WESTWOOD FOOT CLINIC

(Please Print Legibly)

NAME_____
(FIRST) (MI) (LAST) (NAME YOU LIKE TO BE CALLED)

ADDRESS_____ APT #_____

CITY_____ STATE_____ ZIP_____

DATE OF BIRTH_____ AGE_____ SOCIAL SECURITY #_____

PHONE: HOME_____ WORK_____ CELL_____

BEST PHONE TO CONTACT YOU: ___HOME ___CELL ___WORK

PATIENTS EMPLOYER_____ OCCUPATION_____

MARITAL STATUS_____ E-MAIL_____

PERSON TO CONTACT IN CASE OF EMERGENCY_____

RELATIONSHIP_____ CONTACT PHONE_____

<u>**PLEASE PRESENT INSURANCE CARD(S) TO RECEPTIONIST**</u>

PRIMARY INSURANCE_____

Name Policy Listed Under_____ Date of Birth_____

SECONDARY INSURANCE_____

Name Policy Listed Under_____ Date of Birth_____

<u>ASSINGMENT OF BENEFITS</u>: I HEREBY AUTHORIZE PAYMENT OF MEDICAL INSURANCE BENEFITS TO THOMAS E. SILVER, D.P.M. I ALSO AUTHORIZE THE RELEASE OF ANY MEDICAL RECORDS OR OTHER INFORMATION NECESSARY TO PROCESS MY CLAIMS.

SIGNATURE_____ DATE_____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

WESTWOOD FOOT CLINIC

INFORMATION TO HELP THE DOCTOR EVALUATE YOUR FOOT PROBLEM

(please print)

NAME: _____ DATE: _____

MY CURRENT PROBLEM IS; (INCLUDE LOCATION)_____

_____

_____

_____

IT HAS BEEN A PROBLEM FOR: (APPROXIMATELY) _____
Weeks Months Years

IF CAUSED BY INJURY, STATE HOW IT HAPPENED: _____

_____

_____

WHAT CARE HAVE YOU ALREADY HAD FOR THIS PROBLEM? _____

_____

_____

_____

LIST ANY OTHER SIGNIFICANT LOWER EXTREMITY PROBLEMS (FOOT, ANKLE, KNEE, LEG OR HIP) CURRENT OR PAST OR ANYTHING ELSE RELATED TO YOUR CURRENT PROBLEM:

_____

_____

_____

_____

WESTWOOD FOOT CLINIC

HEALTH QUESTIONNAIRE

NAME: _____ DATE: _____

PLACE A CHECK NEXT TO ANY OF THE FOLLOWING THAT APPLY:

___ DIABETES	___NEUROLOGICAL PROBLEMS/DISEASE
___ HIGH BLOOD PRESSURE	___ EPILEPSY
___ LOW BLOOD PRESSURE	___ DIZZINESS
___ HEART PROBLEMS	___ BACK PROBLEMS OR INJURIES
___ STROKE	___ NEUROPATHY-NUMB/BURNING FEET
___ STOMACH ULCER	___ SKIN PROBLEMS
___ LIVER PROBLEMS	___ SCARRING PROBLEMS OR KELOIDS
___ KIDNEY PROBLEMS	___ INFLAMMATION OR CLOT IN LEG VEIN
___ CIRCULATION PROBLEMS	___ SWELLING (EDEMA) IN FEET OR ANKLES
__ BLEEDING PROBLEMS/ANTICOAGULANT	___ JOINT REPLACEMENT__KNEE __HIP L_ R_
___BLOOD DISORDERS	___ FOOT OR ANKLE ULCER
___ EYE PROBLEMS	___ FOOT/ANKLE/LEG FRACTURE: R__ L__
___ UNDER PSYCHIATRIC CARE	___ PRIOR FOOT/ANKLE SURGERY R__ L__
___ RESPIRATORY PROBLEMS	___ CIGARETTE SMOKER: ____ /DAY
___ OSTEOARTHRITIS	___ ALCOHOL: ____DRINKS/DAY__ WK__ MO__
___ RHEUMATOID ARTHRITIS	___ OTHER:
___ GOUT	___ OTHER:

IF NECESSARY, DESCRIBE ANY PARTICULAR HEALTH PROBLEM(S) IN GREATER DETAIL:

_____

_____

PRIMARY CARE PHYSICIAN_____ LOCATION: _____

DATE OF LAST VISIT _____ REASON FOR VISIT: _____

ARE YOU CURRENTLY UNDER A DOCTORS CARE FOR ANY REASON? ___YES ___NO

IF YES, REASON: _____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: (skip if you have a list, too many to write or don't know):

_____

_____

PLEASE CHECK (OR LIST) ALLERGIES TO ANY MEDICATIONS OR OTHER SUBSTANCES:

