



# Patient Medical History

Reason for visit today: \_\_\_\_\_

Have you had any past problems or surgical procedures on your feet? \_\_\_\_\_

Shoe Size: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Are you allergic or sensitive to any medications? \_\_\_\_\_

Do you have any problems with aspirin, betadine (iodine), ibuprofen, latex, lidocaine, novacaine or tape? \_\_\_ Yes \_\_\_ No

If yes, which one? \_\_\_\_\_

Have you ever had a heart valve transplant, hip replacement or knee replacement? \_\_\_ Yes \_\_\_ No

If yes, which one? \_\_\_\_\_ Date of Surgery: \_\_\_\_\_

Are you required to take an antibiotics for this procedure? \_\_\_ Yes \_\_\_ No If yes, which one? \_\_\_\_\_

List exercise activities: \_\_\_\_\_

Do you or any blood relatives have (or had) any of the following? (Check all that apply)

	You	Family Member		You	Family Member
Anemia			High Blood Pressure		
Alzheimer's			High Cholesterol		
Arthritis			HIV / AIDS		
Artificial Heart Valve			Kidney Disease		
Artificial Joints			Liver Disease		
Asthma			Numbness in Feet		
Back Problems			Osteoporosis		
Bleeding Disorder			Parkinson's Disease		
Blood Clots / DVT			Poor Circulation		
Cancer			Psoriasis / Eczema		
Diabetes			Scarlet Fever		
Dementia			Stomach Ulcer		
Epilepsy			Stroke		
Gout			Thyroid Problems		
Heart Disease			Tuberculosis		
Hepatitis					

Diabetic? \_\_\_ Yes \_\_\_ No

If diabetic, what was your last A1C score? \_\_\_\_\_

Do you currently smoke? \_\_\_ Yes \_\_\_ No If yes, how much? \_\_\_\_\_

Former smoker? \_\_\_ Yes \_\_\_ No If yes, how much? \_\_\_\_\_

Do you use recreational drugs? \_\_\_ Yes \_\_\_ No If yes, how much? \_\_\_\_\_

Pregnant:  Yes  No  Maybe  No-Male Patient

Primary Care Doctor: \_\_\_\_\_ Date of Last PCP Visit: \_\_\_\_\_

Do you take Coumadin, Aspirin, Plavix or any other types of blood thinners? \_\_\_\_ Yes \_\_\_\_ No

What other medications are you taking? (If you have a list, reception can make a copy)

Medication Name	Dosage (mg)	How Often?

Please list any major surgeries you have had (and the year):

Type of Surgery (if you need additional space, please use back of page)	Date of Surgery

Preferred Pharmacy Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Patient Financial Responsibility:**

**If you have insurance:** We participate in most insurance plans, including Medicare and Medicaid. If you are insured by a plan we participate with, but we do not have an up-to-date insurance card, payment may be required in full for each visit until the up-to-date card can be provided. Health plan coverages vary significantly by carrier, employer and/or by contract. We cannot know the benefits and exclusions on each patient's health plan. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you might have regarding your coverage.

- **Proof of Insurance:** A copy of your current valid insurance is needed to provide proof of insurance. If you are unable to provide proof of insurance, you will be held financially responsible for the services received.
- **Non-Covered Services:** Please be aware that some - and perhaps all - of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. We may not know these are non-covered in advance of performing services. You are responsible for all non-covered services.
- **DME Coverage:** Prior authorization is obtained for DME when required, but it is not a guarantee of payment. Your insurance will make the final determination of eligibility, allowances, plan limitations and disposition after the claim is received. DME costs may become the patient's responsibility. If you have additional questions regarding coverage, please contact your insurance company.
- **Referrals:** If required, obtaining the proper referral from your Primary Care Physician is your responsibility.
- **Co-payments:** All co-payments must be paid at time of service.
- **Claims Submission:** We will submit your claims in a timely manner and assist in any way we reasonably can to help you get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request.
- **Invoice Payments:**
  - Invoice payment is due within 30 days of receipt.
  - Billing charges which are applied to the insurance policy deductible or co-insurance are the patient's responsibility. This arrangement is part of your insurance plan, which is a contract between you and your insurance company. If you disagree with any aspect of insurance coverage, including co-payments and/or deductibles, we recommend you contact your insurance company as we do NOT have the ability to alter any of these monies.

**If you do not have insurance:** Payment is due in full at time of visit.

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**Check Writing:**

- It is our policy to accept personal checks. If your check is returned to us for insufficient funds, a \$30 service fee will apply in addition to the original payment amount. Cash, Visa, MasterCard or American Express will be required for all future payments.

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**Prescription Requests:**

- Our policy is to complete all prescription request in a timely manner. In an effort to decrease the amount of phone calls coming into our office and to better serve our patients, we kindly ask that you address your prescription needs at your appointment. **Refill requests should be made through your pharmacy.**

**Narcotic Medications:**

- Dr. Rootring and Dr. Feist prescribe Narcotic Medications for a finite period and only in the case of acute injury or after surgery. If you require long term pain control, you will be referred to a Pain Management Specialist. Due to DEA regulations and Ohio state law(s), these medications must be dispensed in person and cannot be called in to your pharmacy or submitted electronically.
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**Medical Record Requests:** Fees will be charged for copies of medical records or preparation of medical paperwork requested by a patient or a patient's representative. Prices are determined by the Ohio Department of Health in accordance with Ohio Revised Code Section 3701.742. The practice requires a 72-hour turnaround time for copies of medical records and 10 business days for preparation of medical paperwork.

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**Missed Appointments:** We strive to be on time for your scheduled appointments and ask that you give us the courtesy of a call when you are unable to keep your appointment. If you arrive 15 minutes past your scheduled appointment time, it may be necessary for us to reschedule your appointment and a missed appointment fee may apply.

- The charge for a missed appointment is \$25.00.
- If you need to cancel or reschedule, please provide us with 24-hours' notice so we may give your appointment to another patient in need. Messages can be left for appointment cancellations if the office is closed.
- Payment of missed appointment fees is required before you can be rescheduled.

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**HIPAA Privacy Notice:** I have read or been given the opportunity to read the HIPAA Privacy Act in the office. I understand my rights as a patient of Choice Podiatry Associates.

- **Purpose of Authorization:** It is the policy of the practice to provide communication with patients, as stated in our Notice of Privacy Practices, "by phone or other means designated by you to provide results from exams and tests and to provide information that describes or recommends alternatives regarding your care." The practice requires the authorization for release of protected health information (PHI) via alternative means (other than to the primary phone number you have provided).
- **Purpose of Request:** I authorize the practice to disclose or provide protected health information to the individual who is listed as my emergency contact on my registration form.

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**ACKNOWLEDGEMENT of Financial, HIPAA and Office Policy of Choice Podiatry Associates**

By signing below, you attest that you have read and understand the Financial, HIPAA and Office Policy and agree to abide by its guidelines:

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Signature of Patient (or responsible party)

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Date

If signing as parent/guardian, please note the name of the patient: \_\_\_\_\_