PODIATRY GROUP

Patient's Full Name _____ Male Female Age_____

Social Security #____ - ____ - _____ Occupation _____ Date of Birth ___/___/_____

Address _____ Your best contact phone number? (Check one)

_____ Cell _____ Home _____ Work _____

City/State/Zip_____ Home Phone (_____)_____-_____

Work Phone (_____)_____-_____

Cell Phone (_____)_____-_____

Emergency Contact:

Name: _____ Relationship to you: _____

Home: (_____)_____-_____ Cell: (_____)_____-_____ Work: (_____)_____-_____

Current Height_____ Current Weight_____ Current Shoe Size_____

Allergies

Please CHECK OFF any medication, food or environmental factor that you are allergic to and the reaction you have to checked allergy.

NO KNOWN ALLERGIES Reactions: ___ Nausea/vomit ____Itching ____Hives ____ Difficulty Breathing

___ penicillin ___sulfa drugs (Bactrim) ___amoxicillin ___keflex ___clyndamycin ___cipro ___asprin

___iodine and/or betadine/shellfish ___ibuprofen ___celebrex ___cortisone ___percocet ___vicoden

___demerol ___phenergan ___tape other_____

Medication: (Regulations Require a List or Copy and Dosage of Your Medications)

*GIVE OUR RECEPTIONIST YOUR MEDICATION LIST TO COPY FOR YOUR ELECTRONIC MEDICAL RECORD OR LIST ON FOLLOWING ATTACHED MEDICATION FORM

PHARMACY NAME AND PHONE NUMBER:

_____

FAMILY/PRIMARY CARE PHYSICIAN NAME: _____ PHONE NUMBER: (_____)_____-_____

DATE OF LAST VISIT:____/____/_____ (*Diabetics must have been seen by a physician within 6 month of care)

Medical History:

Check any of the following you currently have or have had a problem with in the past:

___Anemia
___Arthritis
___Mitral Valve Prolapse
___High Blood Pressure
___Cancer-type:_____
___Diabetes- Insulin Dependent
Last blood sugar test & reading_____
___Gout
___Asthma
___High Cholesterol
___History of Blood Clots
___Congestive Heart Failure
___Diabetes- Non-Insulin Dependent
___Kidney Disease
___Hepatitis
___Neuropathy
___HIV
___Thyroid Disorder
___Joint Replacement
Hip (___L and/or ___R)
Knee(___L and/or ___R)

Other Medical History:_____

Surgical History:

Please CHECK any major surgeries you have had:

___EYES ___TONSILS ___THYROID ___HEART ___STOMACH ___APPENDIX ___GALLBLADDER ___HERNIA
___BREAST ___WRIST ___SHOULDER ___KNEE ___FOOT OTHER_____

Social History:

Do you smoke?	Yes	No	If yes, how many packs/day?___ # of years___ QUIT how many years ago?____
Do you drink alcohol?	Yes	No	If yes, amount and frequency:__social__Moderate &Type:__Beer__Wine__Liquer__All

Family History of Disease(CHECK OFF)

MOTHER: ___ALIVE/___DECEASED FATHER: ___ALIVE/___DECEASED

CIRCLE "F" FOR FATHER OR "M" FOR MOTHER

F / M HEART DISEASE F / M DIABETES F / M CANCER F / M KIDNEY DISEASE F / M STROKE

CURRENT PROBLEM LIST/ REVIEW OF SYMPTOMS: CHECK HERE:_____ If you have NO CURRENT MEDICAL SYMPTOMS BELOW.

ALERTNESS:	___chills	___night sweats	___dizziness	___fever	___tired
EYES:	___blurred vision	___blind			
EARS, NOSE, MOUTH, THROAT:	___ringing in ears	___sinus congestion	___hearing difficulty	___trouble swallowing	
CARDIOVASCULAR:	___chest discomfort	___palpitations			
RESPIRATORY:	___difficulty breathing	___shortness of breath	___sleep apnea	___snoring	
GI:	___nausea	___vomiting	___abdominal pain	___blood in stool	
GU:	___painful urination	___blood in urine	___frequent urination		
MUSCULARSKELETAL:	___neck	___back	___knee	___muscle pain	
INTEGUMENTARY:	___dermatitis	___eczema	___psoriasis	___rash	
NEUROLOGICAL:	___numbness in feet	___numbness in legs			
PSYCHIATRIC:	___anxiety	___depression			
ENDOCRINE:	___fatigue	___rapid weight loss			
HEMOATOLOGIC/LYMPHATIC:	___leg swelling	___foot swelling			
ALLERGIC/ IMMUNOLOGIC:	___gout	___osteoarthritis	___rheumatiod arthritis		
	___other_____				

RICHARD A. MYERS JR., DPM PODIATRY GROUP

Consent of Assignment of Benefits and Treatment

I certify that me or my dependents have insurance coverage with the named carrier on file and hereby authorize the release of all medical information necessary to process insurance claim(s). I hereby assign and authorize direct payment of all medical and/or surgical benefits, including major medical, private insurance and other health plans to Dr. Richard A. Myers Jr., DPM. The above named practice, its agents, and assigns may use my health care information and may disclose such information to the named insurance company (companies) on file and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I grant permission for the above named doctors and their assistants to render care in the diagnosis and or treatment of my foot conditions and release related information to my physician and or emergency medical personnel and as required by law.

