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NEW PATIENT REGISTRATION

Dr. John Rootring Dr. Jay Feist

DEMOGRAPHICS

Legal Name _____ Date of Birth _____
First Name Middle Initial Last Name

Gender: ☐Female ☐Male Marital Status: ☐Married ☐Divorced ☐Widowed ☐Single

SS#_____-_____-_____ E-mail Address: _____

If patient is a minor, Parent's Full Name: _____

Home Phone # _____ Cell Phone # _____

Mailing Address _____
Street City State Zip

Employer _____ Occupation _____ ☐Full-time ☐Part-time ☐Retired ☐Student

Emergency Contact: _____ This is my ☐Spouse ☐Relative ☐Friend ☐Other_____

Home Phone # _____ Cell Phone Number # _____

Family Doctor / PCP: _____ Phone: _____

Were you referred by your Primary Care Physician? ☐Yes ☐No Date of Last PCP Visit: _____

How did you hear about us?
☐ Friend/Relative/Patient _____ ☐Other _____
☐Internet _____

INSURANCE & PAYMENT INFORMATION

Please hand your card to our receptionist. A copy will go in your medical record.

Primary Insurance Company: _____ Policyholder's Name: _____
ID # _____ Group # _____ Patient's relationship to policyholder: ☐Self ☐Spouse ☐Child
Policyholder's SS # _____-_____-_____ Policyholder's Date of Birth _____

Secondary Insurance Company: _____ Policyholder's Name: _____
ID # _____ Group # _____ Patient's relationship to policyholder: ☐Self ☐Spouse ☐Child
Policyholder's SS # _____-_____-_____ Policyholder's Date of Birth _____

Demographics:
Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino
Language: ☐ English ☐ Spanish ☐ Other _____
Race: ☐ Caucasian ☐ African American ☐ Asian ☐ Other

Permission to Treat / Release of Information/Privacy Practices:

1. I HEREBY give my permission to Choice Podiatry to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and treatment of my extremity condition. I HEREBY assign to Choice Podiatry all benefits provided by my insurance company policy/policies for medical & surgical care. I HEREBY acknowledge Receipt of Notice of Privacy Practices. I have been provided a copy of the Notice of Privacy Practices and I have read (or had the opportunity to read if I so choose) and understood the Notice.
2. I AUTHORIZE Choice Podiatry to email, text or call me for appointment reminders/changes, follow-up of treatment or any outstanding issues with my account via ☐ Phone Numbers Provided Above ☐ Email listed above ☐ Both

_____ _____
PATIENT SIGNATURE (PARENT/GUARDIAN IF PATIENT IS A MINOR) **DATE**

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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		
Tuberculosis			Scarlet Fever		
Dementia			Stomach Ulcer		
Epilepsy			Stroke		
Gout			Thyroid Problems		
Heart Disease			Diabetes – Type 1		
Hepatitis			Diabetes – Type 2		

Diabetic? _____ Type 1 _____ Type 2 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? _____

Do you consume alcohol? ____ Yes _____ No If yes, how much? _____

Pregnant: □ Yes □ No □ Maybe □ No-Male Patient

Do you have a living will or advance directive? _____ Yes _____ No

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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: _____

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Financial, HIPPA and Office Policy

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.

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.

Prescription Requests:

- Our policy is to complete all prescription request in a timely manner. If 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, Dr. Kordahi 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.

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.

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.

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:

_____ _____

Signature of Patient (or responsible party) **Date**

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