Welcome to Shenandoah Podiatry and thank you for choosing our office for your podiatric foot and ankle care! In our effort to provide personalized patient care in the most efficient and economical manner possible, we ask that you take a few moments to read over our office policies and fill out the demographic and health history forms for your medical file. If at any time you have a question regarding our policies do not hesitate to contact us and we will be happy to help you.

FINANCIAL POLICY

Your clear understanding of our Financial Policy is important to our professional relationship. We are a Medicare provider and also a provider for most PPO and HMO plans in our area. It is your responsibility to make sure we are on your insurance plan. If your insurance requires a referral or prior authorization, please be sure that this is in place prior to your appointment. We will be glad to assist you if you need help.

We will bill your insurance company as a courtesy to you. **All co-payments, co-insurances, deductibles and non-covered services and supplies will be due at the time of your visit.** If you have a secondary insurance company, we will bill them one time. If your secondary insurance does not pay the balance due within 45 days, the balance will be billed to you and due at that time.

Balances/Collection Fees: If balances are not paid within **30 days** from the statement date, a **$10.00 rebilling fee** will be added to each additional statement sent for the unpaid balance. A consistent attempt will be made to collect outstanding account balances. Past due accounts, more than **60 days**, will be turned over to our collection agency and a **33% fee** of the balance due will be added to cover collection costs.

I have read the above policy and understand my financial responsibility to Shenandoah Podiatry for medical services provided. I agree to pay any balance due/or unpaid by my insurance carrier for myself or the below named person. I also agree that in order for my account to be serviced and to collect any amounts owed that I may be contacted by telephone, including wireless telephone numbers, which could result in charges to me. I may also be contacted by text messages or e-mails, using any e-mail address provided. I understand that methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

Financially Responsible Party:

Patient Name: _____ Signature: _____

Parent or Authorized Representative: _____Date: _____

SHENANDOAH PODIATRY PATIENT INFORMATION

Name: _____
(Last Name) (MI) (Legal First) (Suffix)

Preferred Name: _____ Previous Name: _____

DOB: _____ Sex: □ M □ F SS# _____-_____-_____ OR Driver's License # _____

Physical Address: _____ | Mailing Address: _____

City, State, Zip Code: _____ | City, State, Zip Code: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Email Address: _____ Preferred Contact: □ Home □ Cell □ Work □ Email/Text

Employer Name: _____ Work Number: (_____) _____-_____

Employer Address: _____ City, State, Zip Code: _____

Primary Care Physician: _____

Preferred Pharmacy: _____ | Location: _____

How did you hear about us: □ Insurance □ Referring Physician □ Phone Book □ Sign □ TV □ Our Website

□ Family □ Friend _____ Are they a patient of the practice? □ Y □ N

□ Internet Search _____ □ Newspaper _____ □ Other _____

Optional Section:
Primary Language*:** □English □Spanish Other_____ ***Ethnicity: □ Hispanic/Latino □ Not Hispanic/Latino
Race: □American Indian □Alaska Native □Asian □Black/African American □Hawaiian/Pacific Islander □White

RESPONSIBLE PARTY INFORMATION

Please fill this section out if someone other than the patient is responsible for paying any balance due to Shenandoah Podiatry. This is to whom any statements will be mailed to. **This section must be filled out if the patient is a minor.**

Name: _____ Date of Birth: _____

Relationship to Patient: _____ □ M □ F □ Other: *(please list)*_____

Phone: (_____)_____-_____ SS#:_____-_____-_____

INSURANCE INFORMATION

Primary: _____	Secondary: _____
ID #: _____	ID #: _____
Group#: _____	Group#: _____
Subscriber Name: _____	Subscriber Name: _____
Subscriber DOB: _____	Subscriber DOB: _____
Subscriber Sex: □ M □ F	Subscriber Sex: □ M □ F
Relationship: □ Self □ Spouse □ Parent	Relationship: □ Self □ Spouse □ Parent

Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain pieces of my health information to a Personal Representative of my choosing, since such person is involved with my healthcare or payment relating to my healthcare. In that case, the practice will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my healthcare.

Print Name: _____ DOB: _____ Phone: (_____) _____-_____

Address: _____ Relation: _____

I. Acknowledgement of Receipt - Notice of Privacy Practices and Privacy Statement (HIPPA):

I acknowledge that I was provided a copy of the Notice of Privacy Statement, and that I have read (or had the opportunity to read) and understand the Notice of Privacy Practices and agree to its terms. (see pages 1-7 in the provided folder)

II. Patient Portal--Patient Acknowledgment and Agreement:

I acknowledge that I have read and fully understand the consent form regarding the Patient Portal. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined. I understand and agree to be enrolled in patient portal. (see page 7 in the provided folder)

- To **opt out** of Patient Portal, please initial here (otherwise, leave blank): _____

III. Prescription Monitoring Program and ePrescribing:

NOTIFICATION - Shenandoah Podiatry participates in a Prescription Monitoring Program (PMP) 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 by a physician's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety.