This Assignment will remain in effect until revoked by me in writing. A signed photocopy of this Assignment will be considered as valid as an original.

Signature of Responsible Party X_____ Date_____/_____/_____

Print Name _____

Patient Name (if different from responsible party) _____

Acknowledgement of Receipt of Financial Policy

I acknowledge that I have read and understand the Financial Policy. I understand that Dr. Richard A. Myers Jr., DPM is not ultimately responsible for collecting from my insurance or negotiating settlement of claims.

I understand the financial policies and accept responsibility for payment of any balance owed on my account. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature of Responsible Party X_____ Date_____/_____/_____

Print Name _____

Patient Name (if different from responsible party) _____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices. I have read and understand the notice. By signing this form, I am consenting Dr. Richard A. Myers Jr., DPM to disclosure of my Personal Health Information (PHI) to carry out Treatment, Payment and healthcare Operations (TPO).

Signature of Responsible Party X_____ Date_____/_____/_____

Print Name _____

Patient Name (if different from responsible party) _____

FINANCIAL POLICY

As insurance coverage decreases and the patient's financial responsibilities increases, we understand the need for clear communication of our financial policies. To better service the needs of our patients, we have added valuable tools to help you meet your increased medical expenses.

1. We will continue to look to insurance companies for their payment, and assist you in receiving proper reimbursement for our services. Unfortunately, most insurance no longer cover services fully and most current insurance plans chosen by our patients require significant out-of-pocket expenses to be paid by the patient.
2. Our staff has been trained to be able to communicate with you and answer your questions regarding payment and insurance reimbursement.
3. It is your responsibility to verify that all requirements of your insurance plan are met. We will assist you with pre-certification for procedures ordered by our office, but it is ultimately your responsibility to verify whether any care you receive is covered by your insurance plan. This office is not responsible for the expense of treatment or service, which is not paid by your insurance. With continuous changes in coverage, it is important for you to verify your benefits and be aware of all restrictions and expenses of your plan.
4. In accordance with the requirements of most insurance contracts, we will require payment of office co-payments at the time of service. Any person being seen for treatment or service will be required to pay the necessary co-payment at the time of service. Your insurance company will be notified when this contractual payment is not paid at the time of the appointment.
5. For patients owed balances, we will offer credit card, debit cards and payment plans to assist you in meeting your financial obligations to our office. You must advise us of any payment you receive from insurance or any third party for our services and forward this amount to our office immediately.
6. If we are a contracted provider on your insurance plan, we will file a claim with your carrier and you will be billed when they have responded to our claim. Upon receipt of their response, payment or denial, you will receive a statement for the amount your insurance company notifies us is your responsibility.
7. If Dr. Myers is not a contracted provider for your insurance plan, we will file a claim with the information you provide and you will be billed when they have responded to our claim. You will receive monthly statements and we will look to you for payment. You will be responsible for working with your insurance company to insure prompt payment.
8. If you do not have a current insurance card with you, your will be billed for the entire amount and asked for payment at the time of service. It is your responsibility to give us your card at each visit (if requested). We will not be able to file your insurance without a copy of your card.
9. If you have an insurance plan that requires a referral, we will require that the referral be received in our office before we can see you. We will do our best to assist you in obtaining the referral, but to expedite matters it is best for you to contact your primary care physician and have them fax the referral over to us or bring the referral in with you.

NOTICE OF PRIVACY PRACTICES

I hereby give consent to Dr. Richard A. Myers Jr., DPM to use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment and healthcare Operations (TPO).
I have the right to review the Notice of Privacy Practices prior to signing the consent. Dr. Myers, DPM reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Podiatry Group, at 122 5th Ave. Suite A, McComb, MS 39648.
With this consent, Podiatry Group may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others. However, our policy is not to leave detailed messages regarding Protected Health Information or anything related to treatment, payment or healthcare operations.
With consent, Podiatry Group may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.
With this consent, Podiatry Group may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.
I have the right to request that Podiatry Group restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.
I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Podiatry Group may decline to provide treatment.