Community Foot Clinic of McPherson LLC

Medical Form

Today's Date: _____/_____/_____

Patient Name: _____

Date of Birth: _____/_____/_____ Age _____ Height _____ Weight _____ Shoe Size _____

Family Physician: _____ Date Last Seen: _____/_____/_____

My foot problem involves my (Please Circle): RIGHT LEFT BOTH

Please describe your foot problem: _____

Duration of problem: _____

Was this due to an injury? YES NO - If yes, place of injury? HOME WORK OTHER Date of Injury ___/___/___

CURRENT AND PAST HEALTH CONDITIONS – PLEASE CIRCLE CURRENT CONCERNS

Diabetes	Heart disease	Kidney disease	Bleeding disorder
-insulin dependent	Epilepsy	Fainting spells	Polio
-oral medication	Liver Disease	Anemia	Blood disorder
-diet controlled	Varicose Veins	Stomach ulcers	Osteoporosis
Rheumatic fever	Bursitis	Blood Clots	Nerve disorder
Hepatitis	High Cholesterol	Arthritis	Sciatica
High Blood Pressure	Asthma	Cancer _____	HIV/AIDS
Prone to Infection	Gout	Vascular disease	Fibromyalgia
Thyroid disorders	Neuropathy	Circulation issues	Other _____

PLEASE LIST ALL SURGERIES: _____

_____

Do you have any joint replacements? Y or N Are you pregnant or nursing? Y or N

Do you smoke or have a history of smoking? Y or N Do you use any recreational drugs? Y or N

Do you use alcohol? Y or N Are you being treated for any chronic conditions? Y or No

ALLERGIES:
Please circle:

Novocaine Aspirin
Penicillin Ibuprofen
Sulfa Latex
Codeine Other _____

MEDICATIONS:
Please list all current medications below, or provide us with a current list

_____
_____
_____
_____

Community Foot Clinic of McPherson

Thank you for choosing our office! In order to serve you properly, we need the following information. Please print. All of your information will be confidential.

Patient Registration

Name:_____ SS#:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Marital Status: Married___ Single___ Divorced___ Widowed___ Domestic Partner___

Date of Birth: ___/___/___ Age:____ Phone #:_____ Cell:_____

E-mail Address: _____

Emergency Contact:_____ Phone #:_____

How were you referred? Internet__ Newspaper__ Patient__ Radio__ Phone Book__ Other__

Primary Care Physician:_____ Phone #:_____ Date Last Seen:__/__/__

Preferred Pharmacy:_____ Phone #:_____

Patient Employer Information

Employer Name:_____ Occupation:_____

Insured Person (Main Subscriber, if not the patient)

Name:_____ Phone #:_____

Address:_____ City:_____ State:_____ Zip Code:_____

Date of Birth:___/___/___ SS#:_____ Relationship to Patient:_____

How would you prefer to be contacted? Home___ Cell___ Email___

Acknowledgment of Receipt of Notice of Privacy Practices and Privacy Statement

I understand that it is **my responsibility** to inform the doctor's office if there is a change in my health insurance information and acknowledge I was provided with a copy of the Notice of Privacy Practices and understand and accept its terms:

Any information disclosed in your records will remain confidential and will not be used for any other reason except in providing quality care and treatment as well as to submit your claim to your insurance company and contact you as needed.

_____ _____

Patient Name (please print) Date

_____ _____

Parent or Authorized Representative Signature

Assignment of Benefits

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to **Trent J. Timson, D.P.M,** all insurance benefits, payable for services rendered. I certify that the information I have reported with regards to my insurance coverage is correct. I understand that I am responsible for payment of co-payments, non covered services and other fees at the time of service. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize Release of Medical Information to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

Print Patient Name:_____ Signature:_____

Financially Responsible Party:

Print Name:_____ Signature:_____

Relationship to Patient:_____ Date:_____

Trent J. Timson, D.P.M.

Community Foot Clinic of McPherson

316 W. 4th. St.

McPherson, KS 67460

Phone (620)241-3313 Fax (620)241-6967

Welcome and thank you for choosing this office for you Podiatric and foot care needs. In our continuing effort of provide personalized patient care in the most efficient and economical manner possible, we ask that you take a few moments to read our Financial Policy and fill out our medical history form to bring with you to your appointment. If at any time you have a question regarding our office policies or the attached form, please do not hesitate to call.

Your clear understanding of our Financial Policy is important to our professional relationship. We are a Medicare provider and are also members of various insurance plans and several PPOs and HMOs. It is *your responsibility* to make sure we are on your insurance plan. If your insurance requires a referral of prior authorization, it is *your responsibility* to make sure that this is in place prior to your appointment. We will be glad to help if we can.

We will be happy to bill your insurance company as a courtesy to you. If you have a secondary insurance company, we will bill them only **one time.** If your secondary insurance does not pay the balance due, the balance will be billed to you and will be due at that time.

BALANCES/COLLECTIONS FEES: If balances due are not paid within 30 days from statement date, an **additional fee of $12.00** will be added to your account to cover the cost of rebilling. You will be sent up to **four notices** for your financial responsibility (co-insurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. A *rebilling fee* will be added for each statement generated after the first initial statement. After the fourth and last notice, your account will be forwarded to our collection service. If your account is sent to our collections service, a **35% fee** will be added to your account. You bear complete financial responsibility for any fee(s) incurred.

Complete payment for all podiatric soft goods, supplies and medications are due on the date these supplies are issued. Non-emergency supplies will not be issued unless these charges are paid for in full.

A 24-hour notice is required for cancellation of appointments. If you fail to show for your appointment, you may be charged $25.00 for your missed appointment. Your insurance company *does not* cover this. We will try to accommodate you in rescheduling your appointment as soon as possible.

I have read the above policy regarding *my financial responsibility* to Trent J. Timson, D.P.M. for medical services provided. I agree to pay Trent J. Timson, D.P.M any balance unpaid by my insurance carrier for myself or the below named person.

Print Patient Name:_____ **Signature:**_____

FINANCIALLY RESPONSIBLE PARTY:

Print Name: _____ **Signature:**_____

Relationship to Patient:_____ **Date:**_____