___ ADHESIVES/TAPES	___ NARCOTICS	___ PENICILLIN
___ ASPIRIN	___ NOVACAINE/ANESTHETICS	___ IODINE
___ CODEINE	___ LATEX	___
___	___	___

RECENT OR SIGNIFICANT SURGERY OR HOSPITALIZATION: _____

_____

*FEMALES OF CHILDBEARING AGE: ARE YOU CURRENTLY PREGNANT OR NURSING? __Y __N

Westwood Foot Clinic

NOTICE OF PRIVACY PRACTICES

HIPAA (HEALTH INFORMATION PORTABILITY & ACCOUNTABILITY ACT)
(Effective January 1, 2018)

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

All heath information we receive from you is considered "protected health information" and may not be used by this clinic for any other purpose other than for your health care, except as required by law.

This office may need to contact you or your household to provide appointment reminders, treatment information or follow-up, regarding insurance information or payment on a bill. We will do our utmost to be confidential regarding these phone calls or emails and will not give out any information to anyone who is not initially identified by this office or authorized by you to receive information. You may request that we restrict or deny disclosure of "protected health information" about you to family members and others involved in your care.

The privacy requirements limit the release of your "protected health information" without your knowledge and consent beyond that required for your care.

For disclosure of "protected health information" by us to another provider, such as your physician, a referred physician, physical therapist, for medical testing, for insurance company or attorney review, the release of information must be authorized by you, and the amount of information disclosed will be restricted to the minimum amount necessary to accomplish the intended purpose.

We may access information from your insurance company that is reasonably necessary to provide care and receive payment from the insured.

We will not use, disclose or request any medical record except when this record is specifically justified and reasonably necessary to provide health care for you.

After reading, please sign to acknowledge that you reviewed and/or received this information

Signature of patient or responsible party: _____

Printed name: _____

WESTWOOD FOOT CLINIC'S FINANCIAL POLICY

IF YOU HAVE INSURANCE: we will need a copy of your card at each visit. Please let us know of any coverage changes. If you do not have an up-to-date insurance card, payment will either be required at the time of your visit until we can verify your coverage or treatment will be postponed until you return with a current card.

IF YOU DO NOT HAVE INSURANCE OR INSURED BY A PLAN WE ARE NOT A PROVIDER WITH: then payment in full for services provided is expected at each visit. We also require a copy of your current driver's license or photo ID and a copy of a current credit or debit card. There is an additional 2% Minnesota Care Tax on all non-insurance services provided.

CO-PAYS AND DEDUCTIBLES: All visit co-payments are required to be paid at the time of service. If you are concerned about being able to pay a large deductible, please let us know prior to treatment, so payment arrangements can be made. A copy of a current credit card is required for us to keep on file to apply to your un-met deductible once we hear from your insurance company.

NON-COVERED SERVICES/DISPENSED ITEMS: Some services or dispensed items may not be covered by your insurance carrier. We will let you know if something is not covered & payment will be required at the time of service. Non-covered services may include the routine trimming of corns, nails and/or calluses. Non-covered dispensed items may include pre-fabricated or custom-made foot orthotics, splints, braces, surgical/trauma shoes, cast boots, shoes, socks, creams or pads. Certain custom-made or special order Items may require a deposit. There is an additional 2% Minnesota Care Tax on all purchased items or non-covered services.

REFERRALS: Some managed care plans mandate that you get a referral from your primary care physician prior to seeking care with any specialist. Therefore if a referral is necessary this must be presented at the time of the visit or you will be financially responsible for the services received. If you don't have a referral with you then we may have to reschedule your visit for another time when a referral is issued. Some plans also have limitations on the specific care you can receive from us.

PATIENT STATEMENTS/BILLING: Invoices on any balances are sent out every 30 days. Your prompt payment will assist us in keeping down the cost of your care. Please contact us regarding any questions on your statement or to arrange a payment plan. We will do everything we can to help make your care affordable but will need to hear from you if there is a payment problem or concern or question about a bill.

METHODS OF PAYMENT: CASH, CHECK, VISA, MASTERCARD, DISCOVER OR AMERICAN EXPRESS. A $25 fee will be assessed on all returned or NSF checks. If we have not heard from you regarding any balance after your 3nd statement is sent out and have not been able to contact you, then your account will be forwarded to a collection agency or small claims court. In this case, you will be responsible for collection costs (up to 29% of the balance) along with any additional attorney or court costs incurred.

REFUNDS/RETURNS: Any refunds will be issued to you within 30 days. Purchased products must be returned before a refund can be made.

I have read and understand the payment policy and agree to abide by it:

Signature of Patient or Responsible Party: _____

Printed Name: _____ Date: _____