ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

POCATELLO PODIATRY
Ambulatory Foot and Ankle Clinic
1555 EAST CLARK
POCATELLO, IDAHO 83201

I acknowledge that I was provided a copy of the Notice of Privacy Practices for Pocatello Podiatry and that I have read (of had the opportunity to read if I so chose) and understood the Notice.

_____ _____
Patient Name (please print) Date

_____
Parent of Authorized Representative (if applicable)

_____
Signature

About Financial Arrangements and Medical Insurance

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. To achieve these goals, we need your assistance, and your understanding of our payment policy. We will be happy to help you process your insurance claim-form for your reimbursement.

PLEASE READ OUR OFFICE PAYMENT POLICY CAREFULLY

Your co-payment or 20% will be due at the time of service, unless prior arrangements have been made. *PLEASE TALK TO THE RECEPTIONIST AT THE FRONT DESK TO MAKE PAYMENT ARRAINGEMENTS.* We will gladly accept monthly payments per these condition: Patients who will pay off their entire balance within 30 days after insurance has paid it's share can be given a 15% discount.

Monthly payments:

Balances over $1000.00 will need to be paid off within 1 year of the first date of service,

Balances between $500.00 and $999.00 will need to be paid off within 6 months.

Balance between $1.00 and $499.00 will need to be paid off within 4 months.

Any balances owing will automatically be subject to these conditions, unless other arraignments have been made. It is our goal to work with our patients on financial matters and we will try everything we can to help set up payments that will accommodate your needs.

Any account which are not paid as agreed will be turned over to our collections department for further action.

We accept cash or checks, Visa, MasterCard, American Express, and Care Credit. If you are interested in Care Credit and are not already a member please ask our receptionist for additional information.

Returned checks will be subject to additional collection fees.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

You must realize however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. We are contracted with most insurance companies and will make contractual adjustments per our contract with them. Please ask the receptionist if you don't know if we are contracted with your insurance company.
3. **Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. For example; Orthotic's are not usually covered by most insurance companies including Medicare. Non covered services are the patient's responsibility.**

While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the service is rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.

Signature _____ Date_____

PLEASE COMPLETE PATIENT INFORMATION ON THE OTHER SIDE

OVER

PATIENT INFORMATION FORM

PATIENT

Name Last: _____ First: _____ MI: _____

Mailing Address: _____

City: _____ St: _____ Zip Code: _____

E-mail:_____Home Phone: _____Cell Phone: _____

Current Employer:_____Work Phone:_____Ext:_____

Date of Birth: _____ Age:_____Race_____Ethnicity_____

Marital Status: Single Married Divorced Widowed **Sex:** Male Female

Primary Physician: _____Phone:_____

Whom may we contact in case of emergency? _____Day Phone: _____

How do you prefer to be contacted? __Cell Phone __Home Phone __Text __Email __Fax __Mail

May we leave a message? YES NO Preferred Pharmacy:_____

Social Security # _____Name of Physician who referred you:_____

Females are you pregnant? YES NO

SPOUSE OR RESPONSIBLE PARTY (if different from above)

Name Last: _____First:_____ MI: _____

Date of Birth: _____Race_____Ethnicity_____

Mailing Address: _____

City:_____State:_____ Zip:_____ Phone:_____Cell:_____

Current Employment: _____ Phone:_____Ext:_____

PRIMARY INSURANCE Name: _____

Insured'sName:_____BirthDate:_____SS#:_____

PolicyNumber:_____Group#:_____

Policy Holders Relationship to you _____

SECONDARY INSURANCE Name :_____(if you have a card I will copy it.)

Insured'sName:_____BirthDate:_____SS#:_____

PolicyNumber: _____Group#_____Relationship to policy holder_____

I understand and agree that (regardless of my insurance status); I am ultimately responsible for the balance of my account for any professional services rendered. I have read all information on **both sides** of this sheet and have completed the above answers. I authorize the release of medical or other information necessary to process my claims. I give my permission to Dr. Howard to administer treatment, x-ray and photograph my feet, and to perform such minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of my feet on my approval.

