WELCOME TO ACADIANA FOOT CENTERS

Please **PRINT** – This information is important for our records and your health

PATIENT INFORMATION

Patient Name: ____
First Middle Last

Date of Birth: ___/___/_____ Sex ___ M ___ F Social Security # ______________

Race _______ White _______ African American _______ Latino _______ Asian

Other ______________________________

Ethnicity _________ Not Hispanic Origin ___________ Hispanic

Other ______________________________

Shoe size ________________

Home Address ____ Apt. _________

City __________________________ State ___________ Zip ______________

Marital Status ____ Married ____ Single ____ Partnered ____ Separated ____ Divorced ____ Widowed

Employer ____________________________________

Occupation __________________________________

May we leave a message?

Home Phone (____) _____-_______ Yes No

Work Phone (____) _____-_______ Yes No

Cell Phone (____) _____-_______ Yes No

E-mail address _________________________ Yes No

Spouse Name ______________________ Spouse DOB ____________ Cell (____) ____-______

Emergency Contact ________________________________ Relationship ______________

Phone (____) ____-______ Cell Phone (____) ____-______

Primary Care Doctor ________________________________ Clinic ____________________

Date last seen ________________________

I was referred to this office by: ______ Physician/nurse ______ Friend _____ Health fair

____ Yellow pages/newspaper ____Internet ____ Office Website ____ Insurance company

FINANCIAL INFORMATION

Is the patient responsible for all bills? _______________

If no then:

** Guarantor ____ Relationship to patient _______________

Home Address ____ City_______________________________________

State _____________ Zip __________ Phone (____) ____-______ Date of Birth: ____/____/_____

INSURANCE INFORMATION – WE WILL ALSO COPY YOUR CARDS UPON CHECK IN PLEASE PROVIDE THE INSURED'S DATE OF BIRTH

Primary Insurance Company Name ____

Insured's Name ____ Insured's date of birth ___________________

Relationship to subscriber ____________________________

Secondary Insurance Company Name ____

Insured's Name ____ Insured's date of birth ___________________

Relationship to subscriber ____________________________

CURRENT FOOT PROBLEM

Please describe your foot problem ____

Which foot is affected? ______ Right ______ Left ______Both

How long ago did this problem first start ? ___________________ days/weeks/months/years

Did your pain or problem _______________ Begin all of a sudden ______________ Gradually develop over time

How would you describe your pain? ___ No pain ___ Sharp ___ Dull ___ Aching ___ Burning ___ Radiating

___ Itching ___ Stabbing ___ Other _______________________________________

How would you rate your pain scale from 0 to 10? (Please circle)

(No pain) 0 1 2 3 4 5 6 7 8 9 10 *(worst pain possible)*

Since your pain or problem began, has it ____ Stayed the same _____ Became worse ____ Improved

What makes your pain or problem feel worse? ____ Walking ____ Standing ____ Daily activities ____ Resting

____ Dress shoes ____ High heels ____ Flat shoes ____ Any closed toe shoe ____ Running

____ Other ____

What makes your pain feel better? ____

What treatments have you had for this problem? ____

How long has this problem affected your lifestyle or ability to work? ___________________________________

Was this problem caused by an injury? ____ no ___ yes – describe _____________________________________

____ If yes, was it work related? _________________________

Is this condition causing or are you suffering with any of the following:

Tingling/numbness in:	Pain radiating into:	Weakness of the:
_______ Legs R/L	_______ Ankle R/L	_______ Legs R/L
_______ Ankle R/L	_______ Feet R/L	_______ Ankle R/L
_______ Feet R/L	_______ Toes R/L	_______ Foot R/L

Difficulty with:

_______ Standing	_______ Bending
________ Walking	_______ Lifting
_______ Sitting	________ Kneeling

How much are you on your feet at work? _____ 10% _______ 25% _____ 50% __________75% _______ 100%

Exercise: _____ Never ______ Rare _______ Occasional ________ Weekly _________ Several times a week _______ Daily

Type of exercise ____

Height ________ Weight ______ Shoe Size ___________ Width _____________

YOUR MEDICAL HISTORY: (Have you ever had any of the following?)

Condition		
Anemia	Y	N
Arthritis	Y	N
Asthma	Y	N
Back Trouble	Y	N
Abnormal Bleeding	Y	N
Blood Clots	Y	N
Blood Transfusion	Y	N
Bronchitis/Emphysema	Y	N
Cancer Type ______________	Y	N
Circulation Problems	Y	N
Diabetes Type: I II	Y	N
Emphysema	Y	N
Fibromyalgia	Y	N
Gout	Y	N
Heart Attack	Y	N
Heart Disease/Failure	Y	N

Condition		
Heart Murmur	Y	N
High Blood Pressure	Y	N
Mitral Valve Prolapse	Y	N
Neurological Disorder	Y	N
Neuropathy	Y	N
Open Sores	Y	N
Pneumonia	Y	N
Polio	Y	N
Rheumatic Fever	Y	N
Sickle Cell Disease	Y	N
Skin Disorder	Y	N
Stomach Ulcers	Y	N
Stroke	Y	N
Thyroid Disease	Y	N
Tuberculosis	Y	N
Vascular Issues	Y	N

Please list any other past medical history:

____

ALLERGIES: ____ None known _____ Drug allergies ____

_____ Anesthesia ____

____ Antibiotics ____

____ Tape ____ Latex _____ Iodine _____ Nickel (Metal)

_____ Foods/other ___________________________

CURRENT MEDICATIONS:

Please list all medications you are currently taking (Include prescriptions, over the counter medications and herbal supplements) ***** IF YOU HAVE A LIST, WE WILL COPY IT FOR YOU**

Name Dose How often do you take it?

