NASHVILLE PODIATRY

NEW PATIENT INFORMATION

Patient Demographic Information:

Name: _____ DOB: _____/_____/_____ SSN: _____

Gender: Male Female Age: _____ Email:_____

Address: _____

Phone: Home _____ Work _____ Cell _____

Best number to call (Circle one): Home Work Cell

How would you like our office to contact you? ☐ Phone ☐ Mail ☐ E-mail

If by phone, with whom may we leave a message? ☐ Patient only ☐ Patient or spouse ☐ Anyone

Emergency Contact:

Name: _____ Relationship: _____

Phone: Home _____ Work _____ Cell _____

Preferred Language: English Spanish Other: _____ Decline to Specify

Race: (Circle one) American Indian or Alaska Native Asian Black or African American
Native Hawaiian or Pacific Islander White Decline to Specify

Ethnicity: (Circle one) Hispanic or Latino Not Hispanic or Latino Decline to Specify

How did you hear about us? Friend/Family Internet Insurance Another Doctor Other_____

Responsible Party/Primary Insurance Carrier: ☐ Self ☐ Other (please provide info below)

Name: _____ DOB: _____/_____/_____ SSN: _____

Relationship to patient: _____

Patient History & Medical Information

Primary Care Physician: _____ Phone #: _____

Pharmacy Name: _____ Phone #: _____

Explain your current problem: _____

When did the pain/discomfort begin? _____

What makes the pain/discomfort BETTER? _____

What makes the pain/discomfort WORSE? _____

Has the condition been treated? YES NO If yes, when? _____

How was the condition treated? _____

Height: _____ ft _____ inches Weight: _____ pounds

Past Medical History: ☐ None

☐ Anemia ☐ Diabetes type 2 ☐ High blood pressure ☐ Mitral valve prolapse ☐ Stroke

☐ Arthritis ☐ Epilepsy ☐ High cholesterol ☐ Neurological/nerve disorder ☐ Thyroid disorder

☐ Bleeding disorder ☐ Gout ☐ HIV/AIDS ☐ Osteoarthritis ☐ Other: _____

☐ Cancer ☐ Heart disease ☐ Kidney disease ☐ Prostate disorder _____

☐ Diabetes type 1 ☐ Hepatitis ☐ Lung disorder ☐ Rheumatic fever _____

List all medications/herbs/vitamins: ☐ None

_____

_____

Allergies: ☐ None ☐ Anesthesia ☐ Aspirin ☐ Codeine ☐ Narcotic agents ☐ Penicillin

☐ Radiographic contrast/dyes ☐ Sulfa drugs ☐ Other: _____

Surgical History: ☐ None Please list all major surgeries/dates: _____

_____

Social History: (Check all that currently apply)

☐ Alcohol use ☐ Caffeine ☐ Drug use ☐ Exercise: _____ ☐ Nursing ☐ Pregnant

Tobacco use: (Circle one)

Current daily smoker Current social smoker Former smoker Never smoked

Smokeless tobacco user Former smokeless tobacco user

Family History: **(Please circle M for mother's side and/or F for father's side)** ☐ No family history

☐ Bleeding disorders (M / F) ☐ Heart disease (M / F) ☐ Mental illness (M / F)

☐ Cancer (M / F) ☐ High blood pressure (M / F) ☐ Rheumatoid arthritis (M / F)

☐ Diabetes (M / F) ☐ Kidney disease (M / F) ☐ Stroke (M / F)

Review of Systems:

Please check any of the following that you have recently experienced:

☐ Chills	☐ Chest pain	☐ Back pain	☐ Rash
☐ Fever	☐ Heart murmur	☐ Leg pain	☐ Skin lesion(s)
☐ Night sweats	☐ Irregular heartbeat	☐ Muscle weakness	☐ Sciatica
☐ Weight gain	☐ Stomach ulcers	☐ Leg cramps	☐ Balance difficulty
☐ Weight loss	☐ GERD	☐ Leg/foot swelling	☐ Loss of strength
☐ Hyperglycemia	☐ Constipation	☐ Foot pain with sleeping	☐ Tingling/numbness
☐ Obesity	☐ Diarrhea	☐ Varicose veins	☐ Mood changes
☐ Hypoglycemia	☐ Slow to heal	☐ Cold extremities	☐ Nervousness
☐ Difficulty breathing	☐ Anemia	☐ Dry skin	☐ Tension
☐ Cough	☐ Bleeding problems	☐ Eczema	☐ Anxiety
☐ Shortness of breath	☐ Easy bruising	☐ Itching	☐ Depressed mood

☐ None of the above

To the best of my knowledge, I certify that the information given above is true and correct. I understand that it is my responsibility to notify Nashville Podiatry of any changes to the above information. I understand that providing incorrect information can be dangerous to my health.

