NEUHAUS FOOT & ANKLE

Patient Information Sheet

Last Name:_____ **First:**_____ **MI:**_____

Mailing Address:_____

City:_____ **State:**_____ **Zip:**_____

Home Phone #: (_____)_____

Cell Phone #: (_____)_____

Preferred Method of Contact: ☐ Cell Phone ☐ Home Phone

Appointment Reminder Preference: ☐ Call ☐ Text

Email: _____

Responsible Party (Minors Only)

Name:_____

Mailing Address:_____

City:_____ **State:**_____ **Zip:**_____

Phone #: (_____)_____

Primary Care Physician: _____

Doctor and/or Friend that referred you: _____

Date of Birth:_____ **Gender:** ☐ M ☐ F

Marital Status: ☐ Married ☐ Widowed ☐ Single ☐ Divorced

Social Security Number #: _____-_____-_____

Race: _____ **Hispanic/Latino?** ☐ Yes ☐ No

Language: ☐ English ☐ Spanish ☐ Other _____

EMERGENCY CONTACT

Name: _____

Ph #: (_____)_____ **Relation:** _____

Pharmacy Name:_____ **Pharmacy Number:** (_____)_____

Pharmacy Address/Street:_____

PRIMARY Insurance Company Information	SECONDARY Insurance Company Information
Insurance Name: _____	**Insurance Name:** _____
Policy ID: _____**Group #:**_____	**Policy ID:** _____ **Group #:**_____
Co-pay $: _____ **Referral Required:** ☐ Yes ☐ No	**Co-pay $:** _____ **Referral Required:** ☐ Yes ☐ No
Policy Holder Name: _____	**Policy Holder Name:** _____
Policy Holder Date of Birth: _____	**Policy Holder Date of Birth:** _____
Relationship to Policy Holder: ☐Self ☐Spouse ☐Child ☐Other	**Relationship to Policy Holder:** ☐Self ☐Spouse ☐Child ☐Other

_____ _____

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

Patient Name: _____ Date: _____

Reason for your visit today: _____

When did problem start?_____

Previous treatments include (check all that apply):

- ☐ **Pain Medication**
- ☐ **Injection**
- ☐ **X-rays**
- ☐ **Physical Therapy**
- ☐ **Antibiotics**
- ☐ **Surgery**
- ☐ **Bone Scan**
- ☐ **Ice/Stretching**
- ☐ **MRI**
- ☐ **CT Scan**
- ☐ **Hospitalization**
- ☐ **Other:_____**

►Current Medications

☐ **None or** ☐ **See Attached List**

_____

_____

_____

►Patient Medical History

Have you been diagnosed with any of the following? If so, check all that apply.

- ☐ **Anemia**
- ☐ **Arthritis**
- ☐ **Back Problems**
- ☐ **Blood Clots**
- ☐ **Depression**
- ☐ **Diabetes**
- ☐ **Emphysema**
- ☐ **Fibromyalgia**
- ☐ **Glaucoma**
- ☐ **Gout**
- ☐ **Heart Attack**
- ☐ **High Blood Pressure**
- ☐ **HIV+/AIDS**
- ☐ **Heart Disease**
- ☐ **High Cholesterol**
- ☐ **Irregular Heartbeat**
- ☐ **Kidney Stones**
- ☐ **Kidney Disease**
- ☐ **Liver Disease (hepatitis) A B C**
- ☐ **Stomach Ulcers/Reflux**
- ☐ **Stroke**
- ☐ **Thyroid Disorder**
- ☐ **Tuberculosis**
- ☐ **Other_____**

►Allergies

☐ **None or** ☐ **See Attached List**

_____

_____

_____

►Previous Surgeries

☐ **None or Please list procedure and date performed:**

_____

_____

_____

►Family History
Has anyone in your family been diagnosed with any of the following? If so, check all that apply.

