The Foot Doctors, P.C.
929 E. Montclair, Suite 100
Springfield, MO 65807
417-883-1881
Toll Free 1-800-366-8377

Welcome to The Foot Doctors, P.C.

We would like to take this opportunity to welcome you to our practice. At our office, our Doctors and staff will always put your comfort first. You'll discover our special type of care the moment you make your first contact with our office. Our staff will greet you warmly and do their best to make you feel at ease.

Your appointment is scheduled with Dr. _____

Your appointment date is _____

In order to prepare your initial records and prepare your new patient chart, it is essential that you complete your paperwork prior to your arrival. Please arrive by _____ with your completed paperwork.

If you cannot make this time, we will need to reschedule your visit. If you need to reschedule your appointment, please call our office at least 24 hours in advance. If you are 10 minutes or later for your appointment, it may be necessary to reschedule your appointment to a later date.

Enclosed you will find a map showing directions to our office and the paperwork we will need at the time of your visit. Please fill in the requested information and bring it with you along with a photo ID and any insurance cards you may have.

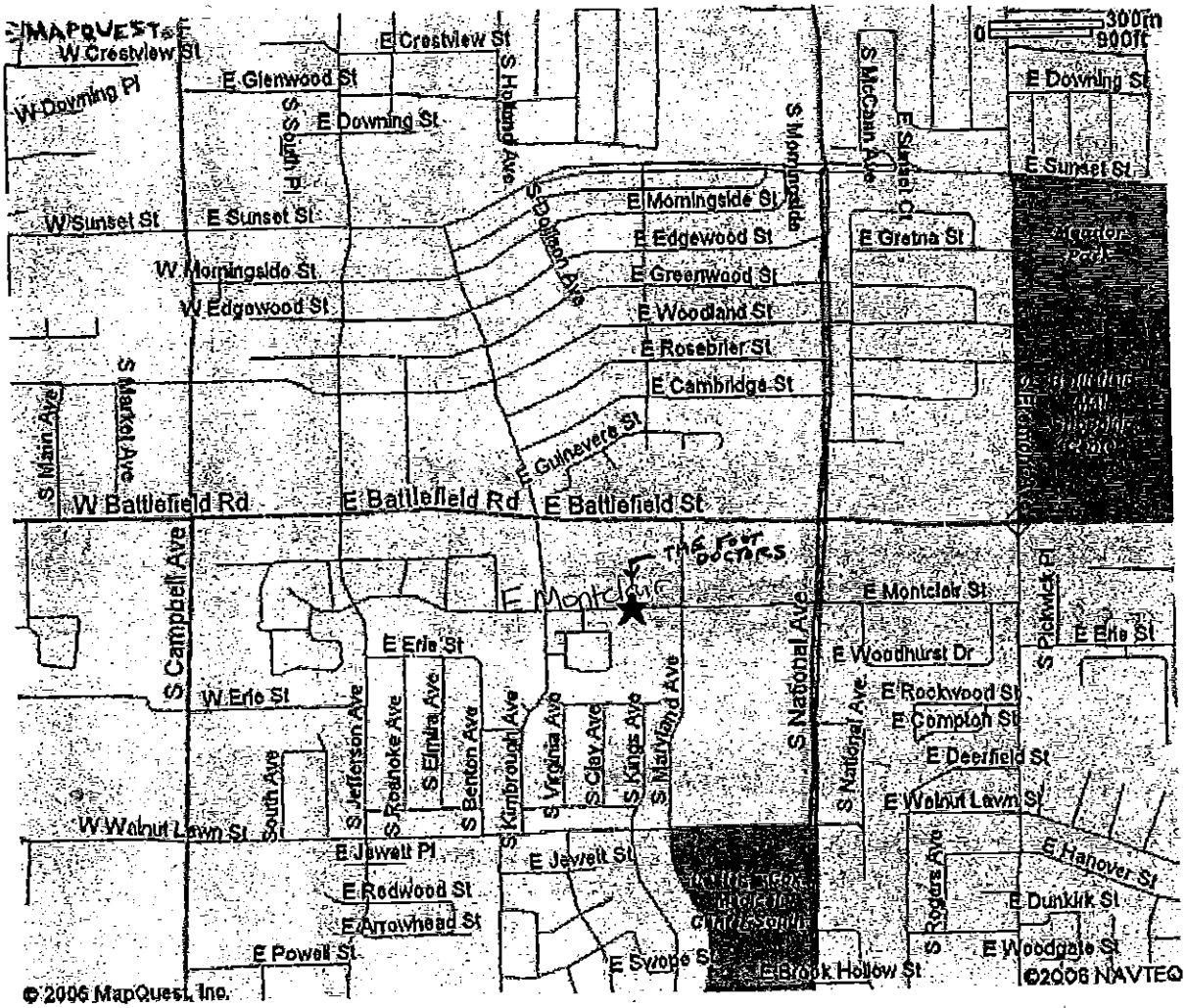
If you have any questions before your appointment, please call our office at the above number.