Patient or guardian signature: _____ Date: _____

Patient Financial Policy

This is an agreement between AdvancedHEALTH , as creditor, and the Patient/Debtor named on this form and indicated by patient/debtor signature below.

In this agreement the words “you”, “your”, and “yours” mean the Patient/Debtor. The word “account” means the account that has been established in your name to which charges are made and payments credited. The words “we”, “us”, and “our” refer to AdvancedHEALTH. By executing this agreement, you are agreeing to pay for all services that are rendered.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect. A copy of your signed financial agreement will be provided to you.

HEALTH INSURANCE – It is YOUR responsibility to:

- Ensure we have been provided with the most current insurance information relative to filing your claim including insurance card, ID number, employer, birth date and patient address. This information will be located on our patient registration form.
- Ensure we are contracted with your insurance carrier to receive maximum benefits.
- Pay your co-payment or patient portion at the time of service.
- Inform us of any insurance changes made after this signed agreement/date of service. Insurance carriers have specific timely filing guidelines and pre-authorization requirements for certain services. If revised insurance information is not provided to us within your insurances’ timely filing limits, you will be required to pay for services in full. If prior authorization was required for services already received and your claim is denied for lack of authorization, you will be required to pay for services in full.
- Contact your insurance company if no correspondence is received by you within 45 days of the date of service.

It is OUR responsibility to:

- Submit a claim to your health insurance carrier based on the information provided by the patient/debtor at the time of service or as updated information is provided.
- Provide your health insurance carrier with information necessary to determine benefits. This may include medical records and/or a copy of your insurance card.
- Provide MVA patients a courtesy health insurance claim form for their records upon request.

PAYMENT OPTIONS: Per our contracted agreement with your insurance carrier, we are required to collect your co-payment on the day of service. If you do not have insurance, you are required to pay for treatment at the time of service unless other arrangements have been formally made. A separate self-pay financial agreement will be provided to you. Our office collects all copays plus estimated coinsurance and deductibles at the time of service.

We accept the following: Cash Check Credit Card (*Visa, Mastercard, Discover, American Express*)

A twenty-five dollar ($25.00) returned check fee will be assessed to the patient account per incident.

For convenience, payments may be made online at **www.ePayItOnline.com.** To utilize this service, you will need your account number, access code, and Code ID. This information can be found on the patient statement you will receive reflecting your balance. **Patients who no-show or cancel or re-schedule with less than 24 hours notice may be subject to a $35 fee.**

PENDING APPROVALS FOR SERVICES: In the event we are unable to obtain approval for services and you wish to proceed, we will not bill your insurance. Services will be reduced to the in-network insurance allowable amount and will apply to the patient’s responsibility.

Patient and/or Debtor Signature: _____ Date_____/_____/_____

General Consent for Treatment

As the patient, you have the right to be informed about your conditions and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify appropriate treatment and/or procedure for any identified condition(s).

I request and authorize medical care as my provider, his assistant or designees (collective called "the providers") may deem necessary or advisable. This care may include, but is not limited to, routine diagnostics, radiology and laboratory procedures, administration of routine drugs, biological and other therapeutics, and routine medical and nursing care. I authorize my provider(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my (the patient) care is directed by my provider(s) and that other personnel render care and services to me (the patient) according to the provider(s) instructions.

I understand that I have the right and the opportunity to discuss alternative plans of treatment with my provider and to ask and have answered to my satisfaction any questions or concerns.

In the event that a healthcare worker is exposed to my blood or bodily fluid in a way which may transmit HIV (human immunodeficiency virus), hepatitis B virus or hepatitis C, I consent to the testing of my blood and/or bodily fluids for these infection and the reporting of my test results to the healthcare worker who has been exposed. _____ **(initial)**

I HAVE READ OR HAD READ TO ME AND FULLY UNDERSTAND THIS CONSENT. I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS AND HAD THESE QUESTIONS ADDRESSED.

Name of Patient: _____

Signature of Patient: _____ Date: _____

☐ Consent of Legal Guardian, Patient Advocate or Nearest Relative if patient is unable to sign

☐ Consent Caregiver if patient is unable to sign

Name of Legal Guardian, Patient Advocate, Nearest Relative or Other: _____

Relationship: _____ Telephone: _____

Address: _____

Signature of the above: _____ Date: _____

Signature of Witness: _____ Date: _____

Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

Patient Name or Legal Guardian: _____

Signature: _____

Date: _____

PRACTICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date: _____ Initials: _____

Reason: _____

_____