

Welcome to East Coast Podiatry, Inc.

PATIENT INFORMATION

Date _____

Name _____
Last First Initial

Social Security# _____ Birthdate ____/____/____ Age _____

Sex: M F Marital Status: SINGLE MARRIED WIDOWED DIVORCED Race: _____

Home Phone# _____ Cellular# _____

Home Address _____

City _____ State _____ Zip Code _____

Email address _____

Emergency Contact/Relationship _____ Phone# _____

VISIT INFORMATION

Family Physician _____ Phone# _____

Pharmacy Name _____ Phone# _____

MEDICAL HISTORY (check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Alzheimer's / Dementia | <input type="checkbox"/> Gout | <input type="checkbox"/> Osteopenia or Osteoporosis |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Hepatitis A / B / C | <input type="checkbox"/> Peripheral Neuropathy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Peripheral Vascular Disease |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Renal Insufficiency/ESRD |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> COPD / Emphysema | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Stroke/TIA Date: _____ |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Venous Insufficiency |
- Do you have **Diabetes**? Yes No If so, Year Diagnosed: _____ Type 1 Type 2 Current A1C _____

Are you currently in **Hospice care**? Yes No If so, Admit Date: _____

SURGICAL HISTORY

Please Include Pertinent Surgeries or Treatments Including Vascular, Lower Extremity, etc. and Dates:

SOCIAL HISTORY

Tobacco Use: NEVER FORMER DATE QUIT _____ CURRENT PPD _____ / YEARS _____

Alcohol Use: NONE RARELY MODERATELY DAILY QUIT

Immunizations: Last Flu Vaccine Date: _____ Pneumonia Vaccine Date: _____

MEDICATIONS

PLEASE LIST YOUR CURRENT PRESCRIPTION AND OVER THE COUNTER MEDICATIONS WITH DOSAGE:

Aspirin Dosage _____ Start Date _____

Blood Thinner: Name _____ Dosage _____ Start Date _____

ALLERGIES (List type and severity of reaction)

No Known Drug Allergies

PATIENT CONSENT AND AUTHORIZATIONS

CONSENT FOR TREATMENT: I, the undersigned patient, parent or legal guardian, do hereby present myself (or the patient) for care or treatment at East Coast Podiatry and voluntarily consent to the rendering of such care or treatment, including performance of diagnostic and/or surgical procedures. I understand that I am under the same care and supervision of my physician and it is the responsibility of the practice and its staff to carry out at the instructions of such physician. I understand that the physician furnishing services to me is an employee of East Coast Podiatry, however, other services such as radiology, laboratory, and pathology may be provided by independent practitioners. All physicians expect payment in full upon receipt of a bill and I will assist in billing appropriate insurance companies if insurance or other benefits are involved. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments or examination in the office. I understand that I am responsible for the outcomes of care or treatment if I do not follow the care, service, or treatment plan.

ASSIGNMENT OF BENEFITS: I hereby assign payment directly to East Coast Podiatry, and the physician accepting this assignment, of all medical benefits applicable and otherwise payable to me. I understand that I am financially responsible to East Coast Podiatry and their physician for charges not covered by this assignment or for any and all charges which the insurance carrier declines to pay.

RELEASE OF MEDICAL INFORMATION: I, the undersigned patient, parent, or legal guardian, do hereby authorize East Coast Podiatry, its offices and employees, to release any third party payer (such as an insurance company or government agency; Example: Blue Cross/Blue Shield of Florida or Medicare) any medical, psychiatric, alcohol, drug abuse, and/or HIV (AIDS and AIDS related complex) treatment information and records, in accordance with the policy of East Coast Podiatry and any applicable State or Federal Statutes, concerning diagnosis and treatment for the above admission when requested by such third party payor for its use in connection with determining a claim for payment for such care, treatment, and/or diagnosis. I authorize the release of any and all medical information to all physicians involved in my care and treatment. I do hereby release East Coast Podiatry from all liability that may arise from the release of the information requested.

FLORIDA LAW: Section 817.234 Florida Statutes, stipulates that any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

FOR MEDICARE AND MEDICAID PATIENTS ONLY – CERTIFICATION AND AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII and/or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary-carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to East Coast Podiatry physician(s). I understand that I am responsible for any health insurance deductibles and coinsurance.

MEDICARE BENEFICIARY NOTICE OF NON-COVERED SERVICES: Medicare does not cover some inpatient, outpatient, and emergency services. Items not covered include, but are not limited to, medications typically self-administered, annual testing, and physicals.

ACKNOWLEDGEMENT OF RECEIPT OF AN IMPORTANT MESSAGE FROM MEDICARE (FOR MEDICARE PATIENTS ONLY): My signature only acknowledges my receipt of this message from East Coast Podiatry as dated below and does not waive my right to request a review or make me liable for any payment.

FINANCIAL AGREEMENT: The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she individually hereby obligates himself/herself to pay the account of East Coast Podiatry physician(s) in accordance with the regular rates and terms of the physician(s). The undersigned will pay all costs and expenses including reasonable collection fees (which may include agency, attorney, interest or court fees) incurred or paid by East Coast Podiatry in collection of this obligation by suit or otherwise. Furthermore, I hereby authorize and appoint the administrator of East Coast Podiatry and/or its physician(s) or his successor/designee as my attorney-in-fact to take measures in my behalf as may be necessary to collect such claims or insurance proceeds and to endorse any checks made payable to me for such claims or insurance proceeds by signing my name as attorney-in-fact for me to any such checks and/or insurance claim forms.

ELECTRONIC PRESCRIPTION HISTORY AND BENEFITS AUTHORIZATION: My signature acknowledges my permission for East Coast Podiatry to electronically download my prescription history from SureScripts and my prescription benefits from my insurance company.

CANCELLATIONS: For future appointments there will be a \$25⁰⁰ cancellation/no show fee charged unless 24 hour notice is given to the office prior to the appointment. If your appointment is not cancelled and you do not show to your scheduled appointment, \$25⁰⁰ will be charged to your account. Of course, we realize emergencies occur, so please notify us of any emergency as soon as possible.

DME RETURN POLICY: All sales are final. Returns will not be permitted on any and all Durable Medical Equipment purchased from East Coast Podiatry, Inc.

I permit a copy of these authorizations and assignments to be used in place of the original which may be on file at East Coast Podiatry.

Print Name

_____/_____/_____
Patient Date of Birth

Patient's Signature

Patient's Representative (Indicate relationship)

Witness

_____/_____/_____
Date