

Dear New Patient,

Welcome to our practice! We realize that you have many options when it comes to podiatric providers, so we are pleased that you have chosen us to care for your foot care needs. We are committed to providing you with high quality podiatric care in a caring, gentle manner.

We are confident that you will be happy with the care we provide. If there are any questions about your care, or information that you still need about insurance coverage, we will be glad to assist.

Please fill out the patient registration and medical history forms. Please complete them at your convenience and bring them with you to your first visit.

Quality patient service is a priority for us and we recognize the value of your time. Except in emergency situations, you can expect us to be on time for you and we appreciate the same courtesy.

We look forward to meeting you.

Sincerely,

Shannon Roesch, D.P.M., F.A.C.F.A.S.

Practice:

Today's Date:

Name: _____ DOB: _____ Chart Number: _____
 Sex: M F Marital Status: Single Married Widowed Divorced SS#: _____
 E-mail: _____ Spouse/Partner Name: _____
E-mail newsletters, reminders, statements, etc. Emergency Name: _____ Phone: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home #: _____ Cell #: _____ Other #: _____
 Employer: _____ Phone: _____
 Employer Address: _____ City: _____ State: _____ Zip: _____

Primary Insurance: _____ Are you the insured? Yes No
Insured Information
 Subscriber Name: _____ Relationship to insured: Spouse Child Self other
 Phone #: _____ Sex: Male Female DOB: ___/___/___
 Address: _____
 Policy ID: _____ Group ID: _____ Employer: _____
 Secondary Insurance: _____ Are you the insured? Yes No
Insured Information
 Subscriber Name: _____ Relationship to insured: Spouse Child Self Other
 Phone #: _____ Sex: Male Female DOB: ___/___/___
 Address: _____
 Policy ID: _____ Group ID: _____ Employer: _____

How did you find out about our practice? Physician Internet Telephone book Family member Friend
 Other: _____
 What is the reason for your visit today? _____
 _____ Result of accident or work injury? Yes No
 How long has this bothered you? 1 2 3 4 5 6 7 days weeks months years
 What treatments have you tried & have they been effective? _____

 On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain? ___/10
 The pain quality is: burning constant dull sharp shooting throbbing tingling Other: _____

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____

Date: _____

History and Physical

Name: _____ DOB: _____ Chart Number: _____

Medical History:

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Blood disorders	<input type="checkbox"/> Circulation problems	<input type="checkbox"/> Musculoskeletal	<input type="checkbox"/> Breathing issues	
<input type="checkbox"/> Liver	<input type="checkbox"/> Sleep apnea	<input type="checkbox"/> Gout	<input type="checkbox"/> Allergies	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Asthma
<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Stomach/bowel	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety disorder	<input type="checkbox"/> Mental illness	<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Blood clot	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Cancer	<input type="checkbox"/> Hepatitis	
<input type="checkbox"/> Neuropathy (specify) _____	<input type="checkbox"/> Thyroid disease (specify) _____	<input type="checkbox"/> Diabetes (type 1, type 2)			
<input type="checkbox"/> Arthritis (specify) _____	<input type="checkbox"/> other (specify) _____	<input type="checkbox"/> HIV	<input type="checkbox"/> CVA		

Are you pregnant? Yes No **Are you nursing?** Yes No Skin disorders Stroke

Surgical History

None Appendectomy C-Section Angioplasty Bypass Cataracts Cholecystectomy

Have you ever had any surgical procedures on foot/ankle or anywhere else on your body? Yes No

If yes, please describe: _____

Do you have any artificial joints? Yes (where? _____) No Do you have an artificial heart valve? Yes No

Social History

Do you smoke? Yes No If yes how many packs per day? 1 2 3 4 5 For how long? _____

Do you drink alcohol? Yes, everyday (5-7 days/week) Yes, occasionally/socially No/Rarely

Substance abuse: Yes, I have a current substance abuse problem. Please specify: _____

Yes, I had a past substance abuse problem. Please specify: _____

No, I have never had a substance abuse problem

What is your occupation? _____ Does it involve mostly standing or sitting

Do you exercise regularly? No, I do not exercise regularly Yes, I do the following regular exercise: _____

Family History

Is there any family history (blood relative) of: (Please indicate family member)

