RIVERDALE FOOT, ANKLE & LEG CLINIC

PHARMACY INFORMATION!!!!

Patient Name: _____

(Nombre del Paciente)

Pharmacy

(Farmacia)

Name: _____

(Nombre)

Location: _____

(Ubicación)

Number: _____

(Numero)

For office staff use only:

*****Please list date, prescription, amount, RX sig. and name of whom you spoke with *****

Call-in prescriptions

Date	RX	Amount	Sig.	Name

2 Patient Medical History - Overview

What is your foot problem? _____

_____

_____

When did problem begin? Date: _____

Describe any accident/event: _____

_____

First visit to a Doctor for this problem? ❑ Yes ❑ No

Previous x-rays? ❑ Yes ❑ No If Yes, Date: _____

Where are they now? _____

Describe any previous treatment or home remedies?

_____

_____

_____

Height: _____ Weight: _____ Shoe Size: _____

How much are you on your feet at work?

❑ 20% ❑ 40% ❑ 60% ❑ 80% ❑ 100%

List any sports/activities: _____

_____

_____

Do you smoke? ❑ Yes ❑ No Packs/Day: ____Years: ____

Did you ever smoke? ❑ Yes ❑ No Packs/Day: ____Years:____

If you quit, how long ago? _____

Alcoholic beverages?

❑ None ❑ Rarely ❑ Moderately ❑ Daily ❑ Quit

Non Prescribed Drugs (not including over the counter)?

❑ None ❑ Rarely ❑ Moderately ❑ Daily ❑ Quit

What kind? _____

Have you been treated for:

❑ Low back pain	❑ Intoeing	❑ Heel pain
❑ Broken foot bone(s)	❑ Callouses	❑ Rash
❑ Hammertoes	❑ Neuroma	❑ Corns
❑ Ankle injury	❑ Knee pain	❑ Arch pain
❑ High arch feet	❑ Bunions	❑ Flat feet
❑ Ingrown nails	❑ Childhood foot problems	

Do you have or have you ever been treated for:

❑ Diabetes	❑ Anemia	❑ Blood disease
❑ Hepatitis	❑ Phlebitis	❑ Heart trouble
❑ HIV	❑ High Blood Pressure	

Are you slow to heal after cuts?	❑ Yes ❑ No
Any abnormal bruising or bleeding?	❑ Yes ❑ No
Any pain in calves or buttocks when walking?	❑ Yes ❑ No
Is the pain relieved by rest?	❑ Yes ❑ No
Do your feet hurt at night?	❑ Yes ❑ No
Currently taking any prescription medications?	❑ Yes ❑ No

List: _____

_____

Allergies to injection, oral or topical administration of:

Penicillin or other antibiotics?	❑ Yes ❑ No ❑ Don't Know
Narcotics?(Morphine, Codeine, Demerol...)	❑ Yes ❑ No ❑ Don't Know
Local anesthetics?	❑ Yes ❑ No ❑ Don't Know
Pain remedies?	❑ Yes ❑ No ❑ Don't Know
Adhesive tape?	❑ Yes ❑ No ❑ Don't Know
Any other drug, medication or treatment?	❑ Yes ❑ No ❑ Don't Know

If "yes" to any of the above, please explain: _____

_____

_____

Have you had a serious illness?	❑ Yes ❑ No
Have you been hospitalized or under lengthy medical care?	❑ Yes ❑ No
Have you had any surgery?	❑ Yes ❑ No

If "yes" to any of the above, please explain: _____

_____

_____

3 Patient Physicians

Family Physician: _____ Date last seen: _____

Phone: ( ) _____

City: _____ State: _____

Did your family Dr. or pediatrician refer you to us? ❑ Yes ❑ No

Specialist Dr:_____ Specialty: _____

Date last seen: _____ Phone: ( ) _____

City: _____ State: _____

Did your specialist Dr. refer you to us? ❑ Yes ❑ No

Previous Podiatrist: _____ Date last seen:_____

Phone: ( ) _____

City: _____ State: _____

Did your podiatrist refer you to us?	❑ Yes ❑ No
Did your Dr. send you for consultation?	❑ Yes ❑ No
Did your Dr. send you for a surgical evaluation?	❑ Yes ❑ No
Did your Dr. send for a 2nd opinion on surgery?	❑ Yes ❑ No
Did you independently come for a 2nd opinion?	❑ Yes ❑ No

4 Family History

Has any blood relative had:

		If "Yes," please indicate who
Tuberculosis?	❑ Yes ❑ No	_____
Cancer or tumor?	❑ Yes ❑ No	_____
High blood pressure?	❑ Yes ❑ No	_____
Heart trouble?	❑ Yes ❑ No	_____
Diabetes?	❑ Yes ❑ No	_____
Birth abnormalities?	❑ Yes ❑ No	_____
Arthritis?	❑ Yes ❑ No	_____
Stroke?	❑ Yes ❑ No	_____
Foot problems?	❑ Yes ❑ No	_____

Welcome To Our Office

Please Print

Patient Information

Date _____ Home Phone ____ _____

Last Name _____ First Name _____ Middle Initial _____ Sex M F

Street _____ City _____ State _____ Zip _____

Social Security # _____ Driver's License # _____ Age _____ Date of Birth __/__/__

Marital Status _____ Children? _____ Ages _____

Employer _____ Phone ____ _____ Ext. ____

Street _____ City _____ State _____ Zip _____

Occupation _____ May we call you at work? _____ Work Hours _____

Financially Responsible Party (If different from patient)

Home Phone ____ _____

Last Name _____ First Name _____ Middle Initial _____

Street _____ City _____ State _____ Zip _____

Social Security # _____ Driver's License # _____ Age _____ Date of Birth __/__/__