	Arthritis	Cancer	Diabetes	High Blood Pressure	Stroke
Mother	□	□	□	□	□
Father	□	□	□	□	□
Sister	□	□	□	□	□
Brother	□	□	□	□	□
Other_____	□	□	□	□	□

►Social History
Please answer the following:

Occupation: _____

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, how much?)_____

(Office Use ONLY: BP _____ P_____)

►Review of Systems
(Please check all conditions and symptoms that you currently have)

General	__Fever	__Chills	__Weight loss/gain	__Appetite loss
Eyes	__Blurry vision	__Double vision	__Poor vision	__Glasses
Ear/Nose/Throat	__Ringing ears	__Sinus congestion	__Hearing Loss	__Sore throat
Heart	__Chest pain	__Irreg. heart beat	__Leg cramps w/ walking	__Murmur
Lungs	__Cough	__Shortness of breath	__Difficulty breathing	__Snoring
Digestive	__Nausea	__Stomach ulcer	__Constipation	__Diarrhea
Urinary	__Burning	__Frequent urination	__Incontinence	__Impotence
Musculoskeletal	__Joint pain	__Muscle weakness	__Joint stiffness	__Deformity
Skin	__Rash	__Sores/Ulcers	__Abnormal scar	__Dry skin
Neurological	__Numbness	__Tingling feet	__Poor balance	__Sciatica
Psychiatric	__Depression	__Mood swings	__Anxiety	__Nervousness
Peripheral Vasc	__Varicose veins	__Leg/foot swelling	__ft pain with sleeping	__Leg cramps
Endocrine	__Hair loss	__Excessive thirst	__Fatigue	__Frequent Urination
Hematological	__Leg swelling	__Bleeding tendency	__Bruise easily	__Slow to heal
OB/GYN	__Pregnant	__Birth control pills	__Hormone therapy	__Menopausal

►Vitals

Weight: _____ Height: _____ Shoe Size: _____

_____ _____

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

Neuhaus Foot & Ankle Financial Agreement

Physicians/Providers at Neuhaus Foot and Ankle are committed to providing you with the best possible medical care. In order to achieve this goal, we need your assistance and your understanding of our payment policy.

PAYMENTS FOR SERVICES ARE DUE AT THE TIME SERVICES ARE RENDERED. We accept cash, personal checks, MasterCard, Visa, Discover and Care Credit. Returned checks are subject to a service charge of $30.00-$40.00 or 5%, whichever amount is greater. You will also lose the privilege to write checks to our office in the future.

MEDICARE - Your deductible and 20% of the allowable charges are due at the time of service.

COMMERCIAL INSURANCE - CO-PAYMENT AND DEDUCTIBLE MUST BE PAID AT THE TIME OF SERVICE. Because we are under contract with your insurance company, we will file your insurance, provided the information is current and given to our office in a timely manner.

MISSED APPOINTMENTS: THERE WILL BE A $50.00 CHARGE FOR ANY APPOINTMENT NOT CANCELED WITHIN 24 HOURS. THIS $50.00 WILL BE THE PATIENT'S RESPONSIBILITY.

MEDICAL RECORDS: There is a $20.00 charge for Medical Records and $5.00 charge for a CD of X-Rays.

FMLA & DISABILITY PAPERWORK: There is a $20.00 charge for FMLA and Disability Paperwork.

HMO INSURANCE - It is your responsibility to obtain a referral from your PCP prior to your appointment. If a referral is not obtained, the appointment will be rescheduled.

WORKERS' COMPENSATION - It is your responsibility to call your employer to get the visit authorized, we will file your company's insurance. In the event you fail to prosecute the claim for Workers' Compensation for this injury or the condition is determined not the result of a compensable Workers' Compensation case, you agree to pay the usual and customary fees for services rendered to you in this case.

CHILDREN OF DIVORCED PARENTS - PAYMENT IS DUE AT THE TIME OF SERVICE no matter who is responsible by order of the divorce decree.