<input type="checkbox"/> Alzheimer's _____	<input type="checkbox"/> Depression _____
<input type="checkbox"/> Arthritis _____	<input type="checkbox"/> Diabetes _____
<input type="checkbox"/> Bleeding disorders _____	<input type="checkbox"/> Emphysema _____
<input type="checkbox"/> Blood clot _____	<input type="checkbox"/> Heart disease _____
<input type="checkbox"/> Cancer _____	<input type="checkbox"/> High Blood Pressure _____
<input type="checkbox"/> Cataracts _____	<input type="checkbox"/> Neurological _____
<input type="checkbox"/> Circulation problems _____	<input type="checkbox"/> Strokes _____
<input type="checkbox"/> Other (specify): _____	

Review of Systems

(Please check the box if you currently have any of these symptoms or check "NONE")

Cardiovascular	<input type="checkbox"/> leg pain when walking	<input type="checkbox"/> fever	<input type="checkbox"/> chest pain/pressure	<input type="checkbox"/> leg swelling	<input type="checkbox"/> cold hands/feet	
	<input type="checkbox"/> fainting	<input type="checkbox"/> palpitations	<input type="checkbox"/> vascular disease	<input type="checkbox"/> valve problems	<input type="checkbox"/> NONE	
Genitourinary	<input type="checkbox"/> blood in urine	<input type="checkbox"/> hesitancy	<input type="checkbox"/> incontinence	<input type="checkbox"/> increased urgency		
	<input type="checkbox"/> decreased frequency	<input type="checkbox"/> excessive urination	<input type="checkbox"/> kidney disease	<input type="checkbox"/> kidney stones	<input type="checkbox"/> NONE	
Gastrointestinal	<input type="checkbox"/> abdominal pain	<input type="checkbox"/> heartburn	<input type="checkbox"/> blood in stool	<input type="checkbox"/> vomiting	<input type="checkbox"/> ulcers	<input type="checkbox"/> constipation
	<input type="checkbox"/> diarrhea	<input type="checkbox"/> trouble swallowing	<input type="checkbox"/> decrease appetite	<input type="checkbox"/> increase appetite	<input type="checkbox"/> NONE	
Integumentary	<input type="checkbox"/> athlete's foot	<input type="checkbox"/> nail abnormalities	<input type="checkbox"/> keloids	<input type="checkbox"/> itchiness	<input type="checkbox"/> dry, scaly skin	<input type="checkbox"/> NONE
Hematologic	<input type="checkbox"/> lower leg ulcers	<input type="checkbox"/> sickle cell disease	<input type="checkbox"/> anemia	<input type="checkbox"/> blood thinners	<input type="checkbox"/> clotting disorders	<input type="checkbox"/> NONE
Neurological	<input type="checkbox"/> tingling	<input type="checkbox"/> weakness	<input type="checkbox"/> seizures	<input type="checkbox"/> numbness	<input type="checkbox"/> headaches	
	<input type="checkbox"/> tremors	<input type="checkbox"/> paralysis			<input type="checkbox"/> NONE	
Musculoskeletal	<input type="checkbox"/> back pain	<input type="checkbox"/> joint swelling	<input type="checkbox"/> muscle weakness	<input type="checkbox"/> muscle pain	<input type="checkbox"/> neck pain	
	<input type="checkbox"/> sciatica	<input type="checkbox"/> joint stiffness	<input type="checkbox"/> joint pain	<input type="checkbox"/> joint instability	<input type="checkbox"/> arthritis	<input type="checkbox"/> NONE
Respiratory	<input type="checkbox"/> chest pain	<input type="checkbox"/> wheezing	<input type="checkbox"/> COPD	<input type="checkbox"/> coughing	<input type="checkbox"/> snoring	
	<input type="checkbox"/> shortness of breath	<input type="checkbox"/> emphysema			<input type="checkbox"/> NONE	

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____

Date: _____

Practice: _____

Today's Date: _____

Name: _____ **Chart #:** _____ **Date of birth:** _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino Declined to specify

Race: Asian American Indian or Alaska Native Black or African American
 White Native Hawaiian or other Pacific Islander Declined to specify
 Declined to specify