Employer _____ Phone ____ _____ Ext. ____

Street _____ City _____ State _____ Zip _____

Occupation _____ May we call you at work? _____ Work Hours _____

Insurance Information (If no card is available to copy)

Primary Insurer _____ Phone # ____ _____ Group # _____

Street(PO Box) _____ City _____ State _____ Zip _____

Insured's name _____ Insured's ID # _____

Secondary Insurer _____ Phone # ____ _____ Group # _____

Street(PO Box) _____ City _____ State _____ Zip _____

Insured's name _____ Insured's ID # _____

Spouse's Information (If appropriate)

Home Phone ____ _____

Last Name _____ First Name _____ Middle Initial _____

Street _____ City _____ State _____ Zip _____

Social Security # _____ Driver's License # _____ Age _____ Date of Birth __/__/__

Employer _____ Phone ____ _____ Ext. ____

Street _____ City _____ State _____ Zip _____

In Case of an Emergency

Who should be notified? _____ Relationship _____ Phone ____ _____

Who may we thank for referring you? _____

Please read and sign below: I directly assign all medical and surgical benefits to the doctor. I understand that I am financially responsible for all charges whether paid by my insurance provider or not. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that fees for service are payable at the time of service, unless other arrangements are made in advance. It is my responsibility to pay any deductible amount or co-insurance.

It is the policy of this office to bill your insurance for reimbursement. However, we shall allow no more than sixty (60) days for payment. After sixty (60) days you will be billed for any outstanding balance on your account. All outstanding balances are due thirty (30) days from the statement date.

I HEREBY GIVE AUTHORIZATION FOR TREATMENT. SIGNED _____

DATE _____

Riverdale
FOOT, ANKLE & LEG CLINIC, PC.
YOUR FIRST STEP TO RELIEF!

TERRY L. DICKERSON, D.P.M.

Office Policies

Financial Policy

1. *Proof of Insurance*:
   Payment is due at the time of service, which includes applicable co-pays, deductibles and co-insurance. Please bring your insurance card(s) with you to every appointment. It is your responsibility to inform the front desk when the cause for treatment should be billed to a liability insurance company or worker's compensation instead of your regular primary insurance. Verification of benefits is required. If benefits are unable to be verified, you are responsible.

2. *Payment is due at the time of service*:
   We accept cash, personal check, debit and credit cards. All deductibles, co-pays, and non-covered services are due at the time of service unless payment arrangements have been made in advance. Patients are also entitled to receive copies only of original x-rays for an at cost fee with payment due upon copy request. If you have Medicare but Medicare may deem the treatment as "medically unnecessary" according to the Centers for Medicare and Medicaid Services (CMS) payment guidelines, you will be required to sign a waiver (advanced beneficiary notice) prior to treatment, and the service is due at the checkout counter. All Medicare patients will be required to pay at the checkout counter the 20% co-pay based upon the current Medicare Fee Schedule unless proof of a secondary policy is evident. Pre-determined co-pays are due when you check in for your appointment. If your co-pay is based on a percent (example 20% is patient's responsibility) and you do not have a secondary policy, please be prepared to pay. Insurance claims are filed as a courtesy; you are ultimately responsible for the rendered services. **If the insurance balance has not been paid within 90 days, the balance may be released to you.**

3. *Our responsibility to report to noncompliance*:
   It is our obligation under many of the managed care contracts to report patients who repeatedly refuse to pay co-pays and deductibles at time of service or who are repeatedly "no show" for appointments. Please know that if you are reported, you could possibly lose your health care benefits. Contact human resources with your employer for further clarification of your benefits and obligations.

4. *Financial Assistance:*
   Our office treats patients regardless of financial status. If you have no insurance, have maximized your benefits, have a high deductible or you are currently medically or financially indigent, but not eligible for Public Assistance or Medicaid, please ask to speak to the Office Manager.

Cont'd. on Back– Please Sign

5. *Billing, Payments, and Over Payments:*
   If an over payment is made by you on the account, a refund will be issued in a timely fashion only if there are no other outstanding debts on the other accounts containing the same guarantor or financially responsible party. Patient balances unforeseen at time of service will be billed to the address you have provided for billing purposes. It is your responsibility to inform us of any changes in address, phone, or employment. All balances are due in full within 14 days of the billing date. Our practice has a $15.00 returned check fee.

6. *Past Due and Delinquent Accounts:*
   Failure to meet your financial obligations may result in our reporting of you to our contracted collection agency who in turn may report you to the credit bureau, filing for a judgment in small claims court or other collection action against you, and you may be terminated as a patient from this facility. All attorney fees, court costs and other expenses related to collecting your account will be added to your outstanding balance.

7. *Professional Courtesy Policy:*
   There will be a zero tolerance to "professional courtesy" extended to any office staff, members of the physician's family, friends, colleagues, clients, patients or referrals. The purpose of this policy is to be compliant with the Civil False Claims Act and the Anti-Kickback Statutes when making writeoffs, adjustments, discounts and no charges.

Our Physicians require you to direct all financial concerns to the Administrative Staff.

I understand and agree that I am absolutely responsible for the balance on my account for professional services rendered.

Patient's Rights Policy

You have privacy rights under a federal law that protects your health information. These rights are important for you to know. You can exercise these rights, ask questions about them, and file a complaint if you think your rights are being denied or your health information isn't being protected. Please review the Patient's Bill of Rights and the Privacy Notice on the New Patient clipboard along with the patient data forms. Copies are available upon request.

Your printed name and signature below indicate that you have read and or acknowledged the Financial and Patient's Rights Policies of the Riverdale Foot, Ankle & Leg Clinic, P.C.

_____ _____

SIGNATURE OF RESPONSIBLE PARTY DATE

_____ _____

PRINTED NAME OF RESPONSIBLE PARTY DATE