FINANCIAL AGREEMENT - We will gladly discuss your proposed treatment and do our best to answer any questions relating to your insurance. You must realize, however that;

- **Your insurance is a contract between you and your employer and the insurance company. We are not party to that contract.** *To enable our office to file your insurance, you must provide accurate information at each visit.*
- **Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover** *(i.e. x-rays, labs, Durable Medical Equipment, elective procedures and pre-existing conditions).*
- **Due to timely filing limits for insurance companies, you must present your current insurance card at the time of check in. If you do not have your insurance card, you can reschedule your appointment or choose to pay out of pocket for your visit.**

In the case of a self-pay patient, you agree to the following terms.

I hereby understand that if I do not have active insurance coverage, I am being accepted by Neuhaus Foot and Ankle, PC as a SELF-PAY PATIENT. I understand that I am financially responsible for all services rendered to my dependents or myself. Please note, a photocopy of this consent shall be considered as valid as the original.

We must emphasize that as your medical care providers, our relationship and concern is with you and your health, not the insurance company. **ALL CHARGES ARE YOUR RESPONSIBILTY FROM THE DATE SERVICES ARE RENDERED.** We review past due accounts frequently and at every statement cycle. Your communication and involvement to ensure your balance is paid timely is important to us. It is imperative that you maintain communications and fulfill your financial agreement and arrangements to keep your account active and in good standing.

If your account becomes sixty (60) days past due, further steps to collect this debt may be taken. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer fees which we incur plus all court costs. In case of suit, you agree the venue shall be Davidson County, Tennessee. In addition, we reserve the right to deny future non-emergency treatment for any and all debtor-related unpaid account balances. *If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.*

I have read and understand the above Financial Agreement.

_____ _____

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

Acknowledgement of Receipt of Notice of Privacy Practices/Authorization to Treat

I hereby consent to the following:

- Administration and performance of all treatment
- 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/test and cultures
- Voluntarily, 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 materials
- 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.
- In order to maintain an accurate and up to date medical record, I give Neuhaus Foot and Ankle permission to import my medication history from an external source.

I fully understand that this consent 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 authorize the physicians of Neuhaus Foot and Ankle, PC or their staff to release information on file regarding my medical bills and/or my medical treatment to the person(s) listed below. I understand that by signing this release, the designated person(s) will be able to speak with any staff member of Neuhaus Foot and Ankle, PC regarding my protected healthcare information (PHI).

Furthermore, I understand that the physician's office cannot be held liable for any information the below stated person(s) may obtain regarding my medical care.

I understand that revocation of this authorization must be provided to Neuhaus Foot and Ankle, PC in writing.

Neuhaus Foot and Ankle, PC may release medical and billing information to the following specified persons other than myself:

◦ To my Spouse _____ □ Yes □No
◦ To my Family Member _____ □ Yes □No
◦ Other _____ □ Yes □No

Relationship: _____

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 Signature: _____ Date: _____

Print Name: _____ Date: _____

Witness Signature: _____ Date: _____

Medical Treatment Authorization for a Minor Form

This form grants temporary authority to Neuhaus Foot and Ankle, PC to provide and arrange for medical care to a minor in the event of an emergency where the minor is not accompanied by either parents or legal guardians and it may not be feasible or practical to contact them.

Minor:

First:_____ MI: _____ Last: _____

Date of Birth: _____ Gender: □ Male □ Female

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

AUTHORIZATION AND CONSENT FOR PARENT(S) OR LEGAL GUARDIAN(S)

I do hereby state that I have legal custody of the aforementioned Minor. I grant my authority for Neuhaus Foot and Ankle, PC to administer treatment for any foot and/or ankle ailments experienced by the Minor. I authorize consent for any X-ray, anesthetic, medication, or other medical diagnosis or treatment necessary. It is understood that this authorization is given in advance of any such medical treatment. I agree to assume financial responsibility for all expenses of such care.

Parent/Legal Guardian Signature: _____

Printed Name: _____ Date of Birth: _____

Witness Signature: _____ Date: _____

DO I NEED A TEST FOR PERIPHERAL ARTERIAL DISEASE (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 seam 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: _____ Date: _____

Physician Signature: _____ Date: _____