THE FOOT INSTITUTE

PATIENT INFORMATION DATE _____/_____/_____

Patient's Name_____ SS#_____

Gender_____ Ethnicity _____

Address_____ City/State_____ Zip Code_____

Date of Birth_____/_____/_____ Marital Status _____ Spouse Name _____

Phone#_____ Cell#_____ Work#_____

Email Address_____

EMERGENCY CONTACT PERSON_____ TELEPHONE#_____

INSURANCE INFORMATION

Name of Primary Insurance_____ Insurance ID#_____

Name of Secondary Insurance_____ Insurance ID#_____

Name of Insured Person_____ Insured Person's DOB_____/_____/_____

Sponsor SS# _____

MEDICAL INFORMATION

Reason for visit _____ Family Doctor_____

___Bunion ___Ingrown nail ____Injury ___Heel Pain Address_____

___Hammertoes ___Diabetic Foot Care __Wart Telephone #_____

___Surgical 2nd opinion ___Other_____ Last Medical Exam Date ___/___/___

HOW DID YOU LEARN OF OUR OFFICE? (Give names)

___Friend:_____ ___Yellow Pages ___Newspaper
___Doctor:_____ ___Insurance Co.:_____
___Website:_____ ___Other:_____

Please sign all attached forms
Please give receptionist your insurance cards and ID for photocopying

The
Foot Institute, LLC

1730 St. Julian Pl.
Columbia, SC 29204

MEDICAL HISTORY

Patient Name_____ Date_____

Do you have or have you had any of the following?

Diabetes ___yes ___ no
Abnormal Heart Condition ___yes ___no
Heart Murmur ____yes ___no
Arthritis ___yes ___no
Kidney or Lung Problem ___yes ___no
Hepatitis or Liver Disease ___yes ___no
Blood clots (phlebitis) ___yes ___no
Stomach Ulcer ___yes ___no
Seizures or Epilepsy ___yes ___no
Abnormal bleeding from a cut ___yes ___no
Difficulty in Healing___ yes ___no
Other_____
Woman: Are you pregnant? ___yes ___no

Do you have any allergies to any of the following?

Penicillin ___yes ___no
Local Anesthetics ___yes ___no
(Novacain)
Aspirin ___yes ___no
Adhesive Tape ___yes ___no
Iodine/Shellfish ___yes ___no
Any other allergies _____
(List)

Any other medical problems:
_____
_____
_____

PLEASE PRINT CLEARLY:

Are you taking any medicine presently? ___yes ___no If yes, name of medicine and for what
_____
_____
_____

Have you ever been hospitalized or had any surgery in the past? ___yes ___ no If yes, list nature and year of hospitalization and type of surgery (include out-patient surgery).
_____
_____

Do you smoke? _____ Former Smoker _____ Never Smoked _____
Do or did you ever drink alcohol? _____Never _____Occasionally _____Regular
What is your foot or ankle problem?
_____

What is your occupation? _____

Do you have a family history of any of the following?
Diabetes ___yes ___no
Heart Disease ___yes ___no
Blood Clots ___yes ___no
Bleeding Problems ___yes ___no
Stroke ___yes ___no
Cancer ___yes ___no

Patient Signature Date Physician Signature

The
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PATIENT MEDICAL INFORMATION (REVIEW OF SYSTEMS)

Do you have or have you had any of the following symptoms in the past three months?

Head/Nose/Eyes/Ear/Throat
___Headache
___Stroke (head bleed)
___Seizures
___Ear Ache
___Retina/visual problems
___Sinusitis
___Upper Respiratory Infection
___Cold or flu
___Sore Throat

Gastrointestinal/Stomach/Liver
___Heartburn
___Stomach ulcers
___Hepatitis/Liver Disease
___Abdominal (belly) pain
___Nausea/vomiting
___Bleeding difficulties
___Diarrhea
___Constipation
___Bloody or tarry stools

Cardiac/Heart/Circulation
___Shortness of breath when active
___Use several pillows to sleep
___Heart attack
___Rhythm problems
___Chest pain
___Murmur
___Leg pain walking ___Leg pain resting

Urinary Bladder
___Burning
___Excessive urination
___Bloody urination
___Urinary Tract infection
___Difficulty urinating
___Discharge

Respiratory/Lung
___Cough
___Tuberculosis
___Asthma
___Shortness of breath at rest
___Pulmonary embolism

Musculoskeletal/Joints/Muscle/Bone
___Arthritis-What joint? _____
___Stiffness
___Low back pain
___Weakness
___Fractures (broken bones)
___Spasms
___Paralysis (inability to move)
___Numbness
___Radiating Pain
___Burning Pain

Patient Signature Date Physician Signature

The
Foot Institute, LLC

Financial Policy

We at The Foot Institute are committed to providing you with the best possible care. If you have Medical Insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Unless **INSURANCE ARRANGEMENT** has been approved in advance by our staff, payment for services is due at the time services are rendered. We accept cash, credit, and money orders only. We will be happy to help you process your insurance claim at each visit.

