



# Shenandoah Podiatry



New Patient Information Form

*\* Please Print Clearly \**

**PATIENT INFORMATION:**

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_  Male  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:  Home Ph  Cell Ph  Work Ph  Email  Text

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

Primary Care Physician \_\_\_\_\_ Phone# (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Date of last visit \_\_\_\_\_

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

Ethnicity:  Hispanic  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:**

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?

Doctor \_\_\_\_\_  Patient \_\_\_\_\_  Friend/Family Member \_\_\_\_\_  Our Sign

Our website  Insurance Website  Google  Yelp

**SIGNATURE ON FILE AND PERMISSION TO TREAT:**

- 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 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

Self  Parent  Legal Guardian  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. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization. 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.

### 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     Yes    No
- Spouse ONLY                                     Yes    No
- Other (Please Specify):                         Yes    No \_\_\_\_\_

### 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.

### PATIENT PORTAL (PATIENT ACKNOWLEDGMENT AND AGREEMENT)

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.

- If you **DO NOT** want to be enrolled in the online Patient Portal, please initial here \_\_\_\_\_.

### 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.
- My signature below thus represents my understanding and my informed consent for 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.
  - If you **DO NOT** authorize the use of PDMP/ePrescribing, please initial here \_\_\_\_\_.

\_\_\_\_\_  
Signature of Patient or Representative (Indicate Relationship Below)

- Self    Parent    Legal Guardian    Representative/Healthcare POA

\_\_\_\_\_  
Date



# Shenandoah Podiatry



## General Policies

**Welcome to Shenandoah Podiatry, and thank you for choosing our office for your 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, please do not hesitate to contact us; we will be happy to help you!

### **AUTHORIZATION TO RELEASE INFORMATION**

- So that I may receive informed care, I authorize release of my medical record information to third party payers and other providers participating in my care that agree to treat my information in a confidential manner, in keeping with all applicable federal, state, and local laws.
- I further authorize any other individual or organization that has provided health care to me to release to **Shenandoah Podiatry** any and all of my medical record information, in both printed or electronic form. I may revoke my consent for the release of this information at any time, except for action(s) already taken related to said consent.

### **ASSIGNMENT OF BENEFITS**

- I hereby request that payment of authorized Medicare, Medicaid, and all other insurance benefits be made on my behalf to **Shenandoah Podiatry** for any services provided to me and/or my dependents. I authorize any holder of medical information related to me and/or my dependents to release to the appropriate organization and its agents any information needed to determine these benefits as payable for related services.

### **GUARANTEE OF PAYMENT**

- **Shenandoah Podiatry** requires that patients place a credit card on file (CCoF) to resolve any remaining balances after treatment. I agree to be responsible for any amounts not paid by my insurance plan. My CCoF will be used for these types of payments. In the event that I default on payment of my account, I understand I am responsible for any and all costs related to the collection of my account. If the debt is assigned to a third-party collection agency, I agree to be responsible for collection fees and interest due to amounts in default.

### **ADDITIONAL CHARGES**

- No Show Charge \$50
- Cancellation Charge \$50 (if not notified within 24 hours prior to appointment)
- Returned Check/Non-Sufficient Funds Charge \$35

### **AGREEMENT TO FINANCIAL/PAYMENT POLICY**

- I acknowledge that I reviewed a copy of **Shenandoah Podiatry's** financial policy and I agree to the terms of payment due.

### **WRITTEN ACKNOWLEDGEMENT OF PRIVACY PRACTICES**

- I acknowledge that I have received and had an opportunity to ask questions concerning the Notice of Privacy Practice of **Shenandoah Podiatry**.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Patient Name Printed

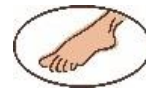
\_\_\_\_\_  
Responsible Party Signature

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date



# Shenandoah Podiatry



## Financial Policy

Thank you for choosing Shenandoah Podiatry as your foot care provider! We are committed to providing you with quality and affordable health care. Your understanding of our Financial Policy is important to our professional relationship. Please read the following policy; feel free to ask us any questions that you may have. Once you accept this policy, kindly sign in the space provided.

