

Bay Area Podiatry Associates, PA

Patient Demographic Information			
Patient's Name:			Date:
SS#:	DOB:	Age:	Sex: F M
Home Address:		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widow <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	
City:	State:	Zip:	
Home Phone:	Cell Phone:		Work Phone:
Emergency Contact:	Phone #:		Relationship:
Email Address:		Referral Source:	
Employer Name:		Position:	
Primary Language:		Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic	
Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White			
REFERRING PHYSICIAN INFORMATION			
Primary Care Physician's Name:			Phone #:
INSURANCE INFORMATION			
Primary Insurance Co. Name:		Secondary Insurance Co. Name:	
Policy #:		Policy #:	
Subscriber's Name:	Relationship to Patient:	Subscriber's Name:	Relationship to Patient:
Subscriber's SS#:	Subscriber's DOB:	Subscriber's SS#:	Subscriber's DOB:
PHARMACY INFORMATION			
Pharmacy Name:		Pharmacy Phone:	

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Name _____ Date of Birth _____ Date _____

PODIATRIC HISTORY

Reason for your visit: _____

Describe Type of Pain:

- Dull Sharp Shooting
- Burning Aching
- Throbbing Tingling
- Numbness Cramping
- Other: _____

Location: Right Left Both

- Foot Ankle Leg

Height: _____
Weight: _____

Duration (How long have your symptoms been present): _____ Days/ Weeks/ Months/ Years

Onset: Slow Sudden Traumatic

If Traumatic: Auto Worker's Comp
 Other

Has Pain Become: Better Worse
 Stayed the same

Symptoms are worse: Morning All Day
 Evening Night

Previous Treatments: _____

What aggravates the condition?

Who is your Primary Physician?

Last time seen? _____

May we contact physician regarding your care? YES NO

MEDICATIONS

Please include prescriptions, over-the-counter medications, and vitamins or (Provide a list to be photocopied):

Name: _____ Dosage: _____ Reason: _____

Name: _____ Dosage: _____ Reason: _____

Name: _____ Dosage: _____ Reason: _____

Name: _____ Dosage: _____ Reason: _____

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MEDICAL HISTORY

Please circle to indicate if you have had any of the following:

AIDS/HIV	Depression	Neuropathy
Acid Reflux	Diabetes	Pacemaker
Anemia	Type_____ How Long_____	Phlebitis
Anxiety	Emphysema	Psoriasis
Arthritis	Fibromyalgia	Shortness of Breath
Artificial Heart Valve	Foot Cramps	Stroke
Artificial Joint	Gout	Thyroid Problems
Asthma	Headaches	Tuberculosis
Back Problems	Heart Attack	Varicose Veins
Bleeding Problems	Heart Murmur	Wt Loss, Unexplained
Bipolar Disorder	Heart Failure	
Blood Clot/DVT	Hepatitis	
Cancer	High Blood Pressure	
Type_____	Kidney Problems	
Chemical Dependency	Leg Cramps	
Chest Pain	Liver Disease	
Circulatory Problems	Lower Blood Pressure	

Women, are you pregnant? Y N **Breastfeeding?** Y N

Other medical problem we should be aware of : _____

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ALLERGIES

Any allergies or adverse reaction to the following?

Local anesthesia	General anesthesia
Aspirin	Latex
Anti-Inflammatory	Tape/Adhesives
Penicillin	Iodine
Sulfa	Betadine
IVP dye	Codeine
Tetanus	Steroids
Nickel	

Other antibiotics (name) _____

Other medications (name) _____

SURGICAL AND HOSPITALIZATION HISTORY

Please list previous surgeries and hospitalizations with approximate dates (year):

