QUALITY FOOT CARE

WELCOME TO OUR OFFICE

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

Last Name	First	Middle Initial	Name preferred

Spouse's Name, Parents' or Guardian's Name if a Minor	Patient's Date of Birth	Age	Sex: ☐M ☐F

Residence Address	City	State	Zip Code

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced ☐ Partnered	Social Security #

Race: ☐Amer. Indian/Alaskan ☐Pacific Islander ☐White ☐Black ☐Asian ☐Native Hawaiian	Ethnicity: ☐ Hispanic ☐ Non-Hispanic	Primary Language: ☐English ☐Spanish ☐Other: _____

Home Phone	Cell Phone	Email

Business Phone	Name of Employer	Occupation

Preferred Method of Contact: ☐Phone ☐Mail ☐Email ☐Fax #:_____	How did you find out about our office?

Name and address of Primary Care Doctor	Phone Number

Name, address and phone of your Emergency Contact	Relationship

If other than patient, name and address of person responsible for this account	Relationship

Do you have a healthcare power of attorney? ☐ Yes ☐ No Do you have a living will? ☐ Yes ☐ No	Name of Healthcare Power of Attorney

Address and Phone Number of Healthcare Power of Attorney	Relationship

Name and Location of the Pharmacy You Use (not mail-order)

I hereby give Dr. Lefkowitz/Dr. Kaplan permission to examine and treat my feet. I authorize use of these forms on all my insurance submissions. I authorize release of information to all my insurance companies. I understand that I am responsible for 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_____

INITIAL CLINICAL HISTORY AND PHYSICAL FORM

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 it alter your job? □ Yes □ No

If yes, explain:_____

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

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

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
I currently live in: □ a house □ an apartment □ a mobile home □a condo □ a retirement facility

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

_____
_____
_____
_____

Females: Are you currently pregnant? □ Yes □ No Date of last menstrual period _____

Patient's General Health History: Do you have or have you had any of the following? (Circle please).

Diabetes	Alzheimer's	Hemophilia	Anemia	Gout
Hypertension	Fibromyalgia	Hepatitis C	Osteoporosis	Rheumatoid arthritis
Heart Disease	Stroke	Kidney disease	Back pain	Osteoarthritis
PVD or PAD	Epilepsy	GERD	COPD	Hypothyroidism
High cholesterol	Polio	Rheumatic fever	Bursitis	Phlebitis
Angina	Stomach ulcers	Depression	Seasonal allergies	HIV/Aids
Varicose veins	Asthma	Anxiety	Cancer, type:_____	

List all other chronic illnesses not included above:

Your *Family* History (circle any that your blood-related parents, siblings or children have had.)

Cancer, list types:				Heart disease	High cholesterol	
Depression	Alcohol abuse	Diabetes	Hypertension	Kidney disease	Stroke	Gout

Review of Systems: Circle any that apply.

NOSE/MOUTH/THROAT	EYES	IMMUNOLOGIC	ENDOCRINE
Nasal congestion	Pain	Sneezing	Excessive sweating
Nasal discharge/bleeds	Discharge	Watery eyes	Excessive thirst
Post nasal drip	Light sensitivity	Itching	Feel too hot
Sore throat	Blurred vision	Clear nasal discharge	Feel too cold
Oral lesions	Changes in vision	Recurrent infections	

CONSTITUTIONAL	CARDIOVASCULAR	GASTROINTESTINAL	GENITOURINARY	NEUROLOGICAL
Weight gain	Chest pain	Abdominal pain	Urinary frequency	Headache
Weight loss	Fainting	Heartburn	Urinary hesitancy	Confusion
Fatigue	Swelling of feet	Vomiting	Incontinence	Numbness
Weakness	Palpitations	Diarrhea	Painful urination	Slurred speech
Fever	Cramping in legs	Blood in stool	Blood in urine	Gait instability
Chills		Constipation	Flank pain	Seizures

MUSCULOSKELETAL	EARS	SKIN/BREAST	PSYCHOLOGIC	BLOOD/LYMPHATIC
Joint swelling	Hearing loss	Rash/itching	Anxiety	Bleeding tendencies
Joint redness	Discharge	Sores	Depression	Lymph node swelling
Joint pain	Ear pain	Lumps	Severe stress	Easy bruising
Muscle pain	Ear ringing	Discharge		

Foot and Leg History: Circle any that apply.

Foot/leg injuries	Foot/leg cramps	Foot/leg numbness	Knee pain	Unequal leg length
Weak ankles	Bunions	Foot skin problems	Toe nail problems	Low back pain

Allergies: □ None known □ Adhesive tape □ Iodine □ Penicillin □ Novocaine □ Oak/Oak pollen

List all other allergies (include description of reaction):

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING

Include all prescription, over-the-counter medications, herbal supplements and medications taken only when needed (ex nitroglycerin).

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

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 it is my responsibility 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

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

I understand that as part of my healthcare Quality Foot Care originates and maintains health records describing my health history, symptoms, examination and 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 reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've 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 is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the practice has already take action in reliance thereon.

I will allow the disclosure of my health information to:

Messages on my home telephone answering machine or voice mail: yes_____ no_____

Relatives: _____

Signature of patient or authorized representative _____

Birthdate: _____Date of consent: _____

This practice maintains patient sign in sheets that are visible and accessible to patients, staff, and others who may enter this office...

QUALITY FOOT CARE
FINANCIAL POLICY

Thank you for choosing Quality Foot Care 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 lasting relationship as your primary health care provider. 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 with 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.*** Please review and sign the following financial policy prior to your office visit.

I) CO-PAYMENTS, DEDUCTIBLES, AND FEES — **All co-payments, insurance deductibles, and fees for services not covered by your insurance policy are due at the time service is rendered.** We accept CASH, CHECK, MONEY ORDER, or CREDIT CARDS (VISA, MASTERCARD ONLY).

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 if your insurance pays the claim, at a later date. If your insurance carrier is not one with which we participate, you are responsible for payment in full. Insurance plans and Medicare considers some services to be "non-covered," in which case you are responsible for payment in full. According to NC Statute 58-22253, insurers are required to pay a properly submitted claim within 30 days. You have a responsibility to provide information to our office so a claim can be properly submitted. **If your insurance company has not paid a claim on your behalf within 90 days because of information that 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.

3) MINORS AND DEPENDANTS — Parents and guardians are responsible for payments for their dependants 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 cancelled at least 24 hours in advance, our policy is to charge for missed appointments.** The fee for a missed appointment is **$35**. 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 billing 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 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