Shenandoah Podiatry

New Patient Information Form

** Please Print Clearly **

PATIENT INFORMATION:

First Name _____ MI _____ Last Name _____ o Male o Female

Date of Birth ___/___/_____ Social Security #_____-_____-_____ -OR- Driver's License #_____

Home Address _____ Apt# _____

City _____ State _____ Zip _____-_____

Mailing Address (if different from above) _____

Home Ph (____) ____ - _____ Cell Ph (____) ____ - _____ Work Ph (____) ____ - _____

Email Address _____Employer Name & Address _____

Preferred Contact Method: o Home Ph o Cell Ph o Work Ph o Email o Text

Preferred Pharmacy (please include cross streets and city, if able) _____

Primary Care Physician _____ Phone# (____) ____ - _____ Date of last visit _____

Race: o American Indian/Alaska Native o African American/Black o Asian o Native Hawaiian/Pacific Islander o White

Ethnicity: o Hispanic o Non-Hispanic

Primary Language: _____ *Translation services are available upon request.

Do you have an Advance Directive? ◯ Yes ◯ No If yes, please describe type: _____

EMERGENCY CONTACT INFORMATION:

Emergency Contact Name _____ Phone (____) ____ - _____ Relationship to Patient _____

PAYMENT AND INSURANCE INFORMATION:

o Check here if no health insurance, or if "Self-Pay"

Primary Insurance _____

Policy Holder _____ Date of Birth _____

Secondary Insurance _____

Policy Holder _____ Date of Birth _____

REFERRAL INFORMATION: How did you hear about our office?

o Doctor _____ o Patient _____ o Friend/Family Member _____ o Our Sign

o Our website o Insurance Website o Google o Yelp

By signing below, you are attesting that all of the following are all true statements:

- The information provided on this form is true and correct to the best of my knowledge.
- I request that payments of authorized benefits be made on my behalf for any services furnished by **Shenandoah Podiatry**.
- I authorize any holder of personal health information about me to release any information needed to determine these benefits, or the benefits payable to related services, to the insurance agent.
- I recognize my financial obligation of any coinsurance, copays or deductibles and non-covered services that may be required.
- I hereby give permission to **Shenandoah Podiatry,** and any qualified staff to evaluate, diagnose and treat my foot and/or ankle condition, as may be deemed necessary.

_____ _____

Signature of Patient or Representative (Indicate Relationship Below) Date

o Self o Parent o Legal Guardian o Representative/Healthcare POA

Shenandoah Podiatry

Privacy Policy

Shenandoah Podiatry will use and disclose your health information for the following purposes: to treat you, to assist other health care providers in treating you, to allow insurance companies to process insurance claims for services rendered to you, to obtain payment for services rendered to you and for certain limited operational activities, such as quality assessment, licensing, accreditation and training of students. We will not use or disclose your health information without your written authorization, except as stated in more detail in the Notice of Privacy Practices. If you have any questions, concern or complaints regarding our privacy practices, please refer to the actual Notice of Privacy Practices provided to you for the person(s) whom you may contact.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (See pages 1-7 in provided folder)

My signature below represents that I have been offered a copy of the Notice of Privacy Practices. I acknowledge that I was provided a copy of the policy and have read (or had the opportunity to read, if I so chose) and understood the Notice.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the above Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below:

Any member of my immediate family	**o Yes**	**o No**
Spouse ONLY	**o Yes**	**o No**
Other (Please Specify):	**o Yes**	**o No** _____

PATIENT PORTAL (PATIENT ACKNOWLEDGMENT AND AGREEMENT) (See page 7, part II, in provided folder)

My signature below represents that I have read and fully understand the consent form regarding the Patient Portal. I comprehend the risks associated with online communications between my physician and me, and consent to the conditions outlined.

I agree to be enrolled in the Patient Portal. **o Yes** **o No**

PRESCRIPTION MONITORING AND ePRESCRIBING

- Shenandoah Podiatry participates in a Prescription Drug Monitoring Program (PDMP), which is a system in which controlled prescription drug data is collected in a database, centralized by each state, and administered by an authorized state agency to promote the appropriate use of controlled substances for legitimate medical purposes while deterring the misuse, abuse, and diversion of controlled substances.
- ePrescribing is defined as a physician's ability to electronically send an accurate, error-free and understandable prescription directly to a pharmacy. The United States Congress has determined that this ability is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety.
- My signature below represents my authorization for Shenandoah Podiatry to view my external prescription history via electronic prescribing services. I understand that this prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies, and pharmacy benefit managers may be viewable by provider(s) and staff at Shenandoah Podiatry and that it may include prescriptions dating back several years and prescriptions to treat HIV, substance abuse, and psychiatric conditions, if applicable. I understand that my prescription history will become part of my Shenandoah Podiatry record.
- I have had the chance to ask questions, and all of my questions have been answered to my satisfaction.

I agree to be enrolled in ePrescribing. **o Yes** **o No**

_____ _____

Signature of Patient or Representative (Indicate Relationship Below) Date

o Self o Parent o Legal Guardian o Representative/Healthcare POA

FINANCIAL POLICY – Please Read Carefully!

Thank you for choosing Shenandoah Podiatry as your foot/ankle care provider. We are committed to providing you with quality and affordable health care and to being transparent with our billing process. Please read the following policy. Feel free to ask us any questions that you may have. Please add your initials to each statement indicating that you understand. When you have accepted the policy, please sign in the space provided. A copy will be provided to you upon request.

