Quality Foot Care Center

Please print and complete the following information for your case history file.

First name: _____ Last name: _____ Middle Initial: _____

Name preferred: _____ Parents' or Guardian's name if a minor: _____

Residence address: _____ City: _____ State: _____ Zip code: _____

Marital status: ☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced ☐ Partnered

Sex: ☐ Male ☐ Female ☐ Non-binary ☐ Prefer not to say

Primary language: ☐ English ☐ Spanish ☐ Other: _____

Home phone: _____ Cell phone: _____ Email: _____

Name of employer: _____ Occupation: _____

Preferred method of contact: ☐ Phone ☐ Mail ☐ Fax: _____

How did you find out about our office? _____

Name and address of Primary Care Doctor: _____

Primary Care Doctor phone number: _____ | Preferred pharmacy: _____

Pharmacy address: _____ Pharmacy phone number: _____

If other than the patient, the name of the person responsible for this account: _____

Relationship: _____ Address: _____

I hereby give Dr. Harvey Jacobs, D.P.M. permission to examine and treat my feet. I authorize the use of these forms on all my insurance submissions. I authorize the release of information to all of my insurance companies. I understand that I am responsible fo my bill. I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies. I authorize direct payment to my doctor. I permit a copy of this authorization to be used in place of the original.

_____ _____

Signature Date

PATIENT HISTORY

Name:_____ Date of Birth :_____/_____/_____

Height:_____ Weight:_____Shoe size:_____ Do you wear inserts or orthotics:_____

My chief foot complaint is:_____

This condition has existed for:_____ Does this alter your job? ☐Yes ☐No

If yes, explain:_____

If you are currently off work due to the problem, how long have you been off of work?_____

Have you had previous treatment by a podiatrist?_____ If so, for what?_____

Allergies:

☐ None known ☐ Adhesive tape ☐ Iodine ☐ Penicillin ☐ Novocaine ☐ Seasonal

List all other allergies (include a description of reaction):

_____

Patient's Social History:

Tobacco Use: ☐ Never ☐Quit-when?_____ ☐Currently smoke/ ___Packs per day

Alcohol Use: ☐ None ☐ Rarely ☐ Socially ☐ Daily ☐ Alcohol Dependent ☐ Recovering Alcoholic

Recreational Drug Use: ☐ Yes ☐ No----------Have you ever been treated for drug addiction? ☐ Yes ☐ No

Exercise: ☐ Never ☐ Rare ☐ Occasional ☐ Weekly ☐ Several times a week ☐ Daily

Patient's Surgical History: Please list any surgeries you have had. Include the year.

_____

_____

_____

Females: Are you currently pregnant? ☐ Yes ☐ No

Patient's General Health History: Do you have or have you had any of the following? (Check all that apply)

☐ Diabetes ☐ Alzheimer's ☐ Hemophilia ☐ Gout ☐ Hypertension ☐ Fibromyalgia ☐ Hepatitis C

☐ Osteoporosis ☐ Rheumatoid Arthritis ☐ Heart Disease ☐ Stroke ☐ Kidney Disease ☐ Back Pain

☐ Osteoarthritis ☐ High Cholesterol ☐ Polio ☐ Rheumatic Fever ☐ Bursitis ☐ Phlebitis ☐HIV/Aids

☐ Stomach Ulcers ☐ Depression ☐ Seasonal Allergies ☐ Varicose Veins ☐ Asthma ☐ Anxiety

☐ PVD or PAD ☐ Epilepsy ☐ GERD ☐ COPD ☐ Hyperthyroidism ☐ Cancer, type:_____

List all other chronic illnesses not included above:

_____

_____

Your *Family* History: Check off any that your blood-related parents, siblings, or children have had.

☐ Cancer ☐ Heart Disease ☐ High Cholesterol ☐ Depression ☐ Alcohol Abuse ☐ Diabetes

☐ Kidney Disease ☐ Stroke ☐ Gout

Review of Systems: Check off any that apply.

Constitutional: ☐ Weight gain ☐ Weight loss ☐ Fatigue ☐ Weakness ☐ Fever ☐ Chills

Eyes: ☐ Pain ☐ Discharge ☐ Light sensitivity ☐ Blurred vision ☐ Changes in vision

Ears / Mouth / Nose / Throat: ☐ Hearing loss ☐ Discharge ☐ Ear pain ☐ Ear ringing ☐ Nasal congestion

☐ Nasal discharge/bleeds ☐ Postnasal drip ☐ Sore throat ☐ Oral lesions

Cardiovascular: ☐ Chest pain ☐ Fainting ☐ Swelling of feet ☐ Palpitations ☐ Cramping in the legs

Gastrointestinal: ☐ Abdominal pain ☐ Heartburn ☐ Vomiting ☐ Diarrhea ☐ Blood in stool ☐ Constipation

