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 your insurance requires a referral (Cox Essence or United HealthCare Compass or Navigate plans), we will need for you to contact your primary care physician and have them fax an insurance referral to our office at (417) 883-4844. If we do not have the referral on file by your appointment date, we will have to reschedule your appointment until we have a valid insurance referral on file.

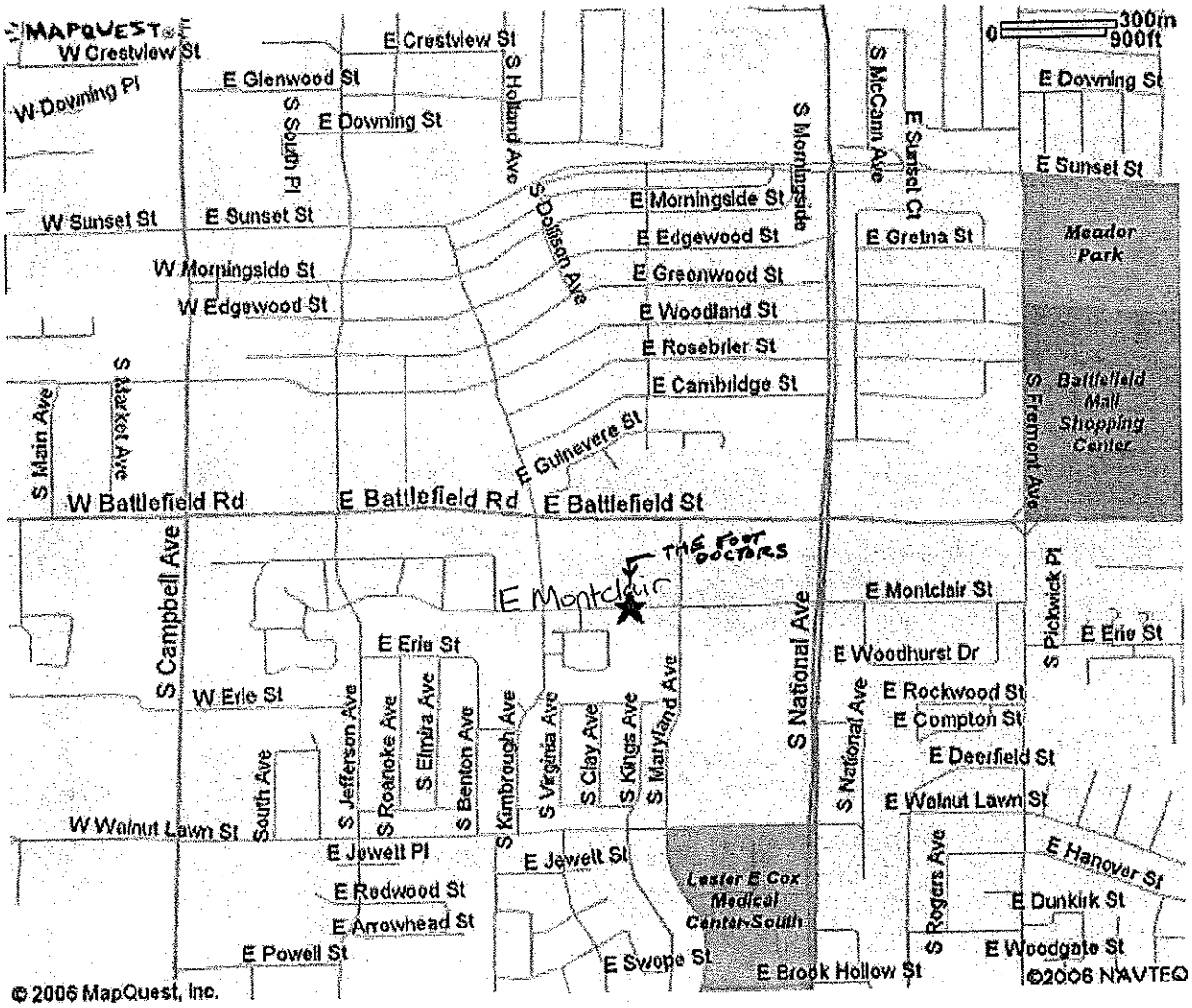
Thank you for choosing our clinic to service your foot care needs. We look forward to seeing you soon.

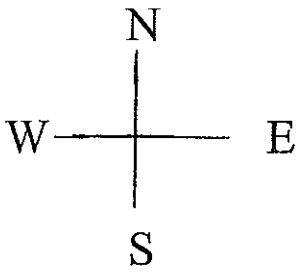
Sincerely,
The Foot Doctors, P.C.
Doctors and Staff

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

****PLEASE USE BLACK INK****

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





WELCOME TO THE FOOT DOCTORS, PC

PATIENT INFORMATION

Name_____Date of Birth_____Marital Status_____

Address_____City_____State_____Zip Code_____

Phone #_____Sex M____F____ Social Security # _____

Employer_____Work #_____Cell Phone #_____

Email:_____

Spouse's Name_____Social Security #_____Phone #_____

Parent/Guardian_____Social Security #_____Phone #_____

Address_____City_____State_____Zip Code_____

Emergency Contact _____Relationship_____Phone #_____

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

Medicare #_____Medicaid #_____

Insurance Company_____Phone #_____

Claims Address_____City_____State_____Zip Code_____

Policy Holder Name_____Date of Birth_____ID#_____

Policy Holder's Employer_____Group #_____

Record Release I give permission for The Foot Doctors, PC to release my records to my insurance company.
Referral Policy If my insurance company requires me to have a referral to see a specialist, I must contact my primary care physician to have the referral in our 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. If an approved referral is not on file by your appointment date, we will have to reschedule your appointment .
Payment Policy The Foot Doctors, PC will file all insurance 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, PC to file my insurance. I understand that if my account if 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_____

