Welcome to Our Office

PATIENT INFORMATION **TODAY'S DATE**_____

Name_____

(First) (MI) (Last)

Birth Date_____ **SS#** _____ **Gender**_____

Marital Status: (circle) S M D W **Student**:(circle) yes or no

Street Address_____ _____

City, State, Zip _____Email _____

Home Phone # _____ **Work #** _____ **Cell #** _____

*********Circle preferred contact #. Appointment confirmations will be made to the preferred number.*********

Emergency Contact (Name/Relationship) _____**Phone**_____

Race:(circle) American Indian/Alaska Native, Asian, Black/African American, Hawaiian/Pacific Islander, White, Other

Primary Language: (circle) English Spanish Other **Ethnicity:** (circle) Hispanic/Latino Non Hispanic/Latino

Employment Status: (circle) Full time Part time Unemployed Retired

Employer_____ **Occupation**_____

FINANCIALLY RESPONSIBLE PARTY INFORMATION

(If different from patient)

Name_____

Social Security No._____ **Birth Date**_____ **Home Phone**_____

Street Address_____ **City, State, Zip**_____

Employer_____ **Employer Address**_____

MEDICAL INFORMATION

Primary Care Physician_____ **Date of last visit**_____

Referring Physician_____ **Date of last visit**_____

Pharmacy Information (Name and Location) _____

INSURANCE INFORMATION

Primary Insurance_____ **Secondary Insurance**_____

Insurance Subscriber Information (if different from patient)

Name_____ SS#_____ DOB: _____Relationship_____

REFERRAL INFORMATION

Please take a moment to tell us how you found out about our practice.

_____

_____

FOOT CARE Specialist
JOEL D. FOSTER, DPM

Patient Name: _____

Employment Status: (circle) Employed Unemployed Retired Student Disabled

Patient History

Please Circle any medical conditions that you have or have had.

Aids/HIV	Arthritis	Asthma	Blood Disorders	Cancer	Cerebral Palsy	Chemical Dependency
Crohn's	Depression/Anxiety	Diabetes	Down's	Emphysema	Epilepsy/Seizures	Fibromyalgia
GERD	Gout	Heart Disease	Hepatitis	Hypertension	Hyperthyroid	Hypotension
Hypothyroid	IBS	Kidney Disorders	Leukemia	Liver Disease	Lung Disease	Lupus
Lymph Edema	Mentally Impaired	MS	Paraplegia	Parkinson's	PVD	Raynaud's
Rheumatoid Arthritis	Skin Cancer	Stomach Ulcer	Stoke	Other: _____		

Allergies: (circle and list reaction) Adhesive tape Aspirin Codeine Demerol Iodine Local Anesthetic Penicillin Seafood Sulfa
Other _____

Please list any medications that you are taking (or provide list) _____
_____
_____

Please list any surgeries that you have had. _____
_____
_____

Do you or currently have you recently had any of the following symptoms?

Eyes: cataracts, blurred vision, impaired vision, blindness, wear glasses or contacts, other _____

Ears, Nose, Mouth, Throat: tinnitus (ringing in ears), halitosis (chronic bad breath), diminished hearing, deafness, difficulty swallowing, other _____

Cardiovascular:, MI(heart attack), palpitations, high blood pressure, CVA(stroke), angina/chest pain, blood clots, varicose veins, lymph edema, other heart problems_____

Respiratory: asthma, shortness of breath, sleep apnea, snoring, sinus congestion/infections, other breathing problems
_____

Gastrointestinal: nausea, vomiting, diarrhea, blood in stool, ulcers, reflux,other _____

Genitourinary: painful urination, blood in urine, frequent urination, impotence, STDs, other _____

Musculoskeletal: back pain, joint pain, muscle pain, bone pain, scoliosis, other_____

Integumentary: dermatitis, eczema, tinea (athlete's foot), psoriasis, rash, or other _____

Neurological: anesthesia, paraesthesia (decreased or unusual sensations), neuropathy, seizures, tremors, numbness/ tingling in hands, Numbness/ tingling in feet, other _____

Psychiatric: anxiety, depression, binging, paranoia, other psychiatric concerns _____

Endocrine: diabetes mellitus, fatigue, or unexplained weight loss or gain, other _____

Immunologic: seasonal allergies, gout, rheumatic disease, other _____

Smoking Status: (circle) Former Smoker Never smoker Every day smoker Some day smoker
Smoking Quantity: (circle) Social/Rare Less than 5cig/day ½ pack/day 1 pack/day more than 1 pack/day

Do you drink alcohol? (circle) YES NO I drink _____ drinks every _____ (circle) day/ week/ month

List any medical conditions that run in your immediate family (specify which family member)._____
_____
_____

Financial & Privacy Policies

Thank you for choosing our office to provide you with medical care. We are committed to serving you with quality care and personal treatment. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

INSURANCE: We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

MEDICARE: We are a participating Medicare provider. We accept Medicare benefit amounts. Medicare as well as your secondary (if any) will be billed for you. However, that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are responsible for any copayments, which are usually 20% of the allowed amount for an item or service.