1. **INSURANCE** – We participate in most insurance plans, including Medicare. If you are not insured by a plan in which we participate, payment in full is expected at each visit. If you are insured by a plan in which we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. **Please understand it is your full responsibility to know and understand the benefits and details of your insurance policy including, but not limited to, in-network versus out-of-network copays, deductibles, co-insurance and non-covered services. Coverage and benefits you are quoted are done in good faith from what we believe to be true, but is in no way a guarantee of payment or coverage.** Please contact your insurance company with any questions you may have regarding your coverage.
  - a. **Proof of Insurance** – All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver’s license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the balance of a claim. If required, obtaining the proper referral from your Primary Care Physician is your responsibility. Patients presenting to our office without a valid referral will be asked to pay in full. This payment will be held for 48 hours and will become non-refundable if the proper referral is not obtained by then.
  - b. **Copayments and Deductibles** – All copayments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company.
  - c. **Coverage Changes** – If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.
2. **NON-COVERED SERVICES** - Please be aware that some (and perhaps all) of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit if we know it is non-covered. Sometimes we will not know until your insurance claim has gone through; for these you will be notified and payment will be made through Credit Card on File (CCoF).
3. **NON-PAYMENT** - Invoices are sent out every 30 days. Your prompt payment will assist us in keeping the cost of healthcare down. If your account is over 60 days past due, you will receive a letter requesting immediate payment. A \$10.00 rebilling fee will be charged for each additional invoice sent out after 30 days. Partial payments will not be accepted unless otherwise approved by our Billing Office. Please be aware that if a balance remains unpaid, we may refer your account to collections and collection fees incurred will be added to your balance. **Returned Checks/Non-Sufficient Funds fee is \$35.**
4. **CLAIMS SUBMISSION** - We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is essentially a contract between you and your insurance company.
5. **MISSED APPOINTMENTS** - Our policy is to charge **\$50.00** for missed appointments that was not cancelled 24-hours ahead of time, or for an understandable reason. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

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 and/or unpaid by my insurance carrier for myself and/or the below-named person. I also agree that in order for my account to be serviced and to collect any amounts owed, I may be contacted by telephone, including wireless numbers, which could result in charges to me. I may also be contacted by text messages or emails, using any email address provided. I understand that methods of contact may include the use of pre-recorded voice messages and/or the use of an automatic dialing device/service, as applicable.

\_\_\_\_\_  
Signature of Patient or Representative (Indicate Relationship Below)  
 Self    Parent    Legal Guardian    Representative/Healthcare POA

\_\_\_\_\_  
Date



# Shenandoah Podiatry



## Authorization for Credit Card on File (CCoF)

In effort to keep our costs at a reasonable level, Shenandoah Podiatry now requires that all patients put a credit card on file to ensure collection of any patient responsibilities after we have received payment from their active insurance plan.

**If you choose NOT to put a credit card on file, please DO NOT complete this form. See the receptionist for payment information.**

The credit card on file (CCoF) will ONLY be used to pay for deductibles, coinsurances, and non-covered services, once the claim has been processed by insurance. Once the insurance company has paid its portion, the patient will receive an Explanation of Benefits (EOB) which will state any remaining balance that must still be paid by the patient.

**PLEASE NOTE:**

- Your credit card information is NOT kept on file in this office; it is kept securely offsite, which means that this office does not have any access to the full credit card number once it is entered into the system for the first time.
- Once we receive payment from the insurance company, the CCoF will be charged for the remaining balance.
- If the remaining balance is over \$100, you will receive a courtesy call prior to your credit card being charged. At the time of this call, you can agree to pay the balance in full or set up an automatically recurring payment plan for the balance.

By signing below, I authorize **Shenandoah Podiatry** to charge the patient-responsible balances on my account, until further notice. These charges may include old balances, copays, coinsurance, deductibles, and non-covered services. These charges will be authorized to be processed using the following credit card:

**Circle One:**      Visa            Mastercard      Discover      American Express

**Last 4 digits of the Credit Card:** \_\_\_\_\_

**Exp. Date (mm/yy):** \_\_\_\_ / \_\_\_\_

**I understand that once my insurance company has paid its portion for my care, I will receive an Explanation of Benefits (EOB) which will state any remaining balance that must be paid by me. I agree that Shenandoah Podiatry may charge my credit card on file for the balance due when they receive a copy of the EOB. If the balance due is more than \$100, I will receive a courtesy call prior to my card being charged, at which time I can agree to pay in full or set up a payment plan for the balance.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_

**Office Use Only:**

TSYS ID # \_\_\_\_\_ Date \_\_\_\_\_ Initials \_\_\_\_\_



# Shenandoah Podiatry



## New Patient Medical History Form

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Shoe Size \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

