rash	☐Yes ☐No
Anemia	☐Yes ☐No	Eye Problems	☐Yes ☐No	Respiratory Disease	☐Yes ☐No
Angina	☐Yes ☐No	Fainting	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No
Arthritis	☐Yes ☐No	Foot or Leg Cramps	☐Yes ☐No	Shortness of Breath	☐Yes ☐No
Artificial Heart Valves or Joints	☐Yes ☐No	Gout	☐Yes ☐No	Sinus Problems	☐Yes ☐No
Asthma	☐Yes ☐No	Headaches	☐Yes ☐No	Special Diet	☐Yes ☐No
Back Problems	☐Yes ☐No	Heart Disease	☐Yes ☐No	Stroke	☐Yes ☐No
Bleeding Disorders	☐Yes ☐No	Hemophilia	☐Yes ☐No	Swelling in Ankles, Feet	☐Yes ☐No
Cancer	☐Yes ☐No	Hepatitis or Jaundice	☐Yes ☐No	Swollen Neck Glands	☐Yes ☐No
Chemical Dependency	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Tired Feet	☐Yes ☐No
Chest Pain	☐Yes ☐No	Kidney Problems	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Chronic Diarrhea	☐Yes ☐No	Liver Disease	☐Yes ☐No	Ulcers	☐Yes ☐No
Circulatory Problems	☐Yes ☐No	Low Blood Pressure	☐Yes ☐No	Varicose Veins	☐Yes ☐No
		Nervous Problems	☐Yes ☐No	Venereal Disease	☐Yes ☐No
		Phlebitis	☐Yes ☐No	Weight Loss, unexplained	☐Yes ☐No

Surgeries you have had_____

_____

_____

Hospitalization other than for the surgeries listed _____

_____

_____

Family Physician _____ Last visit date _____

Are you now, or have you been, under any other doctor's care for any reason over the past two years? ☐Yes ☐No

If yes, please explain _____

_____

_____

6. MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins _____

_____

_____

Pharmacy Name(s) _____

Pharmacy Phone(s)_____

Do you take oral contraceptives? ☐Yes ☐No

7. ALLERGIES

☐Adhesive/Tape
☐Anticoagulant Therapy
☐Aspirin
☐Codeine
☐Demerol
☐Iodine
☐Local Anesthetics
☐Novocaine
☐Penicillin
☐Sea foods
☐Sulfa

Other _____

CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient's Signature _____Date_____

Kentlands Foot & Ankle Center

Dr. Jon M. Sherman
Podiatrist
www.bestfootcare.com

60 Market Street, Suite #202 **Gaithersburg MD 20878** **301-330-5666**

Notice of Privacy Practices

This notice will tell you about the ways we may use and disclose health information that identifies you. We will also describe your rights and certain obligations we have regarding the use and disclosure of health information. We are required by law to maintain the privacy of health information that identifies you; give you this Notice of our legal duties and privacy practices with respect to your health information; and following the terms of our notice that are in effect. This Notice covers all staff at Kentlands Foot & Ankle Center.

How we may use and disclose health information about you

- **For Treatment:** We may use health information to provide you with medical treatment or services. We may also share health information such as prescriptions, lab work or X-rays to coordinate your treatment.
- **For Payment:** We may use and disclose health information so that we may bill for services you receive in our office and collect payment from you, an insurance company or another third party. We may need to give information about your treatment to your insurer, for example. We may also give information to your insurer to receive prior approval or determine eligibility. In the event of overdue bills we may need give information to a collection agency.
- **For Health Care Operations:** We may use and disclose health information for healthcare operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and for operation and management resources.
- **For Health Services:** We may use and disclose health information to remind you of an upcoming appointment or treatment. We may contact you about possible treatment options or health related benefits or services that may be of interest to you.
- **Individuals Involved in Your Care or Payment for Your Care:** We may release information to a person involved in your healthcare or helps pay for your care such as family. We may also notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.
- **As Required by Law:** We will disclose health information when require to do by international, federal state or local law.
- **To Avert a Serious Threat to Health or Safety:** We may use and disclose health information when necessary to prevent a serious threat to your health and safety or the health and safety of the general public. Any disclosure however will be to someone who may be able to prevent the threat.
- **Business Associates:** We may disclose health information to our business associates that perform functions on our behalf such as billing or medical transcriptions. All of our business associates are obligated under contract to protect the privacy of your information.
- **Organ and Tissue Donation:** If you are an organ or tissue donor we may release health information to organizations that handle such operations.
- **Military and Veterans:** If you are a member of the armed forces we may release health information as required by the military command authorities.
- **Worker's Compenation:** We may release health information for worker's compensation or similar programs.
- **Public Health Activities:** We may be required to report your health information to authorities to prevent or control disease, injury or disability. Examples include reporting certain diseases to the Centers for Disease Control or information related to child abuse or neglect.

