



# NEUHAUS FOOT & ANKLE

Welcome To Our Office

## Patient Information Sheet

NAME

First: \_\_\_\_\_ MI: \_\_\_\_\_ Last: \_\_\_\_\_

Social Security Number# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_\_

Circle Gender: M / F Race \_\_\_\_\_ Ethnicity \_\_\_\_\_ Language \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Ph #: (\_\_\_\_\_) \_\_\_\_\_ Cell Ph #: (\_\_\_\_\_) \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Ph #: (\_\_\_\_\_) \_\_\_\_\_  
=====

Pharmacy Name: \_\_\_\_\_ Pharmacy Number: (\_\_\_\_\_) \_\_\_\_\_

Pharmacy Address/ Street \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_

Name of Doctor and/or Friend that referred you: \_\_\_\_\_  
=====

E-mail Address: \_\_\_\_\_

### Primary Insurance Company Information:

Policy Holder Last Name: \_\_\_\_\_

Policy Holder First Name: \_\_\_\_\_

Policy Holders SS# : \_\_\_\_\_ Policy Holders Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Gender:  Male  Female Relationship to Policy Holder:  
 Self  Spouse  Child  Other

Policy Holder's Address:  Same as patient \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance's Name: \_\_\_\_\_

Policy ID: \_\_\_\_\_ Group #: \_\_\_\_\_  
Claim Submission Address: \_\_\_\_\_

Effective Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Referral Required:  Yes  No

Do you have a Co-pay?  No  Yes, Amt \$ \_\_\_\_\_

### Secondary Insurance Company Information:

Policy Last Name: \_\_\_\_\_

Policy Holder First Name: \_\_\_\_\_

Policy Holders SS# : \_\_\_\_\_ Policy Holders Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Gender:  Male  Female Relationship to Policy Holder:  
 Self  Spouse  Child  Other

Policy Holder's Address:  Same as patient \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance's Name: \_\_\_\_\_

Policy ID: \_\_\_\_\_ Group #: \_\_\_\_\_  
Claim Submission Address: \_\_\_\_\_

Effective Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Referral Required:  Yes  No

Do you have a Co-pay?  No  Yes, Amt \$ \_\_\_\_\_

\_\_\_\_\_  
Patient Signature (Parent or Guardian if patient under 18 years old)

\_\_\_\_\_  
Date

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

---

---

Reason for your visit today: \_\_\_\_\_

When did problem start? \_\_\_\_\_

Previous treatment condition?  Y  N

Treatment by: \_\_\_\_\_ Date treated: \_\_\_\_\_

Check all treatments received for this condition:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Pain Medication  | <input type="checkbox"/> Antibiotics    | <input type="checkbox"/> MRI             |
| <input type="checkbox"/> Injection        | <input type="checkbox"/> Surgery        | <input type="checkbox"/> CT Scan         |
| <input type="checkbox"/> X-rays           | <input type="checkbox"/> Bone Scan      | <input type="checkbox"/> Hospitalization |
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Ice/Stretching | <input type="checkbox"/> Other: _____    |
- 
- 

**► Vitals**

Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Shoe Size: \_\_\_\_\_

**► Patient Medical History**

Have you been diagnosed with any of the following? Please circle all that apply. None

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Anemia        | <input type="checkbox"/> Gout                | <input type="checkbox"/> Kidney Disease   |
| <input type="checkbox"/> Arthritis     | <input type="checkbox"/> Heart Attack        | <input type="checkbox"/> Liver Disease    |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> (hepatitis)      |
| <input type="checkbox"/> Blood Clots   | <input type="checkbox"/> HIV+/AIDS           | <input type="checkbox"/> Stomach          |
| <input type="checkbox"/> Depression    | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Ulcers/Reflux    |
| <input type="checkbox"/> Diabetes      | <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Emphysema     | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Fibromyalgia  | <input type="checkbox"/> Kidney Stones       | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Glaucoma      |  | <input type="checkbox"/> Other _____      |

**► Social History**

Please answer the following:

- Occupation: \_\_\_\_\_
- Marital Status? Circle: Single Married Divorced Widowed
- Use of Alcohol?  No  Yes (If yes, how much?) \_\_\_\_\_
- Use of Tobacco?  No  Yes (If yes, how much?) \_\_\_\_\_
- Use of Drugs?  No  Yes (If yes, type/frequency) \_\_\_\_\_