Preferred Language: _____

Pharmacy Name: _____ **Pharmacy Phone:** _____

Pharmacy Address: _____ **City, State, Zip:** _____

Primary Care Physician: _____ **Phone:** _____ **Date Last Seen:** _____

Address: _____

Referring Physician: _____ **Phone:** _____ **Date Last Seen:** _____

Address: _____

Privacy Information Preferences

Do you want to be exempt from public reporting? Yes No Can we send mail to the address on file? Yes No

Can we call the phone number on file? Yes No Can we leave voicemail on machine? Yes No

Will you allow us to send internet based (e-mail) delivery of reminders and newsletters? Yes No

If yes, please provide your e-mail address: _____

Who can we leave messages with? Wife Husband Daughter Son Other:
 Name(s): _____

Smoking Status

Current Every Day Smoker, Current Status Unknown
 Current Some Day Heavy Tobacco Unknown If Ever
 Former Never Light Tobacco I decline to answer

Vital Signs

Blood Pressure: _____ / _____

Height: _____ Weight: _____

Current Medications

No Known Medications I take the following medications:

Name: _____
 Name: _____
 Name: _____
 Name: _____
 Name: _____
 Name: _____
 Name: _____

Use the back of this form if more room is needed

Allergies

No Known Allergies No Known Drug Allergies

Name: _____ Reaction _____
 Name: _____ Reaction _____
 Name: _____ Reaction _____
 Name: _____ Reaction _____
 Name: _____ Reaction _____
 Name: _____ Reaction _____
 Name: _____ Reaction _____

Use the back of this form if more room is needed

Last Flu Shot Date: _____ **Did you get a pneumococcal vaccination?** Yes No

Have you fallen in the last 12 months? Yes No **Were you injured from the fall?** Yes No

Have you completed any Advanced Directives? Yes No

PLEASE READ AND SIGN: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. (Assignment of Benefits): I authorize payment of medical benefits to the practice named above. (Release of Information): I authorize the release of any medical information necessary to process this claim. (HIPAA Privacy): I acknowledge that I received my HIPAA Privacy Practices Notice. (Medication History): I authorize the Doctor's office to retrieve my medication history.

Patient Signature: _____

Date: _____

Patient Financial Policy

Your understanding of our financial policy is an essential element of your care and treatment. If you have any questions please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorization/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept cash or checks.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with certain insurers and health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance deductible at the time of service.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to "not be covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals however, you remain responsible for charges for any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to surgery.
- Past due accounts are subject to collection proceedings. All costs incurred, including but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due to the office.
- There is a service fee of \$25.00 for all returned checks. Your insurance company does not cover this fee.

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party: _____ Date: _____

Witness Signature: _____ Date: _____

Printed Name of Witness: _____

SHANNON ROESCH, D.P.M., F.A.C.F.A.S.

Medicine and Surgery of the Foot

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privacy officer :Dr. Shannon Roesch

effective date April 14, 2003

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We care about our patient's privacy and strive to protect the confidentiality of your medical information at this practice.

New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required by law to abide by the terms of the Notice of Privacy Practices currently in effect and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

Who will Follow This Notice

Any healthcare professional authorized to enter the information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g. a billing service) sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

How We May Use and Disclose Medical Information About You

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses and disclosures. Not every possible use or disclosure in a category is listed.

For Treatment

We may use medical information about you to provide you with medical treatment or services.

Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for your treatment process.

For payment

We may use medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example; We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

For Health Care Operations. We may use and disclose medical information about you for health care operations to assure that you receive quality healthcare. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures That Can Be Made Without Consent or Authorization.

- *As required during an investigation by law enforcement agencies
- * To avert a serious threat to public health or safety
- *As required by military command authorities for their medical records
- * To worker's compensation or similar programs for processing of claims
- *If an inmate, to the correctional institution or law enforcement official
- *In response to a legal proceeding
- *To a coroner or medical examiner for identification of a body
- *As required by the US Food and Drug Administration (FDA)
- *Other healthcare providers' treatment activities
- *Other covered entities' and providers' payment activities
- *Other covered entities' healthcare operations activities (to the extent permitted under HIPPA)
- *Uses and disclosures required by law
- *Uses and disclosures in domestic violence or neglect situations
- *Health oversight activities
- *Other public health activities

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you

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**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY
PRACTICES**

I Acknowledge that I was provided with a copy of the Notice of Privacy Practices and that I have read or had the opportunity to read if I so chose and understood the Notice.

name

Parent or authorized representative