Balances older than 30 days are subject to additional collection fees and interest 1/5% per month. We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

You must realize, however, that:

1. Insurance is a contract between YOU and your INSURANCE COMPANY

2. Our fees generally fall within the acceptable range by most insurance companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of U.C.R. "U.C.R." is defined as Usual, Customary, and Reasonable fees for this region. Thus, our fees are considered Usual, Customary, and Reasonable fees by most insurance companies. This does not apply to companies who reimburse based on arbitrary "schedule" of fees, which bears no relationship to the current standard fees and cost of care in this area.

3. Not all services are covered benefits on your contract. Some insurance companies arbitrarily refuse to cover certain services. We have no control over this.

4. MEDICARE PATIENTS: We would like you to understand that taking ASSIGNMENT means that YOU are responsible for the YEARLY DEDUCTIBLE and for the 20% CO-INSURANCE of what Medicare allows. You are responsible for services that your co-insurance does not cover. If your co-insurance does not pay this amount, YOU are responsible for it.

Unlike some offices, the FILING OF INSURANCE CLAIMS is a COURTESY that we have always extended to our patients. However, all charges are YOUR responsibility, NOT your Insurance Company's. We will make our BEST EFFORT to collect from them, but if despite our best efforts, we are NOT SUCCESSUFL, YOU are responsible for the unpaid balance. We realize that temporary financial problems may affect timely payment of your account. WE do not want financial problems to get in the way of our good relationship with you. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask us. We really are here to help you.

Signature

The
Foot Institute, LLC

PLEASE SIGN THE INSURANCE and/or MEDICARE ASSIGNMENT BELOW:

I authorize payment of MEDICAL BENEFITS be made on my behalf to The Foot Institute, for any services furnished to me. I authorize the release of any medical information held by The Foot Institute to the health care financing administration and its agents, to process my claims.

Signature

The
Foot Institute, LLC

PRIVACY POLICY/MEDICAL RELEASE AND BENEFITS ASSIGNMENTS

I, _____, have been informed of The Foot Institute Notice of Privacy Policies and understand that my protected health information may be released to other healthcare providers, hospitals, insurance companies, etc. as outlined in the Privacy Policy. I also hereby authorize the release of any medical records or x-rays to my insurance company, referring physician, and/or my attorney. I also hereby authorize payment of my insurance carrier directly to The Foot Institute for any charges incurred for medical treatment at said facility in which care is rendered.

By signing below, I certify that I have read the above statement and agree.

_____ _____
Patient or Guardian Signature Date

** In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures on their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Please check ☑ which method would be best for contact (please check all that apply)

__Home phone _____

__Cell phone_____

__Work phone_____

__Email _____

__Written communication (Address) _____

__Fax (Number) _____

I authorize The Foot Institute physicians and staff to talk to and release information to the following individuals regarding my healthcare. (Check all that apply)

__Spouse Name: _____
__Children Name: _____
__Other: _____ relationship: _____
_____relationship: _____

**HIPPA Privacy Notice Act: By signing below, you are stating you have received a copy of HIPPA statement from The Foot Institute.

_____ _____
Patient or Guardian Signature Date

The
Foot Institute, LLC

Consent for Treatment

If I should have poor circulation I understand this is a condition that may/will get worse. I understand there are certain risks, diseases, and complications that is associated with poor circulation, even with professional care and treatment.

I understand that I have the following treatment options:

1. No treatment
2. Special/wider shoes
3. Padding
4. Soaks
5. Periodic treatment to make me more comfortable
6. Antibiotics and/or other medications
7. Limit my walking/weight-bearing time
8. Change in occupation
9. Surgery

I understand that with any treatment of my condition, including surgery, the following risks are present:

1. Infection
2. Delayed healing
3. Wound deterioration or breakdown
4. Additional danger of artery/vein clotting (blood clot)
5. Skin tissue death/skin ulcer
6. Loss of toe, foot, limb, or life
7. Drug reaction

These risks are present in all operations/treatment. However, I understand that if I have a poor circulation condition it will increase my risk for complications. If I have one or more of these complications, I UNDERSTAND THAT FUTURE CARE AND TREATMENT MAY BE MORE DIFFICULT AND THE OUTCOME MORE UNCERTAIN.

NON-TREATMENT OF MY FOOT PROBLEMS also presents serious risks to me. My foot problems could get worse, and I might have new complications such as infection, skin ulcer/breakdown and loss of toe, foot, limb, or life.

I UNDERSTAND AND ACKNOWLEDGE MY PODIATRIST WILL TREAT ONLY MY FOOT (and ankle) CONDITIONS AND WILL NOT TREAT DIRECTLY ANY OTHER PROBLEMS SUCH AS, SYSTEMETIC CONDITIONS (peripheral vascular disease/diabetes).

I have read the information and understand the risk. By signing below, I consent to an evaluation and possible treatment from my podiatrist.

Patient Signature _____ Date _____

Witness Signature _____ Date _____

Physician Signature _____ Date _____