- **Health Oversight Agencies:** We may disclose health information to a health oversight agency for activities authorized by law. These activities include, for example, audits, investigations, inspections and licensure.
- **Lawsuits and Disputes:** If you are involved in a lawsuit or dispute we may disclose health information in response to a court or administrative order. We may also disclose health information in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or obtain an order protecting the information requested.
- **Law Enforcement:** We may release health information if asked by a law enforcement official for the following reasons: in response to a court order, subpoena, warrant, summons or similar process; limited information to identify or locate a suspect, fugitive, material witness or missing person; about the victim of a crime if we are unable to obtain the person's agreement; about a death that may be result of criminal activity; about criminal conduct on our premises; and in emergency circumstances to report a crime, the location of a crime or victims or the identity or description of someone who committed the crime.
- **National Security and Intelligence Activities and Protective Services:** We may release health information to authorized federal officials for intelligence, counter-intelligence, and other national security related activities as authorized by law.
- **Coroners, Medical Examiners and Funeral Directors:** In the event of your death we may release health information to a coroner, medical examiner or funeral director so that they can carry out their duties.
- **Other uses:** Any other uses not covered by this Notice or the laws that apply to use will be made only with your written permission.

Patients Rights: You have the following rights subject to limitations regarding the health information we maintain about you:

- **Right to Inspect and Copy your health information:** We may charge for the cost of copying or mailing or other supplies related to your request.
- **Right to Request Amendments**.
- **Right to an Account of Disclosures of health information:** This is a list of disclosures of health information. The first list you request in a 12 month period is free. For additional lists we may charge you for the costs of providing the list.
- **Right to Request Restrictions:** You have the right to request a restriction or limitation on the health information we use or disclose for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment of your care. We are not required to agree to your request. If we agree will comply with your request unless we terminate our agreement or the information is needed to provide you with emergency treatment.
- **Right to Request Confidential Communications:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example you can request that we only contact you at certain phone numbers. We will accommodate all reasonable requests.

We reserve the right to change this notice. We will post a copy of the current notice in the office.

I _____ have received and read the Notice of Privacy Practices. I understand and agree to the terms above.

_____ _____

Patient/Parent Signature Date

I would like to grant access to my medical information to the following person.

_____ _____

Name Relationship

Kentlands Foot & Ankle Center

Dr. Jon M. Sherman
Podiatrist
www.bestfootcare.com

60 Market Street, Suite #202 **Gaithersburg MD 20878** **301-330-5666**

Financial Policy

Welcome to Kentlands Foot & Ankle Center. Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please ask our front office.

1. Payment is expected at the time of your visit. We will accept cash or credit cards. Payment will include any unmet deductible, co-insurance, co-payment or non-covered charges from your insurance company. If you do not carry insurance, payment in full is expected at time of service. We do ask for a copy of an ID card due to many cases of identity theft.
2. As our patient, you are responsible for obtaining a properly dated referral if required by your insurer. You are also responsible for payment if your claim rejects from lack of one. Please note most insurances will only accept referrals less than 90 days before date of service.
3. Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign benefits to the doctor. If your insurance company does not pay within a reasonable period we will look to you for payment. Due to the differing contracts available, our staff cannot guarantee payment for services rendered. We will attempt to verify benefits for specialized services or procedures, however you remain responsible for charges for any services rendered.
4. You must inform the office of all insurance/address changes and referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
5. **Missed Appointments**: Unless they are canceled at least 24 hours in advance you will be assessed a $25 missed appointment fee. Surgeries must be canceled 7 days in advance or will be assessed a $50 missed fee.
6. **Forms Fees**: Completing insurance paperwork, school forms/letters, and copying medical records requires office staff time and time away from patients for the doctors. A charge of $10 will be assessed for this service plus applicable postage or notary fees. Copying fees for medical records is $10 for the first 20 pages, and $0.50 per page above the initial 20. Kentlands Foot and Ankle will have 15 business days in which to copy records before making them available for patient pick up. Copying will commence after receipt of payment.
7. **Collections**: If your account becomes delinquent it will be sent to collections. Any additional fees for this will be added to your balance. This includes but is not limited to late fees, collections agency fees, court costs, interest and fines.
8. **Note for divorced parents of patients**: The adult who signs this form for the minor into our practice on the day of service accepts responsibility for payment. This office does not promise to send bills or records to the other parent/guardian for issues of payment or communications.

Our office will communicate about treatment and payment with the parent who signs in on the day of treatment.

In an effort to provide you with flexible payment arrangement we have expanded our payment policy. Please read and select a payment method below:

- ☐ Payment by Cash/Check/Credit Card
- ☐ Automatic monthly billing to your VISA/ Master Card
- ☐ Guarantee any amount not covered by insurance with a VISA/MasterCard

Our office is a fully approved and accredited user of the *Visa and MasterCard Health Care Program* which will enable you to use your Visa and MasterCard to automatically cover amounts not paid by your insurance. You may choose a comfortable amount to be automatically billed to your Visa or MasterCard on a monthly basis.

By signing below you understand that you, the patient or parent/guardian are financially responsible to Kentlands Foot & Ankle Center for charges not covered by the assignment insurance benefits.

I _____ have read and understood the practice's financial policy and agree to be bound by its terms.

_____ _____

Patient/Parent Signature Date