I authorize Shenandoah Podiatry to view my external prescription history via electronic prescribing services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies and pharmacy benefit managers may be viewable by my provider and staff at Shenandoah Podiatry and it may include prescriptions back in time for several years, and may include prescriptions to treat HIV, substance abuse and psychiatric conditions, if applicable. I understand that my prescription history will become part of my Shenandoah Podiatry medical record.

Understanding all of the above, I hereby provide informed consent to Shenandoah Podiatry to enroll me in the ePrescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

- To **opt out** of ePrescribing, please initial here (otherwise, leave blank): _____

I certify that the information listed above is correct to the best of my knowledge. By signing below, I acknowledge that I was provided a copy of the (I) privacy policy, the (II) patient portal and I consent to (III) ePrescribing.

- Signature of Patient or Representative: _____ Date: _____

□ Self □ Parent □ Legal Guardian □ Representative/Health Care POA

SHENANDOAH PODIATRY MEDICAL HISTORY

Last Name: _____First Name: _____ MI: _____ DOB: _____

Shoe Size: _____ Height: _____ Weight: _____

Are you currently wearing orthotics? □Yes □No If so, how long? _____

Reason for Visit: _____

_____

Is your condition: □None □Work Related □Due to an Auto Accident □Due to a Liability Claim

Current Treatments: _____

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

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

_____ _____ _____

_____ _____ _____

_____ _____ _____

History: (Women) Are you Currently Pregnant? □ Yes □ No **Currently Breastfeeding?** □ Yes □ No

Do you currently have or ever had symptoms/conditions of:

Arthritis	□	High Cholesterol	□
Acid Reflux (GERD)	□	Liver Disease	□
Anxiety	□	Lupus	□
Back/Spine	□	Mental Illness	□
Bleeding Disorder	□	Mitral Valve Prolapse	□
Blood Clots	□	MRSA Infection	□
Bunions	□	Neurological Disorder	□
Cancer-*what type?* _____	□	Neuropathy	□
Circulation Problems	□	Osteoporosis	□
Congestive Heart Failure	□	Rheumatoid Arthritis	□
COPD	□	RSD/CRPS	□
Depression	□	Seizure Disorders	□
Diabetes: *(circle one)* I OR II	□	Skin Disorder-*what type?* _____	□
Edema	□	Stomach Ulcers	□
Fibromyalgia	□	Stroke	□
High Blood Pressure (Hypertension)	□	Thyroid Disorders	□

Any other condition(s) not mentioned: _____

Allergies/Sensitivities: (Please check those that apply or provide a list to copy) □ See Attached List

	Reaction		Reaction
□ Adhesive Tape	_____	□ Iodine	_____
□ Aspirin	_____	□ IV Contrast Dye	_____
□ Blood Thinners	_____	□ Latex	_____
□ Cephalosporins	_____	□ Local Anesthetics	_____
□ Codeine	_____	□ Penicillin	_____
□ Demerol	_____	□ Seafood/Shellfish	_____
□ Ibuprofen	_____	□ Sulfa	_____

Any other allergy not mentioned: _____

Are you experiencing any of the following symptoms (please circle ALL that apply):

Chest Pain Shortness of Breath GI Upset Burning (feet toes both) Numbness (feet toes both)

Fever Chills Nausea Vomiting Swelling Tingling (feet toes both) Cramping Itching

Other_____

Previous Surgeries:

□Amputation	□Defibrillator	□Lap Band
□Appendectomy	□Gallbladder	□Lower Extremity Bypass
□Angioplasty/Stent	□Hammer Toe	□Neuroma
□Back/Spine Surgery	□Heart Bypass	□Pacemaker
□Blood Transfusion	□Heart Valve Replacement	□Tonsils
□Bunion	□Hysterectomy	□Transplant
□C-Section	□Ingrown Nail	□Tubal Ligation
□Cancer	□Joint Replacement	□Vascular

Any other surgery not mentioned: _____

Any hospitalizations within the last 12 month: Yes_____ or No_____ If yes, please list the reason for admittance below:

_____

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

□ Bunions_____ □ Cancer_____ □ Diabetes_____

□ Heart Disease _____ □ Hypertension_____ □ Mental Illness_____

□ Stroke _____ □ Other_____

Do you use tobacco products? □ Yes □ No □Former

If yes, which product? □ Smoking □ Chewing How much? _____

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

Consent to Treat:

I certify that the above information is true and correct to the best of my knowledge and I, hereby, give my permission to the doctor(s) at Shenandoah Podiatry to perform diagnostic, therapeutic and/or operative procedures as may be deemed necessary in the diagnosis and/or treatment of my feet and/or ankles

➢ Signature of Patient or Representative: _____ Date: _____

□ Self □ Parent □ Legal Guardian □ Representative/Health Care POA