Today's Date_____

951 Transport Drive, Valparaiso
219-464-4100

Patient Information Form

First Name:_____ MI_____ Last Name_____

Date of Birth_____ Social Security Number_____ M____F____

Home Phone_____ Cell Phone_____

Work Phone_____ ***How did you hear about us?***_____

Street address_____ City _____ State _____ Zip _____

Email Address_____

Preferred Method of Contact: Home____ Cell____ Email____

Patient occupation_____ Employer Name_____

If patient is a minor (under 18), name of parent or guardian:_____

Emergency Contact _____Phone_____ Relation to patient_____

Primary Insurance Policy holder's Name_____ DOB_____

SS # if needed for ID #_____Relation to patient_____

Address if different from Patient_____

Secondary Insurance Policy holder's Name_____ DOB_____

SS # if needed for the ID #_____Relation to patient_____

Address if different from Patient _____

Is your foot injury or foot pain related to a work-related injury? ____ YES _____ NO

Do you have a current Workman's Comp case? _____ YES _____ NO

Do you reside in a Nursing Home, Skilled Nursing Facility or Assisted Living? _____ YES _____ NO
If yes, name of facility:_____

Name_____

Preferred Language: English___ Spanish____ Other_____

Ethnicity: Non-Hispanic or Latino____ Hispanic or Latino_____

Race: Asian____ American Indian or Alaska Native____ Black or African American_____

Caucasian or White_____ Native Hawaiian or Pacific Islander____ Other_____

Authorization to Disclose Health Information

Please list below the names of the people to whom you wish to have access to your medical record. Please note that the people listed will have access to billing, medical and appointment information unless otherwise indicated.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

I certify that the information provided on this form is true and accurate to the best of my knowledge.

Patient signature _____Date: _____

If patient is a minor:

Parent or guardian signature_____ Date:_____

Patient's name _____ Today's date _____
DOB _____ Height _____ Weight _____ Shoe size_____
Last blood pressure _____
Allergies _____

Medications _____

_____

Do you give our office permission to access your medications through our computer? Yes ____ No____

Preferred Pharmacy _____ Address _____ Phone_____

For Diabetics Only

What was your last blood sugar reading? _____ When was it taken? _____
When and Where did you have your last eye exam? _____
Name and address of your Diabetic doctor _____
_____
What was your last A1C _____ Date _____

Please circle all of the medical conditions you have

Diabetes	Stomach Ulcers	Thyroid Disease	Hypertension	Heart Disease
COPD	High cholesterol	Lung Disease	Kidney Disease	Cancer
Gout	Depression	Headaches	Fibromyalgia	Asthma
Hepatitis	Foot Deformity	Osteoporosis	Varicose Veins	Bleeding Disorder
Peripheral Vascular Disease		Rheumatoid Arthritis		Leg or foot Ulcers

Family History

Diabetes:	mother	father	brother	sister	son	daughter
Hypertension:	mother	father	brother	sister	son	daughter
Bleeding Disorder:	mother	father	brother	sister	son	daughter
Kidney Problems:	mother	father	brother	sister	son	daughter
Liver Problems:	mother	father	brother	sister	son	daughter
Heart Disease:	mother	father	brother	sister	son	daughter
Stroke:	mother	father	brother	sister	son	daughter

Family Physician name and address _____
Other physicians _____
When and Where was your last flu shot? _____
When and Where was your last Pneumonia shot? _____

Do you smoke cigarettes or use tobacco? _____
If so, what age did you start? _____ How many packs per day? _____
Do you drink alcohol? Never ___ occasionally ___ moderate ___ heavy ___
Any recreational drug use? _____ If yes, explain _____

Name _____ Marital Status _____

Reason for your visit today (be specific) _____
Location of your problem _____
Quality: aching ___ burning ___ stabbing ___ throbbing ___ sharp ___ dull ___ occasional ___
constant ___ worsening ___ improving ___
Severity: no pain ___ mild ___ moderate ___ severe ___
What is your pain level on a scale of 1-10? ____
When did your symptoms begin? (days, weeks, months, etc…) _____
When does it bother you most? (morning or evening) _____
Any known accident or injury? _____ If so, when? _____
Explain: _____
What helps your symptoms? sitting ___ standing ___ lying down ___ heat ___ ice ___ rest ___ elevation ___
medications ___

What makes your symptoms worse? sitting ___ standing ___walking ___ lying down ___ lifting ___ cold weather ___
Any associated symptoms? numbness ___ tingling ___ weakness ___ swelling ___ redness ___ drainage ___

What previous treatments have you had? surgery ___ physical therapy ___ injections ___ braces ___ x-rays ___ MRI ___
If so, when and where? _____

