InStride Hendersonville Podiatry

Name_____DOB_____

Allergies

	Yes	No	*If yes, list reaction		Yes	No	*If yes, list reaction
Adhesive Tape	Y	N	_____	Novocain/lidocaine	Y	N	_____
Latex	Y	N	_____	Penicillin	Y	N	_____
Iodine/Betadine	Y	N	_____	Sulfa Drugs	Y	N	_____

Other _____

Medications

Name	Dose	Name	Dose

Past Medical History

Cardiovascular	heart disease lymphedema coronary artery disease myocardical infarction peripheral arterial disease deep vein thrombosis hyperlipidema hypertension transient ischemic attack (TIA) cerebral infarction (stroke)
Pulmonary	asthma COPD pulmonary artery thrombosis dependence on oxygen tank
Neurologic	neurologic disorder peripheral neuropathy foot drop
Orthopedic	arthritic joints replacement of joint radiculopathy sciatica amputation
GenitoUrinary	renal disease (kidney) dialysis
Gastrointestinal	hepatic disease gastric ulcer Crohn's disease irritable bowel syndrome
Metabolic	diabetes mellitus thyroid disease gout
Dermatologic	ulcer on feet onychomycosis malignant neoplasm of skin psoriasis
Psychiatric	anxiety depression dementia alzheimers cognitive function diminished

Go to Page 2

Name_____DOB_____

Past Surgical History

Non Foot Surgery	pacemaker stent cataract coronary artery bypass appendectomy hernia repair hystrectomy hip replacement knee replacement tonsillectomy other:
Foot Surgery	hammertoe bunionectomy joint fusion amputation infection other:

Social History

Smoking	never previous current (daily) current (occasional)
Alcohol	never moderate recovering alcoholic
Drug	drug use never used drugs recovering from drug addiction
Exercise	none sedentary regularly (how often?)
Work Status	full time part time retired disability

Family History

Grandparents	diabetes heart disease cancer
Father	diabetes heart disease cancer deceased
Mother	diabetes heart disease cancer deceased
Siblings	diabetes heart disease cancer

Odds and Ends

Family Doctor	
Pharmacy	
Vitals	Height: Weight:
Shoe Size	

Signature_____Date_____

First Name_____M.I._____Last Name_____DOB_____

Street Address_____Apt_____City_____State_____ZipCode_____

Home Phone (____)_____Work(____)_____Cell Phone(____)_____

Single □ Married □ Widowed □ Employer/JobDescription_____

How Did You Hear About Our Practice?_____

Treatment Agreement

_____ **(Initial)** I understand that if I do not follow my doctor's instructions concerning my care and treatment, including any necessary physical therapy or medications, the outcome of my care and treatment could be put into jeopardy and less than optimal results may occur.

Release of Information

_____ **(Initial)** For the purpose of payment, I allow *InStride Hendersonville Podiatry* to release my Private Health Information to any and all of my insurance carriers, their third party payors and claim reviewers, until the claim is resolved. For the purpose of treatment, I also allow the above listed practice to release my information or contact any and all of my treating physicians.

Policies

Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you with an assignment of benefits. You are agreeing to have your insurance company pay the doctor directly.
You must provide personal (address, phone numbers, etc) and/or insurance changes (carriers, networks, ID numbers, etc) to the office. In the event the office is not informed, you will be responsible for any charges denied.
You are responsible for all authorizations/referrals/precerts needed to seek treatment with *InStride Hendersonville Podiatry*.
Your portion of payment for ALL office services is due **at the time of service**.
Repetitive cancelled appointments and/or non-compliance may result in discharge from the practice.
We will file a claim with any insurance company that we are in network with and will require you to pay the co-pay/co-insurance/deductible at the time of service. If you are seeing the doctor on an "Out of Network" basis, you will be subject to out of network rates.
Not all services are a covered benefit in all insurance policies. In the event your health plan determines a service to be "non covered/pre-existing" or you do not have an authorization, you will be responsible for all charges. We will attempt to verify benefits for some specialized services; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their insurance company for clarification of benefits prior to services rendered.
We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in managing your account. Any payment exceptions will be agreed upon in writing.
PAST DUE accounts are subject to collection proceedings including the credit bureau. All fees including, but not limited to collection fees, attorney fees, and court fees shall become your responsibility in addition to the balance due the practice.
Accounts no longer maintaining a financial "Good Faith" status will result in the discharge from the practice.
There is a service fee of $25.00 for all returned checks. Upon an NSF or CLOSED ACCOUNT occurrence, all future remittances will need to be in other forms of payment. Restitution of "Theft-by-Check" will be requested from the District Attorney's Office.
InStride Hendersonville Podiatry issues patient refund checks within 90 days of a completed investigation of the potential overpayment.

Authorization of Payment

I hereby assign all Medical benefits directly to *InStride Hendersonville Podiatry* for the payment of any services rendered. I also authorize the release of medical records necessary to process my health claims. I fully understand that in the event my insurance company does not pay within 60 days for the services I received, I will be financially responsible for payment. Please sign below:

I have read *InStride Hendersonville Podiatry's* Policies and Release of Information, and I give consent for treatment.

Print Patient's Name: _____

Signature of Patient or Guardian: _____date_____

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I. Acknowledgement of Practice's Notice of Privacy Practices:

By writing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have had the opportunity to read the Notice of Privacy Practices (NPP) and agree to its terms. **A copy of HIPAA Privacy Practices available in lobby.**

_____	_____	_____	_____
Name of Patient	Date of Birth	Signature of Patient/Parent/Guardian	Date

II. Emergency Contact:

Print Name:_____ Phone Number: _____

I agree that the practice may disclose the following information to my emergency contact : Financial? ▢ Medical? ▢

III. Request to receive Confidential Communications by Alternative Means:

As provided by the Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me as I have listed below:

Home telephone number: _____ **Ok to leave a message? Yes ▢ No ▢**

Mobile telephone number: _____ **Ok to leave a message? Yes ▢ No ▢**

Ok to leave a text message for appointment reminders? Yes ▢ No ▢

Email address: _____ **Ok to send email? Yes ▢ No ▢**

I understand InStride Hendersonville Podiatry will take a photo of myself for the purpose of identification *ONLY*. **Yes ▢ No ▢**

1. The above authorizations are voluntary and I may refuse to their terms without affecting any of my rights to receive healthcare.
2. These authorizations may be revoked at any time by notifying the Practice in writing at the Practice's mailing address marked for the attention of "HIPAA Compliance Officer."
3. The revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.
4. This form was completely filled in before I signed it and I acknowledge that all of my questions were answered to my satisfaction and that I fully understand this authorization form.
5. This authorization is valid as of the date I have signed below and shall remain valid until changed or revoked.

Printed Name _____Signature _____Date _____