Thank you for choosing our clinic to service your foot care needs. We look forward to seeing you soon.

Sincerely,
The Foot Doctors, P.C.
Doctors and Staff

*** PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR ABILITY ***

THE FOOT DOCTORS, P.C.
929 E. MONTCLAIR, STE. 100
SPRINGFIELD, MO 65807
1-800-FOOT-DRS
(417) 883-1881



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THE FOOT DOCTORS, P.C

WELCOME TO THE FOOT DOCTORS, P.C.

PATIENT INFORMATION:

Name_____Date of Birth_____Marital Status_____

Address_____City_____State_____Zip Code_____

Phone #_____Sex M____F____ Social Security #_____

Employer_____ Work Phone #_____Cell Phone #_____

Employer Address_____City_____State_____Zip Code_____

****

Spouse's Name_____Social Security #_____Phone #_____

OR

Parent/Guardian_____Social Security #_____Phone #_____

Date of Birth: _____

Address_____City_____State_____Zip Code_____

In Case of Emergency Contact_____Phone #_____

****

Please advise us who referred you to our office. We would like to thank them.

Dr._____ Family/Friend_____Other_____

****

INSURANCE INFORMATION: **PLEASE BRING INSURANCE CARD TO APPOINTMENT**

Medicare #_____ Medicaid #_____

Insurance Company:_____ Telephone #_____

Address for Claims:_____City_____State_____Zip Code_____

Policy Holder's Name_____Date of Birth_____ID#_____

Policy Holder's Employer_____ Group #_____

Record Release I give permission for The Foot Doctors, P.C. to release my records to my insurance company.

Referral Policy If my insurance company required me to have a referral to see a specialist, I must contact my primary care physician to have the referral in your office by the date of my appointment and to maintain a current referral for all subsequent visits. It is my responsibility to obtain this referral for all subsequent visits. If an approved referral is not obtained, I will be responsible for my medical treatment charges if my insurance company does not pay.

Payment Policy The Foot Doctors, P.C. will file all insurances if the correct information is provided. PPO/HMO charges will be handled in accordance with the policies. Medicare is accepted by assignment. If you have not met your deductible for the year, you will be responsible for that amount. I hereby authorize payment directly to the physician if I allow The Foot Doctors, P.C. to file my insurance. I understand that if my account is turned over to a collection agency due to non payment, I will be responsible to pay the cost of collections, court and legal fees in addition to the balance owed.

SIGNATURE (PATIENT/RESPONSIBLE PARTY)_____DATE_____

HEALTH QUESTIONNAIRE

NAME_____ AGE_____ DATE_____

REASON FOR CURRENT VISIT/BRIEF HISTORY_____PHONE ( )_____

HISTORY OF PAST ILLNESS: Have you had?

Measles	No	Yes	Stroke or Heart Attack	No	Yes
Mumps	No	Yes	Rheumatic Fever or Heart Disease	No	Yes
Chickenpox	No	Yes	Congenital Abnormalities or Birth Defects	No	Yes
Cancer	No	Yes	Tuberculosis	No	Yes

Have you ever been hospitalized or been under medical care over night? No Yes
If yes, for what reason?_____

Injuries:

Have you had any broken bones, sprains, dislocations? No Yes Describe

Family History	Health if Living	if deceased Age (at death) And Cause
Father		
Mother		
Brother/ Sister		
Son/ Daughter		

Has Any Blood Relative Had?		
Cancer	No	Yes
Tuberculosis	No	Yes
Diabetes	No	Yes
Heart Trouble	No	Yes
Stroke	No	Yes
Convulsions, Paralysis	No	Yes
Cirrhosis Hepatitis	No	Yes
Thyroid Disease	No	Yes
Bleeding Tendency	No	Yes
Gout	No	Yes
Arthritis	No	Yes

SOCIAL HISTORY:

Single Married Separated Divorced Widowed
Are you living with your husband or wife?.....No Yes
Do you live alone?.....No Yes
Alcoholic beverages: Never___Rarely___Moderately___Daily___
Tobacco: Cigarettes___, Packs Per Day___, Don't Smoke___, Ever Smoked___
Other Recreational Drugs_____
Are you exposed to fumes, dusts, or solvents?_____

SYSTEMIC REVIEW: Do you have any of the following?