<u>Please circle all of the following that you are currently experiencing</u>

Constitutional: fever, night sweats, weight loss, weight gain, exercise intolerance

Eyes: dry eyes, irritation, vision changes

Ears: difficulty hearing, ear pain

Nose: frequent nose bleeds, nose and or sinus pain

Mouth/Throat: sore throat, snoring, dry mouth, mouth sores, problems with teeth

Cardio: chest pain, shortness of breath, arm pain upon exertion

Respiratory: cough, congestion

Gastrointestinal: abdominal pain, vomiting, diarrhea

Genitourinary: incontinence, difficulty urinating, increased frequency, blood in urine

Musculoskeletal: muscle aches, muscle weakness, back pain, swelling in the extremities

Integumentary: abnormal moles, rashes

Neurologic: loss of consciousness, numbness, seizures, weakness, dizziness, headaches

Psych: depression, sleep disturbances, alcohol abuse

South Shore Foot and Ankle, PC
Financial Policy

Thank you for choosing South Shore Foot and Ankle, PC as your foot care provider. We are committed to providing you with quality and affordable health care. Please read the following office payment policy and fee/free to ask us any questions that you may have. Once you accept this policy, Kindly sign in the space provided. A copy will be provided upon request.

Insurance: We participate in most insurance plans, including Medicare. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is require until we can verify your coverage. Knowing your insurance benefits is YOUR responsibility.

Self-pay: If you are not insured by a plan we participate with, payment in full is expected at each visit.

Claims Submission: We will submit your claims and assist you in any way we reasonable can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

Co-payments and deductibles: All co-payments and deductibles must be paid at the time of service. This arrangement is a part of your contract with your insurance company Failure on our part to collect your co-pay from the patient can be considered Fraud. Please help us in upholding the law by paying your portion of the insurance benefits at each visit.

Non-Covered services: Please be aware that some or/and all the services you receive may be uncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

Proof of insurance: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance card. If you fail to provide us with the correct information in a timely manner 1 you may be responsible for the balance of a claim.

Referral: If required, obtaining the proper referral from your primary care physician is YOUR responsibility.
Covered changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefit.

Nonpayment: invoices are sent out every 30 days. Your prompt pyment will assist us in keeping the cost of healthcare down. If your account is over 60 days past due, we may refer the account to a collection agency. You bear complete financial responsibility for any and all fee(s) incurred.

Payment arrangements: Payment arrangements can be made on a case by case basis. A payment arrangement form will need to be filled out. (Please see our Biller for more details.) We accept the following payment methods: Cash, check, or Visa/MasterCard/Discover. An additional $25.00 will be add to your statement if your check is returned from your bank. If a check is sent back, payment will only be accepted by either cash or credit cards. In the event that your insurance company sends payment to you, the patient, it should be forwarded to our office to be applied to your balance.

Forms and documents: It is our policy to charge $6-$10.00 for completion of all forms, such as disability applications and for medical records, please allow 30 days for completion. The cost for Medical Records are as follows for Indiana residents:
Indiana - The permitted charges for making and providing copies of medical records are set by the Department of Insurance. Title 16, Health and Hospitals. 16-39-9-2. The maximum charge is $1 .00 per page for the first 10 pages. 50 cents per page for pages 11 through 50. 25 cents per page for pages 51 and higher. An additional labor fee of $20 can be charged. If labor fee is charged, there is no cost for the first 10 pages. Actual cost of mailing is charged. Additional $10 for rush jobs (within 2 days). Additional $20.00 for certified copy. (2006 amendments). 760 IAC 1-71-3. General requirements. A provider or medical records company shall consider waiving or reducing the charges if the patient requested the records for his own use and the charge will cause an undue financial hardship on him. 760 IAC 1-71-4. Waiver of charges.

THANK YOU FOR UNDERSTANDING OUR FINANCIAL POLICY. PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS.

I have read the above policy regarding my financial responsibility to South Shore Foot and Ankle, PC for medical services provided.

_____	_____	_____
Signature of patient or responsible party	Date	Relationship to patient

050218 km

Medical Information Release Form
(HIPAA Release Form)

Name:_____ Date of Birth: _____/_____/_____

Release of Information

___ I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

___ Spouse _____

___ Child(ren) _____

___ Other _____

___ Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages

Please call ___ my home ___ my work ___ my cell number_____

If unable to reach me:

___ you may leave a detailed message

___ please leave a message asking me to return your call

___ _____

The best time to reach me is (day) _____ between (time)_____

Signed:_____ Date: _____

Witness:_____ Date: _____