Gentle Foot Care

Treatment & Surgery of the Foot and Ankle

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Steven Grossman, D.P.M.

Date:_____/_____/_____

Patient Name _____ Date of Birth _____ Age ____ Sex: M☐ F☐

Home Address_____ SSN: _____

City _____ State _____ Zip code _____

Home Phone _____ Preferred: Home ☐ Cell ☐

Cell Phone _____ Email _____

Primary Language _____ Ethnicity _____

Do you have a legal guardian or Healthcare Power of attorney? Yes ☐ No ☐

If Yes, NAME _____ Relationship_____ Phone Number _____

Emergency Contact _____ Relationship _____ Phone Number _____

Primary Care Physician Name_____ Phone Number _____

How were you referred to us? _____

Pharmacy Name _____ Phone Number _____

Address _____

Who is responsible for payment? _____

Occupation _____ Employer _____

Is there a family member or other person you would like for us to share your medical information?

Yes ☐ No ☐ Name_____ Relationship _____

What is the reason for your visit today? _____

Are you diabetic? ☐ Yes ☐ No *** If yes, Name of doctor treating your diabetes**: _____

Family History Do you have a family history of: Family Member (example: Mother, Father, Sister, Brother)

- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ High blood pressure
- ☐ Stroke
- ☐ Rheumatoid Arthritis
- ☐ Other

Allergic to: None ☐

Medications ☐ _____

Anesthesia☐ _____

Foods☐ _____

Other☐ Tape ☐ Latex ☐ Shellfish ☐ Iodine ☐ Other ☐_____

Review of Systems: Please note or write in any symptoms that apply to you currently

Constitutional	Nausea ☐ Recent Illness ☐ Fever☐ Chills ☐ Night sweats ☐ Anorexia☐ Fatigue ☐ Insomnia ☐ Weight loss/gain☐
Eyes	Visual changes ☐ Cataract ☐ Glaucoma ☐ Discharge ☐ Injuries ☐ _____ Glasses or contacts ☐
Head, Ears, Nose, Throat	Head Injuries ☐ Headache ☐ Dizziness ☐ Difficulty with Hearing ☐ Pain☐ Discharge ☐ ear Infections ☐ Ventilation Tubes☐ Sinus ☐ congestions ☐ Sore throat ☐ Discharge☐ Difficulty in swallowing ☐ Dental defects ☐ Swollen glands ☐ Masses☐
Lungs	Shortness of breath ☐ Ability to keep up with peers☐ cough ☐ Wheezing☐
Heart	Cyanosis ☐ Arrhythmia ☐ Edema ☐ Heart murmurs ☐ Heart Trouble☐ Pain over heart☐
Gastrointestinal	Nausea ☐ Vomiting ☐ Abnormal bowel movements ☐ Abdominal pain ☐ Jaundice ☐ Reflux☐
Genitourinary	Hematuria ☐ Urethral or vaginal discharge ☐ Sores ☐ Pain ☐ Venereal disease ☐ Pregnant ☐ Abortion☐
Musculoskeletal	Back pain ☐ Stiffness ☐ Swelling ☐ Muscle weakness ☐ Deformities ☐ Difficulty in moving extremities or walking☐ Joint pains ☐ Swelling ☐ Muscle pains or cramps☐
Skin	Skin cancer ☐ Rashes ☐ Calluses ☐ Nail changes ☐ Psoriasis ☐ Cellulitis ☐ Skin color change ☐ Abnormal moles ☐ Easy bruising or bleeding ☐
Neurologic	Headaches ☐ Fainting ☐ Dizziness ☐ Seizures ☐ Numbness ☐ Tremors☐
Psychiatric	Nervousness/anxiety ☐ Drug use or abuse ☐ Psychosis ☐ Suicidality☐
Endocrine	Hypo-thyroid ☐ Hyper-thyroid ☐ Hyperglycemic ☐ Diabetes☐

Height ___ Ft. ___ In Weight _____ Pounds Shoe Size _____

Please List all prior surgeries:

Type of Surgery	Date

Please List all Medications you are currently taking
(Include prescriptions, over the counter meds and herbal supplements):

Name	Dose	Reason

Medical Problems: Which of these following conditions are you currently being treated for or have been treated for in the past (Please Check)

☐Diabetes

☐Heart	☐Stroke	☐Cancer
☐Disease/Murmur	☐Liver problems	☐Anemia or blood problems
☐Angina	☐Low blood pressure	☐Tonsillitis
☐Shortness of breath	☐Sinus Problems	☐Depression/Anxiety
☐Eye disorder/Glaucoma	☐Hepatitis ___	☐Ulcers/colitis
☐Asthma	☐Headaches/Migraines	☐Swollen ankles
☐Seizures	☐Arthritis (rheumatoid or osteoarthritis)	☐Ear Problems
☐Kidney/Bladder problems		☐Psychiatric care
☐High blood pressure	☐Heartburn (reflux)	☐Thyroid problems
☐Lung Problems (cough/COPD)	☐Seasonal allergies	☐Infectious disease (HIV, AIDS)
	☐Neurological problems	

