SOUTH SHORE FOOT & ANKLE

P 219-464-4100 | F 219-464-4114 | 951 TRANSPORT DRIVE VALPARAISO, IN 46383 | SOUTHSHOREFOOTANDANKLE.COM

NEW PATIENT REGISTRATION

Name First _____ **Name Last** _____

Birthdate _____ **SS #** _____

Sex: ☐ Male ☐ Female ☐Other **Marital status**: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home address _____

City _____ **State** _____**Zip** _____

Mobile Phone #_____ **Home Phone #**_____

Email: _____

Preferred Method of Contact: ☐ Home ☐Cell ☐ Email

☐ **I agree to receive automated text, voice messages and/or email to the provided information including important updates about the office, appointments and offer promotions.**

Your Primary Doctor : _____

Referred by: _____**/ Google**

Occupation: _____ **Employer**: _____

Health Insurance: Primary Insurance _____ Secondary Insurance _____

Policy #: _____ Policy #: _____

Name of Insured (if different than patient) _____ DOB:_____

SSN # :_____ Relationship to patient: _____

Preferred Language: ☐ English ☐Spanish ☐Other _____ **Ethnicity:** ☐ Non-Hispanic/Latino ☐Hispanic/Latino

Race: ☐ Asian ☐American Indian or Alaska Native ☐Black /African American ☐Caucasian/White

☐Native Hawaiian or Pacific Islander ☐ Other_____

EMERGENCY CONTACT: Name _____

Relationship to Patient: _____ **Primary Phone #** _____

Do you authorize us to discuss your health information with this person? ____YES ____NO

******* If patient is a minor (under age 18), parent or guardian to fill out *******

Parent or Guardian Name _____

Relationship to Patient _____ **Primary Phone Number**_____

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/ Guardian signature_____ **Date:**_____

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COMPREHENSIVE HEALTH REVIEW

Patient Name: _____ **Date of Birth:**_____

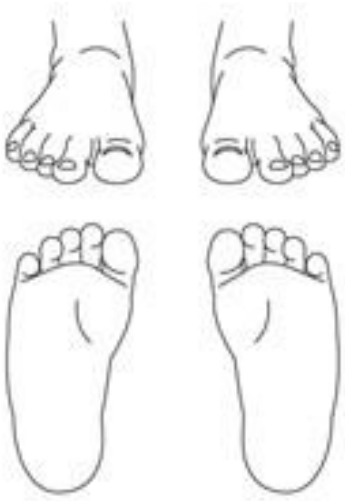
Age _____ **Height** _____ **Weight** _____ **Shoe Size** _____ **BP** _____

What is your specific foot/ankle problem?

_____

_____

RIGHT LEFT



When did this begin? _____

The problem is: ☐ Improving ☐ Worsening ☐ Unchanged

Onset: ☐ Sudden ☐ Gradual

What makes it worse? _____

What makes it better? _____

Does it hurt? ☐ Yes ☐ No **Duration:** ☐ Constant ☐ Every now and then

Rate the pain level: 0 (no pain) 1 2 3 4 5 6 7 8 9 10 (worse pain)

Describe the pain: ☐ Sharp ☐ Dull ☐ Achy ☐ Burning ☐ Shooting ☐ Clicking ☐ Cramping

☐ Itching ☐ Other _____

Describe previous treatment: _____or ☐ None

Describe previous surgical treatment: _____or ☐ None

Is this from an injury? ☐ Yes ☐ No **Is it work-related?** ☐ Yes ☐ No

REVIEW OF SYSTEMS (Circle if you **currently** experience any of the following):

Constitutional: sudden weight loss or weight gain, fever, fatigue

Head: headache, dizziness, vision changes

Cardiovascular: cold feet, night cramps, pain in calves when walking, pain in legs at rest, chest pain, swelling in legs

Respiratory: cough, difficulty breathing

Musculoskeletal: joint pain or aches, low back problems, weakness

Neurological: shooting or burning pain, numbness, tingling

Psych: depression, suicidal thoughts, forgetfulness, dementia, mood swings

Gastrointestinal: nausea, vomiting, upset stomach, indigestion

Skin: rashes, dry skin, itchiness, open sores, toenail fungus, nail changes, callus, plantar warts

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PAST MEDICAL HISTORY (Circle if you have/had):

AIDS / HIV	Bleeding, clot disorder	Gout	Kidney problems
Arthritis	Cancer	Headaches/migraines	Liver disease
Anemia	Chest pain	Hepatitis A / B / C	Neuropathy
Artificial heart valve/heart disease	Circulation problems	High or low blood pressure	Psychiatric care
Asthma or shortness of breath	Diabetes Type 1	Sexually transmitted disease (STD)	Stroke
Back problems	Diabetes Type 2	Stomach ulcers	Tuberculosis
	Epilepsy/seizure		Other:
	Eye problems		

HOSPITALIZATIONS / SURGICAL HISTORY:

_____
_____
_____

FAMILY MEDICAL HISTORY

Mother _____
Father _____
Siblings _____

SOCIAL HISTORY

I live with: ☐ no one ☐ spouse ☐ children ☐ parents ☐ other

I stand ____ % of my day I exercise, per week: ☐ 0 days ☐1-2 days ☐ 3+ days

List sports/activities _____

Tobacco or nicotine use, # of years _____Recreational drug use _____

Former smoker quit date _____Alcohol use (# drinks/week) _____

ALLERGIES :☐ Codeine ☐ Contrast dye ☐ Latex ☐ Penicillin ☐ Sulfa ☐Shellfish ☐Other:_____

CONSENT FOR ELECTRONIC PRESCRIBING/EXTERNAL PRESCRIPTION HISTORY:

South Shore Foot & Ankle will obtain the history of my past prescriptions. I understand that those prescriptions will become part of my electronic health record. Electronic Prescribing greatly reduces medication errors and enhances patient safety.