General

Last physical examination_____
Last tetanus shot_____
Changes in appetite (eat more/less).....No Yes
Recent weight change.....No Yes
Excessive thirst.....No Yes
Have you been in good general health most of your life.....No Yes

Skin

Skin diseases.....No Yes
Jaundice.....No Yes
Hives, eczema or rash.....No Yes
Frequent infections or boils.....No Yes
Abnormal pigmentation.....No Yes

Head-Eyes-Ears-Nose-Throat

Eye disease or injury.....No Yes
Do you wear glasses?.....No Yes
Double Vision.....No Yes
Headaches.....No Yes
Glaucoma.....No Yes
Itching eyes or nose.....No Yes
Sneezing or runny nose.....No Yes
Nosebleeds.....No Yes
Chronic sinus trouble.....No Yes
Ear Disease.....No Yes
Impaired hearing.....No Yes
Dizziness or transient episodes of unconsciousness.....No Yes

Respiratory

Long term or frequent cough.....No Yes
Long term sore throat.....No Yes
Asthma or wheezing.....No Yes
Difficulty breathing.....No Yes
Pneumonia.....No Yes

Neck

Stiffness.....No Yes
Enlarged glands.....No Yes

SYSTEMIC REVIEW: Do you have any of the following?

Cardiovascular

Chest pain or angina pectoris.....No Yes
Shortness of breath w/walking or lying down.....No Yes
Heart trouble or heart attacks.....No Yes
Swelling of hands, feet or ankles.....No Yes
Phlebitis or blood clots.....No Yes
Heart murmur.....No Yes
Blood pressure problems.....No Yes
Any pain in calves or buttocks on walking
that is relieved by rest.....No Yes

Gastrointestinal

Peptic ulcer (stomach or duodenal).....No Yes
Vomiting blood or food.....No Yes
Liver trouble.....No Yes
Hepatitis.....No Yes
Painful bowel movements.....No Yes
Bleeding with bowel movements.....No Yes
Recent change in bowel habits.....No Yes
Frequent diarrhea.....No Yes
Heartburn or indigestion.....No Yes

Genitourinary

Frequent urination.....No Yes
Night time urination.....No Yes
Burning or painful urination.....No Yes
Blood in urine.....No Yes
Kidney trouble.....No Yes
Kidney stones.....No Yes

Gynecological

Any reason to suspect you may be pregnant.....No Yes
Number of pregnancies_____
Number of live births_____

REACTIONS TO MEDICATIONS

Penicillin.....No Yes
Morphine, Codeine, or Demerol.....No Yes
Novocain or other anesthetics.....No Yes
Aspirin, Empirin, or other pain reliever.....No Yes
Sulfa drugs.....No Yes
Tetanus antitoxin or other serums.....No Yes
Adhesive tape.....No Yes
Iodine, IV dye, or merthiolate.....No Yes
Other.....No Yes

Name of Primary Care Physician_____
Address_____
Referring Physician_____
Signature of Patient_____

Source of information if other than patient_____

Locomotor/Musculoskeletal

Varicose veins.....No Yes
Leg cramps with activity.....No Yes
Leg cramps in bed at night.....No Yes
Heel pain, arch pain with
prolonged activity.....No Yes
Burning feet.....No Yes
Ankle or knee pain w/activity.....No Yes
Shin splints.....No Yes
Joint pain or morning stiffness.....No Yes

Neuro-Psychiatric

Convulsions.....No Yes
Paralysis.....No Yes

Hematologic

Are you slow to heal after cuts.....No Yes
HIV.....No Yes
Anemia.....No Yes
Abnormal bruising or bleeding.....No Yes

Endocrine

Thyroid disease.....No Yes
Diabetes.....No Yes
Hormone therapy.....No Yes
Change in hair growth.....No Yes
Have you become more cold.....No Yes
Has your skin become more dry.....No Yes

Height_____ Weight_____

Shoe Size_____

Describe Reaction

_____
_____
_____
_____
_____
_____
_____
_____
_____

The Foot Doctors, P.C.
Medical Health Page

Name _____ Date _____

Pharmacy Name & Address _____

Please List

Medications you are currently on	Hospitalization/Surgeries

Patient/Guardian Signature_____

CONSENT FOR TREATMENT: As a patient of The Foot Doctors, P.C., I agree, request, and authorize my attending physician to administer such treatment as is necessary. This includes their associates and/or assistants. Treatment may include such services, care, diagnostic procedures, and/or medical treatments, as the physician(s) deems reasonable and necessary. This would also include, but not limited to, the performance of services involving pathology and radiology.