Signature_____

Date_____

Parent (if patient is a minor) _____ Date_____

PATIENT HISTORY FORM NAME DATE

Are you diabetic? YES NO **Attending Diabetic Physician** _____

Do you have Hepatitis ? A / B ? YES NO Attending Physician _____

Are You HIV Positive? YES NO Attending Physician _____

Podiatric History

What is the chief complaint for which you came to be treated?(include all complaints with foot, ankle, thigh or hip complaints)_____

_____

_____

Have you ever been to a Podiatrist before? YES NO, if yes date of last visit _____

Athletic activities in which you participate _____

Please circle any foot problems you now have or have had in the past year

Ankle Pain Athlete's Feet Bunions Corns and Calluses Numbness in Feet Leg or Foot Cramps

Heel Pain Ingrown Nail Gout Plantar Warts Swelling of Ankles of Feet Tired Feet Arch Pain

Accident Information

Was it caused by an accident or injury? YES NO

If YES give explanation. _____

Date: _____ Time: _____ Place: _____

If this happened at work is it covered under workman's comp? _____

Please list claim #_____ Workman's comp. ins._____

Medication and Allergies

List any medications you are currently using:_____

_____

_____

Circle any of the following that you are allergic to: PENICILLIN MORPHINE CODEINE IODINE ADHESIVE TAPE ANTIBIOTICS ASPIRIN SULFA DRUGS NO KNOWN DRUG ALLERGIES

List any allergies not listed:_____

List any reactions:_____

Family History

Is there any history of any of the following in your family? Please circle all that apply.

DIABETES BUNIONS BLEEDING DISORDERS HAMMERTOES

How is that person related to you?_____

Medical History

Please circle the symptoms you currently have or have had in the past 2 weeks.

General
Depression/ Nervous
Loss of Sleep
Loss of Weight
Sweats
Numbness/ Forgetfulness
Excessive Thirst

Eyes Ears Nose Throat
Vision Changes
Difficulty swallowing
Earache/Discharge
Loss of Hearing
Nosebleed
Persistent Cough

Muscle/Joint Pain
Pain / Weakness
Numbness in Limbs
Joint Stiffness
Joint Swelling
Pain in walking

Cardiovascular
Chest Pain
Varicose Veins
Irregular Heart beat
Swelling of Ankles
Swelling of Feet
Cold Feet

Respiratory
Cough
Wheezing
Shortness of breath
Denies

Neurological
Mood changes
Attention difficulty
Speech difficulty
Pins & Needles
Seizures

Endocrine
Hypothyroidism
Hyperthyroidism
Heat/Cold intolerance
Excessive hunger/thirst

Hematologic
Anemia
Easy bruising
Blood transfusions
Sickle cell trait

Gastrointestinal
Poor Appetite
Bloating
Bowel Changes

Skin
Changes in Moles
Hives/ Itching/ Rash
Sores that won't heal

Genito-Urinary
Blood in Urine
Painful Urination
Frequent Urination

Do you take Coumadin? YES NO **Do you take Aspirin regularly?** YES NO

Do you smoke? YES NO If No- Never or Quit Smoking

If Yes - How many packs a day?_____ Are you interested in quitting? Yes NO

Do you use alcohol? YES NO

CURRENT MEDICAL HISTORY

Please circle any that pertain to you

Aids	Diabetes	Kidney Disease	Rheumatic Fever	Arthritis
Liver Disease	Lupus	Raynouds	Stroke	Chemical Dependency
Bleeding Disorders	Breast Lump	Heart Disease	Multiple Sclerosis	Cancer
Thyroid Problems	Hepatitis	HIV Positive	Tuberculosis	Herpes
High/ Low Blood Pressure		Pacemaker	Ulcers	Parkinson's

Other_____

List any past Surgeries you have had in the past 5 years: _____

_____

_____

List any complications of Surgeries:

_____

_____

Treatment Consent

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary. To the best of my knowledge the above information is true and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, or Guardian_____ **Date**_____

MEDICARE SIGNATURE ON FILE

I request that payment of authorized Medicare benfits be made on my behalf to Pocatello Podiatry for any services furnished me by the listed physicain/ supplier. I authorize any holder of Medical information about me to release to Medicare and its agents any information needed to determine these benfits or the benefits payable to related services.

I request payment of authorized Medigap benefits be made to this provider and also authorize any holder of medical information about me to realease to the below named Medigap Insurer any information needed to determine benfits payable for services from this provider.

I understand my signature below requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Block 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare Carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determeination of the Medicare Carrier.

Patient's Name Patient Signature

Patient's Medicare Number

Address

City STATE ZIP

Name of Medigap Insurer

Medigap Policy Number

ONLY SIGN THIS FORM IF YOUR HAVE MEDICARE AS YOUR INSURANCE CARRIER