History of Past Illness:

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

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	Cirrhosis/Hepatitis	No	Yes
Tuberculosis	No	Yes	Thyroid Disease	No	Yes
Diabetes	No	Yes	Bleeding Tendency	No	Yes
Heart Trouble	No	Yes	Gout	No	Yes
Stroke	No	Yes	Arthritis	No	Yes
Convulsions/Paralysis	No	Yes			

Social History

Single Married Separated Divorced Widowed
Are you living with your husband/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 No Yes

Systemic Review

General

Last physical examination_____
Last tetanus shot _____

Changes in appetite (eat more/less)	No	Yes
Recent weight loss	No	Yes
Excessive thirst	No	Yes
Have you been in good general health most of your life	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/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

Skin

Skin diseases	No	Yes
Jaundice	No	Yes
Hives, eczema, rash	No	Yes
Frequent infection/Boils	No	Yes
Abnormal pigmentation	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 (con't)

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 when 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 movements	No	Yes
Frequent diarrhea	No	Yes
Heartburn or indigestion	No	Yes

Genitourinary

Frequent urination	No	Yes
Night time urination	No	Yes
Burning/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 _____

Locomotor/Musculoskeletal

Varicose veins	No	Yes
Leg cramps w/activity	No	Yes
Leg cramps in bed at night	No	Yes
Heel/arch pain w/prolonged activity	No	Yes
Burning feet	No	Yes
Ankle/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/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_____

Weigh _____

Shoe size _____

Signature of patient_____

Source of information if other than patient_____

THE FOOT DOCTORS, PC
MEDICAL HEALTH PAGE

Name_____ Date_____

Pharmacy Name & Address_____

Please List

Medications you are currently on	Hospitalizations/Surgeries

REACTIONS TO MEDICATIONS

			Describe Reaction
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	

Patient/Guardian Signature _____

CONSENT FOR TREATMENT: As a patient of The Foot Doctors, PC, 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 that the physician(s) deem reasonable and necessary. This would also include, but not limited to, the performances 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, PC sets forth the ways in which my personal health information may be used or disclosed by The Foot Doctors, PC and outlines my rights with respect to such information. A copy of the Notice of Privacy Practices is available at the Front Desk.

I acknowledge that on _____(date):

_____ I received a copy of The Foot Doctors, PC Notice of Privacy Practices

_____ I declined a copy of The Foot Doctors, PC Notice of Privacy Practices

_____ I was previously provided a copy of The Foot Doctors, PC Notice of Privacy Practices

_____ _____

Signature of patient, parent if minor child, or guardian Date
(If patient is unable to sign, representative name and relationship)

Primary insured, if different from patient

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

The Foot Doctors, PC
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, PC services who may be responsible for determining the necessity, appropriateness, payment or other matters related to The Foot Doctors, PC treatment or services; (b) This includes but is not limited to, insurance companies, health maintenance organizations, preferred provider organizations, worker's compensation carriers, welfare funds, the Centers for Medicare and Medicaid Services (CMS) or its intermediaries or carriers; (c) I further authorize The Foot Doctors, PC, 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, PC and/or the Independent Contract Groups named in the Notice of Privacy Practices, the benefits due me covering The Foot Doctors, PC 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, PC to obtain information from the Social Security Administration regarding my entitlement and health insurance claim numbers.

4. **Financial Obligation for The Foot Doctors, PC, any physician employee of The Foot Doctors, PC 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, PC 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, PC and my insurer, or if prohibited by state of 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 collections, I will pay all collections 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 be filed in Greene County, Missouri. This includes patient's account balances and the collection of other expenses related to the patient's account balances 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 stated.

_____

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

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

Authorization for Use and Disclosure of Protect Health Information

Patient Identification

Printed Name: _____ Date of Birth: _____
Address: _____
_____
Social Security #: _____ Telephone: _____

Information To Be Released – Covering the Periods of Health Care

From (date) _____ To (date) _____

Please check type of information to be released:

___ Complete Health Record ___ Diagnosis & Treatment Codes ___ Discharge Summary ___ History & Physical Exam
___ Consultation Reports ___ Progress Notes ___Lab Results ___ X-ray Reports
___ X-ray films/images ___ Photographs/Videos ___ Billing Records ___ Itemized Bill

Other (please specify): _____

Purpose of Request

___ Treatment or Consultation ___ At the Request of Patient ___ Billing or Claims Payment

Who and Where to Send/Release Information

TO: **THE FOOT DOCTORS, PC**
929 E. Montclair, Ste. 100
Springfield, MO 65807
(417) 883-1881

FROM: **PCP/Endocrinologist Information** _____
_____
_____
_____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release *Circle One*: YES NO

I understand if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release *Circle One:* YES NO

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been take in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to The Foot Doctors, P.C., 929 E. Montclair, Suite 100, Springfield, MO 65807. Unless revoked, this authorization will expire on the following date **1 year from date signed**, or 180 days from date of signature, unless otherwise specified.

Re-disclosure

I understand the information disclosed by this authorization may be subjected to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed.

I authorize The Foot Doctors, P.C. to use and disclose the protected health information specified above.

Signature _____ Date _____

Authority to Sign if Not Patient: _____

Identity of Requestor Verified via *Circle One* Photo ID Matching Signature Other, specify _____

Verified by: _____