Surgery/Hospitalization _____ Date: _____

Surgery/Hospitalization _____ Date: _____

Surgery/Hospitalization _____ Date: _____

Surgery/Hospitalization _____ Date: _____

Printed Name: _____

Signature: _____

Date: _____

Insurance Coverage Disclaimer/Clinic Financial Policy

Due to changes within the insurance industry, effective immediately **Bay Area Podiatry Associates** is requesting all patients to verify and be familiar with their insurance benefits prior to being seen in our office. **As a courtesy, our staff will continue to verify and bill your insurance, but we cannot guarantee coverage or that the information we have received from your carrier and conveyed to you is accurate or complete.** Please read and sign that you have received and understand the following:

I understand that **Bay Area Podiatry Associates** will bill most insurance carriers and that all co-pay and deductible amounts are expected to be paid at the time of my appointment unless other arrangements have been made in advance. Should I have a balance for any reason after my insurance has processed the claim, a statement will be sent to me. **It will be my financial responsibility to pay this balance due.**

_____ Patients Initials

I understand that if my insurance company requires a referral, preauthorization or prescription, it is my responsibility to obtain this referral from my medical doctor prior to my appointment. I accept full responsibility of keeping track of the number of visits allowed and the number of visits used.

_____ Patients Initials

I have read and understand that if my insurance does not pay in full for the services provided by the health care providers in this clinic, I assume liability for the allowed unpaid portion within the confines of my policy.

_____ Patients Initials

I authorize the release of any medical records that might be necessary to facilitate payment of services and authorize the insurance company to make payments directly to the clinic and /or provider. It is understood that the providers within this office have access to each other's records without further authorization, and that may records may be released to other physicians directly involved in my care.

_____ Patients Initials

I also understand that it is my responsibility to fully understand my insurance benefits and that the benefits quoted to me by this office are based on information provided to **Bay Area Podiatry Associates** by my insurance carrier. I understand that **Bay Area Podiatry Associates** must abide by the rules governing my insurance coverage, but ultimately coverage is based upon, my contractual agreement with my insurance carrier. **All services are subject to medical necessity.** I further acknowledge that if it is requested of me, that I agree to assist my provider in obtaining the proper documentation and/or referrals from my primary medical provider to substantiate the medical necessity of my treatment in this office.

_____ Patients Initials

Signed: _____ Date: _____

Orthotic and Durable Medical Equipment Policy (DME) for Bay Area Podiatry Associates

Due to the changes within the insurance industry, effective immediately Bay Area Podiatry Associates is requesting that all patients sign a Orthotic and Durable Medical Equipment acknowledgement. The staff at Bay Area Podiatry Associates as a courtesy to you has verified your benefits. We verify orthotic and DME benefits on all patients in the event that you as the patient might have the need for Orthotics or Durable Medical Equipment. Even though we have verified your benefits this is not a **GUARANTEE of PAYMENT** by your **INSURANCE COMPANY**. Benefits are decided once your insurance has received our claim. You are responsible for all non-covered services, co-insurance and deductible amounts.

Orthotics are custom made for each patient. The fee for orthotics is **\$500.00**. Effective immediately we will be collecting **\$250.00** at the time of your scan for orthotics. Once our claim has been paid by your insurance company, any refunds will be issued. If the orthotics are deemed a non-covered benefit, you as the patient will be responsible for paying the other half of the balance on the orthotics. There will be no refunds for orthotics, as they are custom made and cannot be returned. Orthotics usually arrives 3 to 4 weeks after you have been scanned or casted.

There is a no refund policy on our durable medical equipment (can walker, night splint, etc.) Please make sure that your equipment fits and is comfortable before you leave the office. Once a product has been worn, it is considered used and we can no longer dispense this to another patient. You as the patient are responsible for any co-pays, co-insurance and deductible amounts.

I have read and fully understand the policies regarding orthotics and DME products. I understand that Bay Area Podiatry Associates is not responsible for non-payment from the insurance company. I understand that Bay Area Podiatry Associates can in no way, guarantee coverage. Benefits are determined by your insurance at the time your claim is processed. All benefit calculations are only an estimate, based on information obtained from your insurance company. The actual final Total Patient's Responsibility may be different than what was previously calculated by Bay area Podiatry Associates.

Printed Name: _____

Signature: _____

Date: _____