Musculoskeletal: ☐ Joint swelling ☐ Joint redness ☐ Joint pain ☐ Muscle pain

Skin / Breast: ☐ Rash/Itching ☐ Sores ☐ Lumps ☐ Discharge

Neurological: ☐ Headache ☐ Confusion ☐ Numbness ☐ Slurred speech ☐ Gait instability ☐ Seizure

Psychological: ☐ Anxiety ☐ Depression ☐ Severe Stress

Immunologic: ☐ Sneezing ☐ Watery eyes ☐ Itching ☐ Clear nasal discharge ☐ Recurrent Infections

Endocrine: ☐ Excessive sweating ☐ Excessive thirst ☐ Feel too hot ☐ Feel too cold

Blood / Lymphatic: ☐ Bleeding tendencies ☐ Lymph node swelling ☐ Easy bruising

Foot and Leg History: Check off any that apply

☐ Foot/leg injuries ☐ Foot/leg cramps ☐ Foot/leg numbness ☐ Knee pain ☐ Unequal leg length

☐ Weak ankles ☐ Bunions ☐ Foot skin problems ☐ Toenail problems ☐ Lower back pain

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:
Include all prescriptions, over-the-counter medications, herbal supplements, and medications taken only when needed

If you carry a list of your medications, you may provide us that list to photocopy in lieu of writing it down.

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that my responsibility is to inform the doctor and office staff of any changes in my medical status.

_____ _____

Signature If other than patient, relationship to patient Date

QUALITY FOOT CARE CENTER
FINANCIAL POLICY

Thank you for choosing Quality Foot Care Center to serve you and your family's health needs. We are pleased to participate in your family's health care and look forward to establishing a long-lasting relationship as your podiatrist. As part of this relationship, we wish to establish our expectations of your financial responsibility as outlined in our financial policy. **Your medical insurance is a contract between you and your insurance company. We can often help by providing information to help you in filing claims, but you are primarily responsible for any charges that you have incurred as a patient with *Quality Foot Care Center.*** Please review and sign the following financial policy prior to your visit.

1) CO-PAYMENTS, DEDUCTIBLES, AND FEES - **All co-payments, insurance deductibles, and fees for services not covered by your insurance policy are all due at the time the service is rendered.** We accept CASH, CHECK, MONEY ORDER, or CREDIT CARDS.
2) INSURANCE - Patients must complete and sign information and insurance forms prior to seeing the physician. **You must present a CURRENT insurance card at each visit. If you or your children do not present a current insurance card, you will be responsible for payment at the time of your visit.** You will receive reimbursement from Quality Foot Care Center if your insurance pays the claim, at a later date. If your insurance company is not one with which we participate, you are responsible for payment in full. Insurance plans and Medicare consider some services to be "non-covered," in which case you are responsible for payment in full. You have a responsibility to provide information to our office so a claim can be properly submitted. **If your company has not paid a claim on your behalf within 90 days because of information you have not provided, the balance will be transferred to your account and you will be responsible for payment.** If we receive payment at a later date, you will be reimbursed by Quality Foot Care Center.
3) MINORS AND DEPENDENTS - Parents and guardians are responsible for payments for their dependents at the time the service is rendered. **Minors and dependents must present a valid insurance card at each visit if a claim is to be filed.** See item #2 above if an insurance card is not presented.
4) MISSED APPOINTMENTS - **Unless they are canceled at least 24 hours in advance, our policy is to charge for missed appointments.** The fee for missed appointments is **$25.** This fee is not covered by your insurance plan and is your responsibility.
5) PROMPT PAYMENT - Just as we make every effort to accommodate you when you are in need of medical care, we expect that you will make every effort to pay your bill promptly. If you have a financial hardship or if you are unable to pay your bill in its entirety, please contact our office to discuss payment options. ***There will be a 1.5% late fee added per month on any account that is past due over 60 days.*** **If your account becomes delinquent and you have not established or made payment arrangements with our billing office, your account will be turned over to a collection agency. A collections fee of $75 will be added to your account in addition to the 1.5% late fee. We may also ask you to seek your podiatric care from another podiatric office.**

I have read the financial policy and agree to its terms.

Patient Signature _____ Date signed _____

QUALITY FOOT CARE CENTER

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my health care Quality Foot Care Center originates and maintains health records describing my health history, symptoms, examination, test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that Quality Foot Care Center reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Quality Foot Care Center is not required to agree to these restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the practice has already taken action in reliance thereon.

I will allow the disclosure of my health information to:

Messages on my home telephone answering machine or voicemail: ☐ YES ☐ NO

Relatives: _____

Signature of patient or authorized representative: _____

Birthdate: _____ Date of consent: _____