AUTHORIZATION FOR DISCLOSURE: I give express permission to discuss with the individual(s) I have listed:

PLEASE CHECK THE APPROPRIATE LINE

____Any aspect of my health care ____Health information only ____Financial information only

I understand that I am responsible for notifying this office, in writing, of any changes to this authorization to disclose my personal health information.

Name_____Relationship_____Phone #_____

Name_____Relationship_____Phone #_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FORM: This Notice of Privacy Practices of The Foot Doctors, P.C. sets forth the ways in which my personal health information may be used or disclosed The Foot Doctors, P.C., and outlines my rights with respect to such information. I acknowledge that on _____(date),

_____I received a copy of The Foot Doctors, P.C. Notice of Privacy Practices.

_____I declined a copy of The Foot Doctors, P.C. Notice of Privacy Practices.

_____I was previously provided a copy of The Foot Doctors, P.C. Notice of Privacy Practices.

_____ _____

Patient, parent if minor child, or guardian Date

Primary insured, if different from patient

Date

(If patient unable to sign, representative's name)

Secondary insured, if different from patient
Guarantor, if different from patient

A copy of this authorization shall be as effective and valid as the original

The Foot Doctors, P.C.
Springfield, Missouri

Authorization to Release Information, Assignment of Benefits, and Consent for Treatment

1. **Release of Information:** I authorize the disclosure of any or all of the information in my medical record to: (a) Any person, corporations, or agency responsible for all or part of The Foot Doctors services who may be responsible for determining the necessity, appropriateness, payment, or other matters related to The Foot Doctors treatment or services; (b) This includes but is not limited to, insurance companies, health maintenance organizations, preferred provider organizations, workers compensation carriers, welfare funds, the Centers for Medicare and Medicaid Services (CMS) or its intermediaries or carriers. (c) I further authorize The Foot Doctors, at its discretion, to disclose such information to its insurance carrier or carriers when so requested by such carrier.

2. **Assignment of Benefits:** I assign to The Foot Doctors and/or the Independent Contract Groups named in the Notice of Privacy Practices, the benefits due me covering The Foot Doctors services, under my policy(s), managed care plan, HMO, or the Centers for Medicare and Medicaid Services (CMS) or its intermediaries or carriers.

3. **Medicare Patient:** I authorize The Foot Doctors to obtain information from the Social Security Administration regarding my entitlement and health insurance claim numbers.

4. **Financial Obligation for The Foot Doctors, any Physician Employee of The Foot Doctors, and the Independent Contract Groups named in the Notice of Privacy Practices:** I agree that I am financially responsible for payment of all amounts for services provided by The Foot Doctors and/or physicians. I am responsible to pay for my services regardless of insurance coverage or other responsible parties. I will not be responsible to pay if my obligation is waived by contractual agreements between The Foot Doctors and my insurer, or if prohibited by state or federal laws or regulations. If my insurance plan is a Health Maintenance Organization (HMO), I understand that I am financially responsible for non-covered services or deductibles, copay, or coinsurance as defined in my policy or plan. I also agree that if the account is placed for collection, I will pay all collection agency costs, and reasonable attorney fees. I agree to waive venue and do agree that any action filed to collect any amounts due for services rendered shall by filed in Greene County, Missouri. This includes patient's account balances and the collection of other expenses related to the patient's account balance such as service fees, court costs, and attorney fees.

5. **Guarantor's Responsibility:** I have read and understand the financial obligations above and agree to the terms as stated.

_____

Patient, Parent if minor child, or guardian Date
(If patient is unable to sign, Representative name and relationship)

A copy of this authorization shall be as effective and valid as the original

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OUR FINANCIAL POLICY

We want to make the financial portion of your visit as simple as possible. To provide quality care, reduce your cost and eliminate misunderstandings we would like to advise you of our payment policy.

1. If you do not carry insurance, full payment is expected at the time of service.

2. If you have insurance, please consult your insurance benefits handbook or call your insurance carrier if you are not certain of your responsibility. Your copay is due at the time of your visit.

3. If you carry Medicare and a supplimental insurance, no payment is required if your deductible has been met. If you carry Medicare only, a payment of 20% will be expected once payment has been received from Medicare.

4. Please present all current insurance information at the time of your visit. **If a referral is required, it is the insured's responsibility to provide this before service is rendered.**

5. For your convenience, we gladly accept cash, check, MasterCard and Visa.

If you have any questions or concerns, please do not hesitate to contact us. WE WANT TO HELP YOU.

Thank you,

The Foot Doctors, P.C.
Doctors and Staff