Initial only one: _____ **I provide informed consent to enroll me in the e-Prescribe program OR**

_____ **I DO NOT give permission for access to the above information.**

Preferred Pharmacy: _____ **City:** _____

MEDICATION List of medication, herbal supplement (or provide a copy of your list) with dosage and frequency.

_____

_____

I hereby give my permission to the doctor(s) at South Shore Foot and Ankle to perform diagnostic, therapeutic, and/or operative procedures as may be deemed necessary in diagnosis and/or treatment of my feet and/or ankles.

Print Name: _____

Signature: _____ Date:_____

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CONSENT TO TREATMENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended.

This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician and other health care providers, or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

If you are not the patient, please specify your relationship to the patient
Parent/Guardian
Other

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FINANCIAL POLICY / OFFICE FEES

Thank you for choosing South Shore Foot and Ankle, PC as your foot care provider. We are committed to providing you with high quality health 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 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. Please contact your insurance company with any questions you may have regarding your coverage.

MEDICARE: We are a participating Medicare provider. We accept Medicare benefit amounts. Medicare as well as your secondary insurance (if any) will be billed for you. However, not all services are covered by Medicare. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any copayment.

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company.

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

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 to assist your insurance company to pay your claims. Your insurance benefit is a contract between you and your insurance company.

COPAYMENTS/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 not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for full payment of these services at the time of service.

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 you may be responsible for the balance of a claim.

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan which mandates us that when you visit a specialist, you must have a referral from your primary care physician prior to seeking specialty care. Therefore- you are financially responsible for the services rendered, unless your referral is presented at the time of your visit. If required, obtaining the proper referral from your primary care physician is YOUR responsibility.

PATIENT BILLING: All co-payments, co-insurance, or deductibles amounts must be paid AT THE TIME OF SERVICE. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your portion of insurance benefits at each visit.

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PHYSICIAN PHONE CALLS: Phone calls with our physician(s) are a billable service, may be billed to your insurance company/companies, and are subject to your insurance benefits. You are responsible for your portion of insurance benefits for physician phone calls.

NON-CUSTOM DURABLE MEDICAL EQUIPMENT RETURNS: If a patient is unsatisfied with any non-custom Durable Medical Equipment item, it must be returned within 30 days per Medicare guidelines. Returns after 30 days will not be permitted.

DISABILITY/MISCELLANEOUS FORMS: All paperwork will take 7-10 business days and requires a $15.00 fee collected prior to form completion.

COPY FEE: We will provide copies of patient records at the patient's request. Any copies of medical records is subject to a fee. The chart fee is $20 (1-20 pages), 21-50 pages is $0.50 per page, and 51+ pages is $0.25 per page. You will bear complete financial responsibility for any fee(s) incurred.

CANCELLED/MISSED APPOINTMENT FEE: We understand cancellations may happen from time to time. In order to be respectful to other patients requiring medical attention, please call to cancel or reschedule promptly.
Appointments cancelled within 24 hours or you do not show at your appointment (no-show) may be charged **$50 fee**.
If you miss 3 or more appointments, you may be required to pay a **$50 deposit** to hold any future appointment time slots.
If you arrive >15 minutes late for an appointment, we may need to reschedule your appointment. You will bear complete financial responsibility for any fee(s) incurred. Repeated missed or late appointments may result in dismissal from our practice.

COLLECTIONS FEE: You will be sent up to three notices for your financial responsibility (co-insurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After the third and last notice, your account will be forwarded to our collection agency. "All delinquent accounts are subject to interest at the rate of 1.5% per month (18% per annum). Should your account be sent to collections, patient will be responsible for all collection costs, including attorney fees and court costs.". You bear complete financial responsibility for any fee(s) incurred.

Payment arrangements can be made on a case-by-case basis. We accept the following payment methods: Cash, check or VISA/Mastercard/Discover. An additional $35.00 fee will be added to your statement if the check is returned from your bank. If your insurance company sends payment to you, the patient, it should be forwarded to our office to be applied to your balance.

Please Initial:

_____ I have read the above policy (or had it explained to me) regarding my financial responsibility to South Shore Foot and Ankle for medical services provided. I agree to pay South Shore Foot and Ankle any balance unpaid by my insurance carrier for myself or the below named person. I agree to the office fees as outlined by South Shore Foot and Ankle.

Signature: _____ Date _____

Print Name: _____