(Office Use ONLY: BP \_\_\_\_\_ P \_\_\_\_\_)

**► Allergies**

None or List all known allergies:

---

---

---

**► Family History**

Has anyone in your family been diagnosed with any of the following? **None**

- |                                    |  |
|------------------------------------|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart disease       |
| <input type="checkbox"/> Cancer    | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Stroke              |

**► Current Medications**

None or  See Attached List

---

---

---

**► Review of Systems**

(Please check all conditions and symptoms that you currently have)

- |                 |   |  |  |   |
|-----------------|---|--|--|---|
| General         | <input type="checkbox"/> Fever          | <input type="checkbox"/> Chills              | <input type="checkbox"/> Weight loss/gain      | <input type="checkbox"/> Appetite loss      |
| Eyes            | <input type="checkbox"/> Blurry vision  | <input type="checkbox"/> Double vision       | <input type="checkbox"/> Poor vision           | <input type="checkbox"/> Glasses            |
| Ear/Nose/Throat | <input type="checkbox"/> Ringing ears   | <input type="checkbox"/> Sinus congestion    | <input type="checkbox"/> Hearing Loss          | <input type="checkbox"/> Sore throat        |
| Heart           | <input type="checkbox"/> Chest pain     | <input type="checkbox"/> Irreg. heart beat   | <input type="checkbox"/> Leg cramps w/ walking | <input type="checkbox"/> Murmur             |
| Lungs           | <input type="checkbox"/> Cough          | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Difficulty breathing  | <input type="checkbox"/> Snoring            |
| Digestive       | <input type="checkbox"/> Nausea         | <input type="checkbox"/> Stomach ulcer       | <input type="checkbox"/> Constipation          | <input type="checkbox"/> Diarrhea           |
| Urinary         | <input type="checkbox"/> Burning        | <input type="checkbox"/> Frequent urination  | <input type="checkbox"/> Incontinence          | <input type="checkbox"/> Impotence          |
| Musculoskeletal | <input type="checkbox"/> Joint pain     | <input type="checkbox"/> Muscle weakness     | <input type="checkbox"/> Joint stiffness       | <input type="checkbox"/> Deformity          |
| Skin            | <input type="checkbox"/> Rash           | <input type="checkbox"/> Sores/Ulcers        | <input type="checkbox"/> Abnormal scar         | <input type="checkbox"/> Dry skin           |
| Neurological    | <input type="checkbox"/> Numbness       | <input type="checkbox"/> Tingling feet       | <input type="checkbox"/> Poor balance          | <input type="checkbox"/> Sciatica           |
| Psychiatric     | <input type="checkbox"/> Depression     | <input type="checkbox"/> Mood swings         | <input type="checkbox"/> Anxiety               | <input type="checkbox"/> Nervousness        |
| Peripheral Vasc | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Leg/foot swelling   | <input type="checkbox"/> ft pain with sleeping | <input type="checkbox"/> Leg cramps         |
| Endocrine       | <input type="checkbox"/> Hair loss      | <input type="checkbox"/> Excessive thirst    | <input type="checkbox"/> Fatigue               | <input type="checkbox"/> Frequent Urination |
| Hematological   | <input type="checkbox"/> Leg swelling   | <input type="checkbox"/> Bleeding tendency   | <input type="checkbox"/> Bruise easily         | <input type="checkbox"/> Slow to heal       |
| OB/GYN          | <input type="checkbox"/> Pregnant       | <input type="checkbox"/> Birth control pills | <input type="checkbox"/> Hormone therapy       | <input type="checkbox"/> Menopausal         |