Are you currently wearing orthotics?  Yes  No If so, how long? \_\_\_\_\_

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

_____	_____	_____
_____	_____	_____
_____	_____	_____

### History:

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

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

- |                          |   |                       |                          |
|--------------------------|---|-----------------------|--------------------------|
| Back/Spine               | <input type="checkbox"/>  | Heart Condition       | <input type="checkbox"/> |
| Bleeding Disorder        | <input type="checkbox"/>  | High Blood Pressure   | <input type="checkbox"/> |
| Blood Clots              | <input type="checkbox"/>  | High Cholesterol      | <input type="checkbox"/> |
| Bunions                  | <input type="checkbox"/>  | Liver Disease         | <input type="checkbox"/> |
| Cancer                   | <input type="checkbox"/> Type or Location: _____                | Mitral Valve Prolapse | <input type="checkbox"/> |
| Circulation Problems     | <input type="checkbox"/>  | MRSA Infection        | <input type="checkbox"/> |
| Congestive Heart Failure | <input type="checkbox"/>  | Neurological Disorder | <input type="checkbox"/> |
| COPD                     | <input type="checkbox"/>  | Neuropathy            | <input type="checkbox"/> |
| Depression               | <input type="checkbox"/>  | Osteoporosis          | <input type="checkbox"/> |
| Diabetes:                | <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 | Seizure Disorders     | <input type="checkbox"/> |
| Edema                    | <input type="checkbox"/>  | Stomach Ulcers        | <input type="checkbox"/> |
| Fibromyalgia             | <input type="checkbox"/>  | Stroke                | <input type="checkbox"/> |
| Gout                     | <input type="checkbox"/>  | Thyroid Disorders     | <input type="checkbox"/> |

Any other condition(s) not mentioned: \_\_\_\_\_

### Allergies/Sensitivities: (Please check those that apply or provide a list we may copy) See Attached List

Trigger	Reaction	Trigger	Reaction
<input type="checkbox"/> Adhesive Tape	_____	<input type="checkbox"/> Iodine	_____
<input type="checkbox"/> Aspirin	_____	<input type="checkbox"/> IV Contrast Dye	_____
<input type="checkbox"/> Blood Thinners	_____	<input type="checkbox"/> Latex	_____
<input type="checkbox"/> Cephalosporins	_____	<input type="checkbox"/> Local Anesthetics	_____
<input type="checkbox"/> Codeine	_____	<input type="checkbox"/> Penicillin	_____
<input type="checkbox"/> Ibuprofen	_____	<input type="checkbox"/> Sulfa	_____
<input type="checkbox"/> Demerol	_____	<input type="checkbox"/> Seafood/Shellfish	_____

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

Other \_\_\_\_\_

**Previous Surgeries:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Amputation         | <input type="checkbox"/> Gallbladder             | <input type="checkbox"/> Lower Extremity Bypass |
| <input type="checkbox"/> Angioplasty/Stent  | <input type="checkbox"/> Hammer Toe              | <input type="checkbox"/> Neuroma                |
| <input type="checkbox"/> Back/Spine Surgery | <input type="checkbox"/> Heart Bypass            | <input type="checkbox"/> Pacemaker              |
| <input type="checkbox"/> Bunion             | <input type="checkbox"/> Heart Valve Replacement | <input type="checkbox"/> Transplant             |
| <input type="checkbox"/> Defibrillator      | <input type="checkbox"/> Joint Replacement       | <input type="checkbox"/> Vascular               |

Any other surgery not mentioned: \_\_\_\_\_

Any hospitalizations within the last 12 months? Yes \_\_\_\_\_ or No \_\_\_\_\_

If yes, please describe the reason for admittance: \_\_\_\_\_

**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)
<input type="checkbox"/> Bunions	_____	<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> Heart Condition	_____
<input type="checkbox"/> Hypertension	_____	<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Other	_____		

Do you use tobacco products?  Yes  No  Former (How Long Ago \_\_\_\_\_)

If yes, which product?  Cigarettes  Cigars  Chewing Tobacco How much/how often? \_\_\_\_\_

Do you drink alcohol?  Yes  No If yes, how much/how often? \_\_\_\_\_

**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) and staff 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 (Indicate Relationship Below)

Self  Parent  Legal Guardian  Representative/Healthcare POA

\_\_\_\_\_  
Date