Others/any additional information regarding your medical conditions:

_____

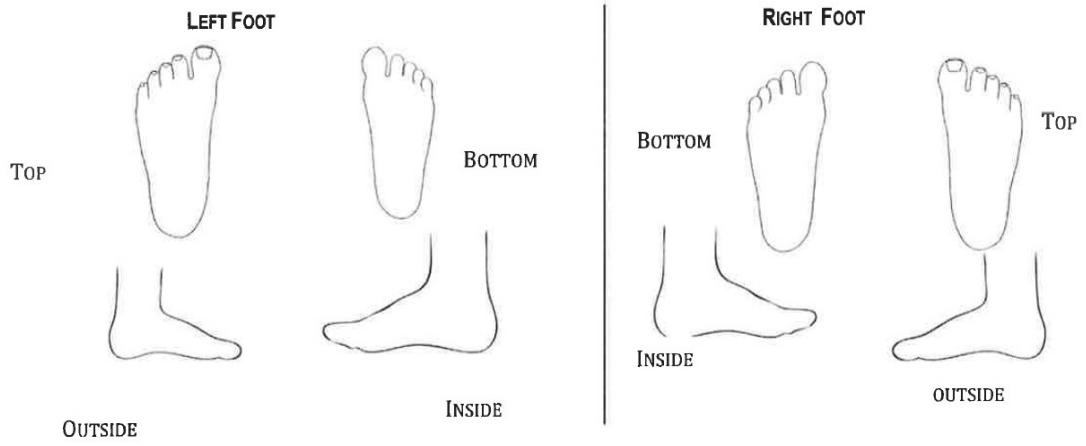
_____

Was this problem caused by an injury? No ☐ Yes ☐ If yes, please describe below

_____

_____

Where is the pain/problem located? Please mark on the picture 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 _____ Date_____

Print Name _____

Relation to patient _____

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Notification of Office Policies and Procedures

Reading the following policies and procedures annually will keep you informed about our office.

1. **APPOINTMENTS:** To allow for greater access of care, our team of physicians are available by appointment during posted hours.
2. **CANCELLATION / NO SHOW POLICY:** Any established patient who fails to show for their appointment and has not contacted our office with at least 24 hours notice will be considered a no-show and a $25 fee will be charged to your card on file.
3. **EMERGENCY / AFTER HOURS:** During a medical emergency, patients should call 911 or proceed to the nearest emergency room. For non-emergency, please call our answering service.
4. **BENEFITS:** Gentle Foot Care will reiterate the benefits that were disclosed to us by your insurance plan. We will then collect based on the benefit level all applicable copays, deductibles, coinsurances, and balances that apply at the time of service.
5. **PAYMENT:** Gentle Foot Care requires a credit card on file for the following commercial insurance companies if there is no secondary coverage: Aetna, Anthem, Aultcare, Cigna, Coresource, Gateway Health, GEHA, Golden Rule, Humana, MedBen, Medical Mutual, Meritain, Mutual Health Services, Ohio PPO Connect, Optima Health, PAI, Physicians Mutual, UMR, and United Health Care.

   *****Copays are required at the time of service per insurance contract or you will be rescheduled.
   *****If deductible is not met, it is required that payment be made towards deductible amount on services rendered at the time of service and once explanation is received from insurance the balance due from patient will be charged to the credit card on file on the first business day of the month not to exceed $250.00.
   *****We accept VISA, Mastercard, American Express, Discover, cash, and checks. We do not offer a payment plan.
6. **INSURANCE CLAIMS:** Gentle Foot Care files claims electronically for the patients for primary contracted plan and accepts payments via the patient's assignment.
7. **MULTIPLE POLICIES:** When multiple policies exist, it is the policy holder's responsibility to inform us of their primary plan. Delaying filing to the primary plan can result in violating timely filing limits, resulting in denial of service and full patient responsibility.
8. **INSURANCE NETWORKS:** Gentle Foot Care only files to carriers with whom we have a contractual relationship.
9. **NON-COVERED SERVICES:** Gentle Foot Care will not submit claims for non-covered OTC items.
10. **REFERRALS:** Gentle Foot Care may refer patients to other providers, facilities, and labs. Gentle Foot Care is not responsible for these entities. The patient should contact these non GFC providers, facilities, or labs directly regarding any billing inquires. The policy holder is also responsible for all insurance prior authorizations, and/or managed care referrals necessary for payment to Gentle Foot Care.
11. **RETURNED CHECKS:** A $50.00 fee will be assessed on all returned checks. Any NSF or closed account will result in future services on a prepay cash or credit basis. The District Attorney's Office will prosecute unresolved checks.
12. **REFUNDS:** Gentle Foot Care issues patients refunds by check within 30 days of a completed investigation of the potential overpayment as long as other outstanding accounts have been resolved.
13. **RETURNS:** Only unworn and non-custom items are returnable within 14 days of receipt if no visible signs or wear, tear, or odor. Custom items are specifically tailored to meet individual needs and are not returnable and/or refundable.
14. **MEDICAL RECORDS:** The cost for copied medical records and completion of disability forms will be charged to the patient and collected prior to replicating. The fees for these services are regulated by HIPPA.

