SHENANDOAH PODIATRY

New Patient Form

PATIENT INFORMATION: Please Print Clearly

First Name _____ MI _____ Last Name _____ ○ Male ○ Female

Date of Birth _____ Age _____ SS#_____-_____-_____ OR Driver's License #_____

Home Address _____ Apt# _____

City _____ State _____ Zip _____

Mailing Address (if different from Home) _____

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) _____

Primary Care Physician _____ PCP# (_ _ _) _ _ _ - _ _ _ _ Date of last visit _____

Race: ○ American Indian/Alaska Native ○ African American/Black ○ Asian ○ Native Hawaiian/Pacific Islander ○ White
Ethnicity: ○ Hispanic ○ Non-Hispanic
Primary Language: _____

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

EMERGENCY CONTACT INFORMATION: Please Print Clearly

Emergency Contact Name _____ Phone (_ _ _) _ _ _ - _ _ _ _ Relation _____

PAYMENT AND INSURANCE INFORMATION: Please present your insurance card and Driver's License upon arrival.

○ 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
Internet: ○ 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.

_____ _____

Patient (or Authorized Representative) Signature Date

If not patient, state relationship _____

SHENANDOAH PODIATRY PRIVACY STATEMENT

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

My signature represents that I have been offered a copy of the policy. I acknowledge that I was provided a copy of the Notice of Privacy Practices and have read (or had the opportunity to read, if I so chose) and understood the Notice (**see pages 1-7 in provided folder**).

PATIENT PORTAL (PATIENT ACKNOWLEDGMENT AND AGREEMENT)

My signature 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.

(**TO OPT OUT** of Patient Portal, please initial here_____.)

PRESCRIPTION MONITORING AND ePRESCRIBING

- 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 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 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 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.

(**TO OPT OUT** of ePrescribing, please initial here_____.)

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

_____ _____

Signature of Patient or Representative (Indicate Relationship Below) Date

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

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).

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 much 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.

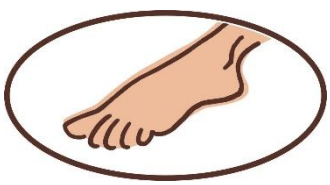
2. **NON-COVERED SERVICES -** Please be aware that some (and perhaps all) of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit if we know it is non-covered. Sometimes we will 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. **NONPAYMENT -** 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.
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.

Financially Responsible Party:

_____ _____

Signature of Patient or Responsible Party Date



AUTHORIZATION TO KEEP CREDIT CARD ON FILE AND PROCESS AUTOPAY

PLEASE NOTE:

Your credit card information is not kept on file in this office. It is kept securely offsite; this office does not have access to the full credit card number once it is entered into the system for the first time.

You **must choose one** of the following options. Once you have done so, **please sign below, regardless of your selection**.

☐ **Authorization**

Until further notice, I authorize **Shenandoah Podiatry** to charge the patient-responsible balances on my account, including old balances, copays, coinsurance, deductibles, and non-covered services, to 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). The insurance plan EOB 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.

--OR—

☐ **Statement of Non-Participation**

I prefer NOT to participate in the **Shenandoah Podiatry CCOF Program.**

I understand that, having decided not to participate in the CCOF program, I will be required to provide payment for any traditionally non-covered services (e.g., injections, X-rays, etc.) at the time of my visit. Charges for usually covered services will be submitted to my insurance company. Once my insurance company has paid its portion for my care, I will receive an Explanation of Benefits (EOB). The insurance plan EOB will state any remaining balance that must still be paid by me.

Signature _____ Date _____

Printed Name _____

SHENANDOAH PODIATRY MEDICAL HISTORY

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:

(Women) Are you Currently Pregnant? ☐ Yes ☐ No Currently Breastfeeding? ☐ Yes ☐No

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

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

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
☐	Adhesive Tape	_____	☐	Iodine	_____
☐	Aspirin	_____	☐	IV Contrast Dye	_____
☐	Blood Thinners	_____	☐	Latex	_____
☐	Cephalosporins	_____	☐	Local Anesthetics	_____
☐	Codeine	_____	☐	Penicillin	_____
☐	Ibuprofen	_____	☐	Sulfa	_____
☐	Demerol	_____	☐	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:

☐Amputation	☐Gallbladder	☐Lower Extremity Bypass
☐Angioplasty/Stent	☐Hammer Toe	☐Neuroma
☐Back/Spine Surgery	☐Heart Bypass	☐Pacemaker
☐Bunion	☐Heart Valve Replacement	☐Transplant
☐Defibrillator	☐Joint Replacement	☐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)
☐	Bunions		☐	Diabetes	
☐	Cancer		☐	Heart Condition	
☐	Hypertension		☐	Stroke	
☐	Other				

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

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: _____ **Date:** _____

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