**► Previous Surgeries**  None or Please list procedure and date performed:

---

---

---

**Patient Signature (Parent or Guardian if patient under 18 years old)**

**Date:**

---

---



### Financial Policy

- As a courtesy to our valued patients that have insurance plans, our office will file insurance claims for reimbursement for all rendered services. *Actual benefit payments are determined only when the claim is processed by your insurance company. Therefore, it is the insurance company that makes the final determination of benefits. If the insurance payment does not fully reimburse for the treatment rendered, the financially responsible person is responsible for the remainder of the balance.*
- **Co-payments:** Your insurance company requires co-payments to be paid in full at the time of service. Because this is an insurance requirement, we cannot bill you for these.
- **Referrals:** If your insurance company requires a referral it is **YOUR** responsibility to obtain the referral. Failure to obtain the referral and/or prior authorization for treatment may result in a lower payment or denial from the insurance company.
- **Orthotics and Diabetic Shoes:** We require patients to obtain insurance verification before either can be ordered. We will provide you with an insurance verification form which will walk you through what is needed by the insurance company. If you do not have coverage for custom orthotics the cash price is \$300 per pair. We require a \$100 deposit at the time of the order and the remainder when you pick them up.
- There will be a \$25.00 fee charged for any returned checks (insufficient funds).
- **Worker 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.
- **Missed appointment Fee:** Any patient who does not show up for an appointment, or cancels with less than 24 hours notice will be subject to a \$25.00 charge after the 2<sup>nd</sup> occurrence. This fee must be paid before a new appointment is scheduled. Patients with *THREE* missed appointments will be asked to transfer their records to another doctor.
- **Monthly Statement:** If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, and any payments or credits applied to your account during the month.
- **Payments:** Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the due date on your statement. We are always willing to work out a payment plan if needed.
- **Past Due Accounts:** If necessary a collection agency will be employed to collect overdue accounts and the collection fee will be charged to the patient's account. Consequently, credit agencies will be notified of delinquent accounts. You understand that if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record and you consent to such disclosure.

I, as the patient, financially responsible person and/or guardian for this account, certify that I have read, understood, and agreed to this financial policy.

---

Signature \_\_\_\_\_ Date \_\_\_\_\_ Patient's Name (printed) \_\_\_\_\_

**Responsible Party Info:**

Please complete ONLY if the responsible for payment is NOT the Patient or Insurance Policy holder

**Responsible Party Name (Last/ First):** \_\_\_\_\_

**Relationship to patient:** \_\_\_\_\_

**Responsible Party Address:** \_\_\_\_\_ **SS#:** \_\_\_\_\_

**Authorization to Treat / Acceptance of Financial Responsibility / HIPAA**

I hereby consent to the following treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures / tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees
- Voluntarily and without compensation authorize Neuhaus Foot and Ankle to take and use pictures and/or videos of my foot for educational and advertising purposes which may include office screen saver, websites or other promotional material.

I fully understand that this is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I hereby authorize Neuhaus Foot & Ankle, PC to furnish information to insurance carriers concerning my illness and treatment. I hereby assign to Neuhaus Foot & Ankle, PC all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by my insurance.

I hereby understand that, if I do not have active insurance coverage, that I am being accepted by Neuhaus Foot & Ankle, PC as a Self-Pay patient. I understand that I am financially responsible for all services rendered to my dependents or myself.

In accordance with HIPAA , I have had the opportunity to read and receive a copy of the Privacy practices located in the office of Neuhaus Foot & Ankle, PC. I understand my information will be used for the purposes if treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

**NOTE: Original x-rays are the property of this office. Copies may be purchased for \$5.00 each.**

**I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.**

\_\_\_\_\_  
**Patient**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Responsible Party**

\_\_\_\_\_  
**Date**

## DO I NEED A TEST FOR PAD

Peripheral Arterial Disease (PAD) is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain, or kidneys, because narrowed or clogged. It affects over 8 million Americans, most over the age of 50. It may result in leg discomfort with walking, poor healing of leg sores/ulcers, difficult to control blood pressure, or symptoms of stroke. People with PAD are at significantly increased risk for stroke and heart attack. Answers to these questions will determine if you are at risk for PAD and if a vascular exam will help us better assess your vascular health status.

Name \_\_\_\_\_ Date \_\_\_\_\_

**Circle "YES" or "NO":**

Do you have foot, calf, buttock, hip or thigh discomfort (aching, fatigue, tingling, cramping or pain) when you walk which is relieved by rest? **YES NO**

Do you experience any pain at rest in your lower leg(s) or feet? **YES NO**

Do you experience foot or toe pain that often disturbs your sleep? **YES NO**

Are your toes or feet pale, discolored, or bluish? **YES NO**

Do you have skin wounds or ulcers on your feet or toes that are slow to heal (8-12) weeks? **YES NO**

Have you suffered a severe injury to the leg(s) or feet? **YES NO**

Do you have an infection of the leg(s) or feet that may be gangrenous (black skin tissue) **YES NO**

Patient Signature \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_



**ACKNOWLEDGMENT OF RECEIPT**

**OF**

**NOTICE OF PRIVACY PRACTICES**

I acknowledge that I was provided 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.

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Authorized Representative (if applicable)

\_\_\_\_\_  
Signature