Health History Update Form - Shore Podiatry

Name: ______________________________ Date of Birth: ________ Today's Date:________

Address: ____ Marital Status: ____________

Home Phone #: (______)_________________ Cell Phone #: (_____)______________________

Preferred Phone #: Home/Cell E-Mail Address: ________________________________

Allergies: ____

List all Medications with Dosages: ____

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____

Medical Conditions: ____

____

Is there a family history of (Check appropriate boxes): Diabetes: ☐ Mother ☐ Father ☐ Sister ☐ Brother

Hypertension: ☐ Mother ☐ Father ☐ Sister ☐ Brother Cancer: ☐ Mother ☐ Father ☐ Sister ☐ Brother

Are you a Diabetic? ☐ Yes ☐ No If you are diabetic, what was your last HbgA1c?_______

Do you currently smoke? ☐ Yes ☐ No If so, how many packs per day? ___________

If you do not currently smoke, did you ever smoke? ☐ Yes ☐ No

Do you drink alcoholic beverages? ☐ Yes ☐ No

How many drinks do you consume: in a day? ____ in a week? ____ in a month? ____

Blood Pressure: ________/_________ Weight: _________lbs. Height: ___________

Date of last flu immunization: __________ Date of last pneumonia immunization: __________

Do you have a living will? ☐ Yes ☐ No

Primary MD's name and location: ____

Pharmacy name and location: ____

Emergency Contact (Name and Phone): ____

Relationship of Emergency Contact: ____

Primary Insurance Carrier: ________________________ Name of Insured: ________________

Relationship to Patient: __________ ID # of Primary Insurance: _________________________

Secondary Insurance Carrier: _______________________ Name of Insured: _______________

Relationship to Patient: __________ ID # of Secondary Insurance: _______________________

Signature: ________________________________

Shore Podiatry Signature Sheet

Patient Name ____ Date of Birth ___________________________________

Certification and Consent

I, the undersigned certify that the information submitted on the patient information and medical history forms is true and correct to the best of my knowledge. I give permission for the doctor to administer and perform such procedures as deemed necessary in the diagnosis and treatment of my feet/ankles.

Assignment and Release

I, the undersigned certify that I (or my dependendent) have insurance coverage and assign directly to Shore Podiatry all insurance benefits, if any, otherwise payable to Shore Podiatry for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. If I receive any payments from my insurance company in error, I will sign them directly over to Shore Podiatry. I hereby authorize the use of this signature on all insurance submissions.

Notice of Privacy Practices

I hereby acknowledge that I understand the office's Notice of Privacy Practices. I understand that the notice sets forth my rights relating to the use and disclosure of my personal health information and explains how Shore Podiatry may use or disclose my personal health information with and without my authorization. (A copy of the Notice of Privacy Practices is posted on the website or can be received from the front desk)

Signature ____ Date ____

Permission to Disclose

I hereby give my permission to release my records, including all medical notes, test results, or x-rays to the following person(s)

Person 1 ____ Relation to Patient _________________________________

Person 2 ____ Relation to Patient _________________________________

Signature ____ Date ____

☐ I give permission to be reminded of appointments by telephone and for these reminders to be left as messages on my answering machine or with whomever answers.

☐ I DO NOT give permission to be reminded of appointments by telephone and for these reminders to be left as messages on my answering machine or with whomever answers.

Signature ____ Date ____

Medicare Authorization

I request that the payment of authorized Medicare benefits be made either to me or on my behalf to Shore Podiatry for any services rendered by Doctor Spector. 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 that 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 non covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature ____ Date ____

SHORE PODIATRY FINANCIAL POLICY

This financial policy has been established to prevent misunderstandings. We like to acknowledge patients who take a responsible approach for paying their medical care. **Insurance:** We must obtain a copy of your insurance card to provide proof of insurance. We will bill your insurance, but if payment is denied, You, the patient, will be responsible for payment for services rendered by the doctors on staff. **Knowing your insurance is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.**

Co-Pays & Deductibles: I understand that it is my responsibility to pay my co-pay on the day service is rendered. This arrangement is part of your contract with your insurance company. If you have a high deductible plan, after we receive notice from your insurance company, we will invoice you, the patient responsibility based on your deductible.

Appointments: If any appointment is broken or canceled without giving 24 hour notice, a charge of $25.00 will be applied to your account with potential discharge from the practice. **Medicaid:** If you have medicaid as either a primary or secondary insurance: please be advised that if your medicaid coverage is not active on your day of service, you will be responsible for your copay and any balance after.

- I understand and agree to this term: Please initial: X___________

Assignment of Benefits/Non-Payment: I authorize payment of medical benefits to SHORE PODIATRY for services rendered to me. Any balance to an account is due within 30 days of receipt of the bill. If the account balance goes unpaid, a rebilling charge of $5.00 a month will be applied to your account. It is understood and agreed that in the event of any outstanding balance has to be referred to a collection agent or attorney for recovery, that the patient will be fully responsible for any costs, including, but not limited to attorney fees.

For Patients that Need Insurance Referrals: If your insurance requires a referral from your primary care physician to a specialist, it is your responsibility to know this & obtain the referral prior to your visit. If the referral is not in place on the date of service, you will be asked to sign a waiver stating, if the referral is not received in a timely filing limit, you will be billed for the services rendered.

Non-Covered Services: Please be aware that some & perhaps all of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurances. You must pay for there services in full at the time of the visit. A form will need to be signed stating the services are not covered.

Self-pay: Payment in full is due at the time services are delivered

Returned Checks: Returned checks are subject to $30.00 service charge. In the event of a returned check your privilege to pay by check on future visits will be terminated. You will be subsequently expected to pay with cash or a credit card.

Please sign below to indicate that you have read and fully understand this policy.

Patient Name: X_________________________ Date: X______________________

Signature: X_________________________________

Relationship if Legal Guardian: X_____________________________