_____ It is my responsibility to **provide up-to-date insurance** information prior to my appointment and each time my insurance changes.

_____ Shenandoah Podiatry must maintain a copy of my Insurance and ID Cards as protection for me against fraud.

_____ If I do not have an insurance that Shenandoah Podiatry participates in or I fail to provide up-to-date insurance information for a plan Shenandoah Podiatry does participate in, I will need to pay in full for all charges.

_____ It is my **full responsibility to know and understand the details of my insurance policy** including, but not limited to, in vs.out of network, co-pays, deductibles, co-insurance and non-covered services.

_____ **Coverage & benefits quotes I am given are provided in good faith** from what Shenandoah Podiatry has been told by my insurance, but are in **no way a guarantee of payment or coverage**. It is my responsibility to contact my insurance company with questions I have regarding my coverage.

_____ If required, it is **my responsibility to obtain a proper referral**. Failure to do so will result in my paying in full for all charges. This payment will be held for 48 hours and will become non-refundable if proper referrals are not presented by that time.

_____ **All anticipated patient responsible charges must be paid at the time of service**, this includes co-pays, co-insurance, deductibles and non-covered services. If it is not known that a service is non-covered until after the appointment, I will be billed for that service.

_____ Services associated with my visit will be promptly sent to insurance for claim processing. After my insurance has processed the claim(s), I will receive a statement listing charges that are my responsibility. **I agree to pay in full within 30 days of statement date.**

_____ If there is an outstanding balance on my or my family's account(s), I will need to **pay in full at the time of check-in**.

_____ Shenandoah Podiatry does NOT accept cash, and that all major credit cards and checks are accepted.

_____ Unpaid balances **past 30 days are subject to a $10 repeat statement fee.**

_____ Unpaid balances **past 60 days may be sent to a collection agency**. I agree to reimburse the fees of any collection agency, which may be based on a percentage at a maximum of 25% of the debt, and all costs, and expenses, including reasonable attorney's fees, incurred in such collections efforts.

_____ Shenandoah Podiatry does not offer payment plans. Note: Care Credit is available for application through our office.

_____ Shenandoah Podiatry will submit my claims and assist me in any way reasonable to help get my claims paid. My insurance company may need me to supply certain information directly. **It is my responsibility to comply with their request**.

_____ Appointments not cancelled,and not kept are deemed 'No-shows' and will incur a $50 fee.

_____ After 3 No-shows, I will be required to leave a non-refundable deposit for future appts. The deposit will be applied to any balance due at kept appointments.

I have read and understand the payment policy and agree to abide by its guidelines:

_____

Signature of patient or responsible party Date

Shenandoah Podiatry

New Patient Medical History Form

Last Name _____ **First Name** _____ **MI** _____ **DOB** ____/____/_____

Reason for Visit: _____

Height: _____ft. _____in. **Weight:** _____lbs.

My condition is... □Work Related □Due to an Auto Accident □Due to a Liability Claim □None of these

Current Treatments: _____

How long has this condition existed? _____ **Pain Scale** (0 = none to 10 = extreme) _____

Current Medications: (Include prescriptions, over-the counter medications, vitamins/herbal supplements) □ **See Attached List**

_____ _____ _____

_____ _____ _____

_____ _____ _____

(Females Only) Are you Currently Pregnant? □ Yes □ No Currently Breastfeeding? □ Yes □No

Do you currently have, or have you ever had, symptoms/diagnosis of:

□ Back/Spine Pain	□ COPD	□ Heart Condition	□ Neurological Disorder
□ Bleeding or Thyroid Disorder	□ Depression	□ High Blood Pressure	□ Neuropathy
□ Blood Clots	□ Diabetes - □ Type I □ Type II	□ High Cholesterol	□ Osteoporosis
□ Bunions	□ Edema	□ Liver Disease	□ Seizure Disorders
□ Cancer - _____	□ Fibromyalgia	□ Mitral Valve Prolapse	□ Stomach Ulcers
□ Congestive Heart Failure	□ Gout	□ MRSA Infection	□ Stroke

□ Other(s):_____

Allergies/Sensitivities: _____

Are you experiencing any of the following symptoms? (Please circle ALL that apply)

Burning (feet toes both)	Fever or Chills	Nausea	Swelling
Chest Pain	GI Upset	Numbness (feet toes both)	Tingling (feet toes both)
Cramping	Itching	Shortness of Breath	

Other _____

Previous Surgeries: _____

_____

Any hospitalizations within the last 12 months? Yes_____ or No_____

If yes, what was the reason: _____

Family History: Please check all that apply, state the member in your family, and if the member is living or deceased:

Condition	**Relative (Living/Deceased)**	**Condition**	**Relative (Living/Deceased)**
□ Bunions	_____	□ Diabetes	_____
□ Cancer	_____	□ Heart Condition	_____
□ Hypertension	_____	□ Stroke	_____
□ Other	_____		

Do you use tobacco products? □Yes □No □Former - How Long Ago _____

If yes, which product? □ Cigarettes □Cigars □Chewing Tobacco **AND** How much/how often? _____

Do you drink alcohol? □Yes □No If yes, how much/how often? _____