SECONDARY INSURANCE: As a courtesy, your medical claim will be forwarded to your secondary insurance (if any) after payment and /or explanation of benefits (EOB) is received from your primary insurance company.

INSURANCE APPEALS PROCESS: Joel D Foster DPM PC Foot Care Specialist makes every attempt to verify your insurance benefits prior to treatment. At times, benefits provided by your insurance carrier do not align with how they process claims. If your insurance claim is denied, an appeal will be filed on your behalfby Joel D Foster DPM PC Foot Care Specialist. Please know that all charges are ultimately patient responsibility regardless of the appeals process and as such any outstanding balance must be paid in full within 120 days of the initial date of service.

SELF PAY: Payment in full is due at the time of service if you do not have health insurance.

NON-COVERED SERVICES: Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for full payment of these services at the time of service.

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan. When you visit a specialist you may need a referral from your primary care physician or your insurance company prior to seeking specialty care. Therefore, you are financially responsible for the services received, unless your referral is presented at the time of visit, and one is required, you will be financially responsible for all services received due in full upon completion of the visit. You will also be given the option to reschedule your appointment.

CLAIM SUBMISSION: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

PATIENT BILLING: All co-payments, co-insurance, or deductible amounts must be paid AT THE TIME OF SERVICE.The arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your portion of insurance benefits at each visit. As a courtesy, our office does verify benefits with your insurance carrier; however, the insurance agreement is a contract between you and your insurance carrier. It is recommended that you verify your benefits with your carrier as well.

Patient Initials_____

FOOT CARE Specialist
JOEL D. FOSTER, DPM

NON-CUSTOM DURABLE MEDICAL EQUIPMENT RETURNS: If a patient is unsatisfied with any non-custom Durable Medical Equipment item, it must be returned within 30 days per Medicare guidelines. Returns after 30 days will not be permitted. The item will only be accepted as a return if it is in returnable condition. Any custom durable medical equipment item may not be returned for any reason.

COPY FEE: We will provide copies of patient records at the patient's request. Copies or medical records may be subject to a fee. There is a **$5.00** charge for copies of x-rays. You will bear complete financial responsibility for any fee(s) incurred.

MISSED APPOINTMENT FEE: If you cannot keep your appointment time, please call our office at least 24 hours prior to your scheduled appointment time. There will be a **$50.00 fee** for any missed appointments. If you arrive late for an appointment, we may need to reschedule your appointment.

COLLECTIONS FEE: You will be sent up to three statements for your financial responsibility (co-insurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After the third and last notice, your account will be forwarded to a collection agency. If your account is sent to a collection agency, a **30%fee** will be added to your account. You bear financial responsibility for any fee(s) incurred.

Payment arrangements can be made on a case by case basis. We accept the following payment methods: Cash, Check or VISA/Mastercard/American Express/Discover. An additional **$40.00** will be added to your statement if the check is returned from your bank. We do not accept starter checks. If your insurance company sends payment to you, the patient, it should be forwarded to our office to be applied to your balance.

I have read the above policy regarding my *financial responsibility* to Joel D Foster DPM PC for medical services provided. I agree to pay Joel D Foster DPM PC any balance unpaid by my insurance carrier for myself or the below named person.

PRIVACY STATEMENT: Any information disclosed in your records will remain confidential and will not be used for any other reason except in providing quality care and personal treatment as well as to submit your claim to your insurance company and contact you as needed.

PATIENT ACKNOWLEDGE OF NOTICE OF PRIVACY PRACTICES: By signing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have (or had the opportunity to read if I so chose) and understand the Notice and agree it its terms.

I, the undersigned, certified that I (or my dependent) have coverage with my insurance as presented and assigned directly to **Joel D Foster DPM PC** all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, co-insurance, non-covered services and other fees **AT THE TIME OF SERVICE**. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize Release of Medical Information to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information and acknowledge I was provided with a copy of the Notice of Privacy Practices and understand and accept its terms:

PRINT Patient Name:_____Signature:_____

If patient is under the age of 18, please complete the following for the ***FINANCIALLY RESPONSIBLE PARTY***:

PRINT Name:_____Signature:_____

Relationship to Patient:_____ Date:_____

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JOEL D. FOSTER, DPM

DISCLOSURE OF PROTECTED HEALTH INFORMATION TO ANOTHER PARTY

I also authorize the doctor(s) at Joel D. Foster DPM PC to use and/or disclose certain protected health information (PHI) about to the party or parties listed below:

Family Member:_____Relationship_____phone number_____

Family Member:_____Relationship_____phone number_____

Family Member:_____Relationship_____phone number_____

Check applicable information:
_____Medical Information
_____Testing /Radiology/MRI Results
_____Billing/Insurance Information
_____Authorized to leave message on voice mail
_____ Scheduling and Appointment information
_____Other, Describe_____

When my information is used or disclosed pursuant to this authorization, it may subject to disclosure by the recipient and may no longer be protected by the federal HIPPA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at 6 NW Sycamore St. Suite A Lees Summit, MO 64086.

Signature of Patient or Legal Guardian_____Date_____

Printed Name _____