The undersigned certifies that he/she has read and understands the foregoing, 1-13 statements and is either the patient or is dually authorized by the patient as the patient's general agent to execute the above and accepts its terms.

_____	_____	_____	_____
Printed Name of Patient or legal representative	Signature	Relationship to patient	Date

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Authorization from patient or legal representative

1. **CONSENT TO TREAT:** The undersigned consents to any initial or follow up evaluations, examinations, x-rays, laboratory procedures, other tests, medications, medical treatment, surgery, physical therapy, home instructions, orthotics, other durable medical equipment, photographing and/or videotaping and/or other services rendered to the patient by Gentle Foot Care and its providers. The undersigned agrees that it is their responsibility to contact and/or schedule with Gentle Foot Care for any follow up visits, other services, prescriptions, and items orders for the patient. The undersigned understands that Gentle Foot Cares providers exercises their care with responsible skill and diligence; but make no guarantee as to the results or cure that will be attained.
2. **ASSIGNMENT OF BENEFITS:** I hereby irrevocably assign, to transfer and convey to Gentle Foot Care and any practitioner providing care and treatment to me/my child, any and all benefits and all interests and rights (including causes and action, the right to enforce payment and the right to appeal an adverse benefit determination) to which I am entitled under an employee benefit plan sponsored by my employer, all policies, benefits, any third party reimbursements or prepaid health care plan or services or products that I receive from Gentle Foot Care.
3. **MEDICARE ASSIGNMENT:** I certify that the information given by me in applying for payment under XVII of the social security act is correct and agree to complete the Medicare screening form annually. I authorize the release of information concerning me to the social security administration or its intermediaries as well as any information needed for filing a Medicare claim. I request that payment and authorized benefits be made on my behalf. I assign benefits payable for services to Gentle Foot Care.
4. **AUTHORIZATION TO RELEASE INFORMATION:** I consent and authorize Gentle Foot Care and its agents to release my health information for the purpose of payment, treatment and healthcare operations to any of the following: Insurance Company and its affiliates, any practitioner, support staff or faculty involved in my plan of care or transfer of care. In addition, I understand that the potential uses and disclosures of my health information are detailed in the privacy notice. The HIPPA notice of Privacy Practices are available in the office and posted in the lobby. I have read/had the opportunity to read my HIPPA rights, which include Gentle Foot Cares fees for records.
5. **DISIGNATION OF AUTHORIZATED REPRESENTATIVE:** I designate and appoint Gentle Foot Care (and its agents) as my authorized representative and authorize it to act on my behalf to 1) request and receive a copy of the summary plan description, to 2) Pursue a benefit claim, 3) appeal an adverse benefit determination and/or 4) file a legal action to recover benefits from my employee benefit plan, insurance policy and any third party reimbursement or prepaid health plan. I understand and agree that my authorized representative shall have full authority to act and receive notices on my behalf with respect to an initial determination of a claim for health benefits relating to treatment and healthcare services received by me/my child at Gentle Foot Care, any requests for documents relating to the claims and adverse determination of the claims.
6. **FINANCIAL AGREEMENT:** I hereby promise to pay for all products received or services rendered to me/my child to the extent I am legally responsible for such payment according to the language of the physician's insurance contract. I understand that I am responsible for all health insurance copayments, deductibles, coinsurances, OTC, convenience items, non-covered services, and any other amounts that apply at the time of service and at the pre-operative appointment. Regardless of the assignment of benefits, should the insurance misrepresent their coverage or delay payment of a claim greater than 60 days, as the designated responsible party I am responsible for all the monies owed to Gentle Foot Care. I also understand that the insurance policy is a contract between me and the insurance company, therefore the policy holder should contact the insurance carrier first when there are questions regarding the explanation of benefits.

The undersigned certifies that he/she has read and understands the foregoing statements 1-6 and is either the patient or dually authorized by the patient as the patient's general agent to execute the above and accepts its terms. This document shall remain in force until a written revocation by me is delivered to Gentle Foot Care.

_____	_____	_____	_____
Print name of patient or legal representative	Signature	Relationship to patient	Date