____

____

____

Pharmacy _________________________ Location ________________________ Phone (____) ____-______

Do you take blood thinners? ________________ Name of medication ____

Do you use insulin? ________________________ Are you pregnant? ___________

Please list all prior surgeries:

Type of surgery	Date	Type of surgery	Date

Do you have any artificial joints?

________ Knee ________ Hip

____________________ Other

Do you have a heart replacement valve?

______ Yes ________ No

Do you have a pacemaker?

________ Yes ________ No

Social History

Use of tobacco _______ Never ______ Quit – how long ago? ________ Smoke ____ packs/day for _______years

Use of alcohol: _______ Never ______ No longer use _____ History of alcohol abuse

Current use ________________ Type _______Rare _______ Occasional __________ Moderate __________Daily

Use of recreational drugs ____________ Never ______ Quit – how long ago? _________ Type ____________________

Current use ________________ Type _______Rare _______ Occasional __________ Moderate __________Daily

Family History

Are your parents living? ______ Father ______ Mother

Is there a family history of:

	MOTHER	FATHER	SISTER	BROTHER	MATERNAL GRANDMA	Maternal Grandpa	Paternal Grandma	Paternal Grandpa
Diabetes								
Cancer Type ____________								
Heart Disease								
High Blood Pressure								
Stroke								
Coronary Artery Disease								
Thyroid Disease								
Rheumatoid Arthritis								

CONSENT:

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILTY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS. I REQUEST AND AUTHORIZE ACADIANA FOOT CENTERS TO DIAGNOSE AND ADMINISTER TREATMENT FOR MY CONDITION.

PATIENT SIGNATURE ____ DATE ____________________

ACADIANA FOOT CENTERS
FINANCIAL POLICY

We at Acadiana Foot Centers are committed to providing you with the best possible care. If you have Medical Insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding on our payment policy.

1. Full payment is expected on the day medical services are provided unless you have health insurance coverage with a plan that we have a written agreement with. Our financial policy offers you a number of payment options such as: cash, check, Visa, MasterCard and Discover. Patients with insurance must pay, when applicable: **Deductible-** an amount you must pay first out of your own pocket each year before insurance will pay for any services. **Co-payment-**an amount you must pay upon each visit to a doctor that is due at the time of service. **Co-insurance-**an amount which usually is a percentage of the fee that your insurance company will not pay. Deductibles, co-payment and co-insurance are patient responsibility. Custom orthotics require a deposit of $100.00 and $60.00 casting fee at the time of casting. The balance is to be paid upon orthotic dispense.

2. Insurance is a contract between you and your insurance company.

3. In accordance with your insurance member handbook, it is your responsibility to provide accurate insurance information and to present your insurance ID card at the time of your visit. If you do not have insurance or do not present a valid insurance card, you will be responsible for payment at the time of service. We will provide you with a copy of our billing form so that you can obtain reimbursement from your insurance company.

4. It is your responsibility to ensure that our physician is in your insurance network.

5. If your plan requires a referral, it is your responsibility to obtain this prior to being seen by our providers.

6. Payment is due for rendered services 10 days from receipt of your billing statement. Unpaid previous balances must be paid in full prior to any additional visits, unless arrangements have been made with our financial counselor.

7. The returned check fee is $25.00.

8. Administrative Services: There is a $25.00 charge for forms completion for family medical leave and disability.

9. Workman's Compensation – We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

10. Personal Injury – If you are being treated as part of a personal injury lawsuit or claim, payment of the bill remains the patient's responsibility. Even if a personal injury claim or lawsuit is pending.

11. All sales are final with over the counter or DME items.

12. Not all services are a covered benefit in all contracts. Some insurance companies refuse to cover certain services. We have no control over this.

Patient Signature: ____ Date ______________

Printed Patient Name: ____

Patient Spouse/Parent/Guarantor Signature ____ Date ______________

Printed Spouse/Parent/Guarantor Name ____

ASSIGNMENT OF BENEFITS & AUTHORIZATION TO RELEASE INFORMATION

If I am entitled to benefits under the Medicare, the Medicaid or any insurance policy or other health benefit plan (covering me or anyone legally responsible for me), in consideration for services provided to me by Acadiana Foot Centers, I assign, transfer and convey the benefits payable under such program, policy or plan for services rendered to me. I authorize payment of benefits directly to Acadiana Foot Centers, with such benefits to be applied to my bill. **I understand and acknowledge that this assignment does not relieve me of financial responsibility for charges incurred by me or anyone on my behalf, and I hereby acknowledge responsibility for and agree to pay charges not paid under this assignment, including any coinsurance amounts, deductibles, Durable Medical Equipment and any charges for services deemed to be non-covered, not pre-certified or not pre-authorized by my insurance plan.**

_______ *(initial)* I give my consent for examination and treatment by Acadiana Foot Centers

_______ *(initial)* I acknowledge that I was provided or offered a copy of the Notice of Privacy Practices and that I have read and understand this form

_______ *(initial)* I acknowledge that I have received and read the Financial Policy of Acadiana Foot Centers

I, ____ hereby give my permission for the persons stated below to discuss my financial and medical records, and discuss my treatment and diagnoses with Acadiana Foot Centers.

1. ____
2. ____
3. ____

HIPPA High Tech Form – Automated Opt In

Acadiana Foot Centers is initiating an automated appointment reminder system. The system has the capability of reminding you by email or phone.

We are also updating our records with email addresses so that we may send you appointment reminders.

I authorize the use of an automated appointment reminder system to remind me of upcoming appointments. I understand that signing below signifies my intention to opt in. I understand that I may opt out at any time.

Email address ____________________________________

Signature ____

Printed Name ____ Date ______________________