Palmetto State Surgical Podiatry Associates

230 Cherokee Road
Florence, SC 29501
Phone 843.773.6246 Fax 843.731.9384

Patient Demographic Information

Patient Name: _____ **Date:** _____
(Last) (First) (MI)

Street: _____ **City:** _____ **State:** ___ **Zip:** _____

Home Phone: (____) _____ **Date of Birth:** _____ **Age:** _____

E-mail address (will not be shared in any way)**:** _____ **Sex:** __M __F

Race: _____ **Language Spoken:** _____

Occupation: _____ **Cellular #:** (____) _____

Employer: _____ **Work Phone:** (___) _____

Business Address: _____

Spouse's Full Name: _____ **Number of children:** _____

Your Pharmacy: _____ **Town:** _____ **Phone #:** _____

Emergency Contact - Name: _____ **Relationship:** _____

Phone: (_____) _____

SS#: _____ **Medicare #:** _____

Primary Ins. Co.: _____ **Policy #:** _____

Name of Insured: _____ **Group #:** _____

Soc. Sec. # of Insured: _____ **D.O.B of Insured:** ____/____/____ **Relationship:** _____

Secondary Ins. Co.: _____ **Policy #:** _____

Name of Insured: _____ **Group #:** _____

Soc. Sec. # of Insured: _____ **D.O.B of Insured:** ____/____/____ **Relationship:** _____

Primary Care Physician: _____ **Date last seen:** _____

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Medical History

How did you hear about our office? _____
Current Shoe Size: _____
Current Weight: _____ **lbs**
Height: _____

Have you ever worn custom made arch supports (orthotics) ___Y ___ N

Do you smoke? ___Y___N How many packs per day: _____
Do you drink alcohol? ___Y___N How many glasses per day_____

Illnesses: (check those which apply)
Poor Circulation/PVD___ Heart Disease___ Diabetes___ Arthritis___ Kidney disease/Dialysis___
Hepatitis/HIV___ Bleeding Disorders___ Asthma/COPD___ Gout___ High Blood Pressure___ Stroke___
Numbness in Feet/Neuropathy___ High Cholesterol___ Heart Attack/MI___
Other_____

If Diabetic: Last BS: _____ **Last HbA1C**: _____

Family History: (Please check those which apply):
Poor Circulation/PVD___ Heart Disease___ Diabetes___ Arthritis___ Kidney___ disease/Dialysis___
Hepatitis/HIV___ Bleeding Disorders___ Asthma/COPD___ Gout___ High Blood Pressure___ Stroke___
Numbness in Feet/neuropathy___ High Cholesterol___ Heart Attack/MI___
Other_____

Allergies to Medications: (Please check those which apply):
Penicillin___ Aspirin___ Codeine___ Adhesive Tape___ Iodine___
Sulfa___ Sea Food/Shellfish___ Local Anesthetic___ **Other**_____

Medications You are Currently Taking: (*Both* prescription and non-prescription)
_____
_____
_____
_____

Prior Surgery and/or Illnesses:
_____
_____
_____
_____
_____

I hereby give my permission to the doctor at Palmetto State Surgical Podiatry Associates, P.C. to perform diagnostic, therapeutic and/or operative procedures as may be deemed necessary in diagnosis and/or treatment of my feet and/or ankles.

PATIENT SIGNATURE: _____ **DATE:** _____

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Name: _____

Podiatric Pain &Fall Analysis Survey

What problem or pain are you having with your foot/feet?

_____

How would you grade your pain on a scale from 1 to 10 with 10 being the worst pain?.
_____

Where is most of your pain on your foot and or ankle? (circle)

Left / right top / bottom toes /heel/ arch / nail(s)

Have you suffered from a fall in the last year? Y / N

How many falls have you had this year? _____

_____ _____
Patient Signature Date

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Financial Policy

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

INSURANCE: We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

MEDICARE: We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. However; that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any Copayments, which are usually 20% of the allowed amount for an item or service.

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company.

COPAYMENTS AND DEDUCTIBLES: All co-payments and deductible must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

SELF PAY: Payment in full is due at the time of service if you do not have health insurance.

NON-COVERED SERVICES: Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payment of these services.

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan which mandates us that when you visit a specialist such as ours, you must have a referral from your primary care physician prior to seeking specialty care. Therefore, you are financially responsible for the services received, unless your referral is presented at the time of this visit. If you do not have a referral from your primary care physician at the time of a visit, you will be financially responsible for all services received due in full upon completion of the visit. Full credit will be given if a referral is presented to our office within 48 hours of this visit. You will also be given the option to reschedule your appointment.

CLAIM SUBMISSION: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

PATIENT BILLING: You will be sent up to three notices for your financial responsibility (co-insurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After the third and last notice, your account may be forwarded to collections. Please let the billing office know if you have any difficulties resolving your bill. Payment arrangements can be made on a case by case basis. We accept the following payment methods: Cash, Check or VISA/Mastercard. An additional $25.00 will be added to your statement if the check is returned for

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insufficient funds. In the event that your insurance company should happen to send payment to you, the patient, we expect that you would forward it to our office to be applied to your balance.

Financial Policy (cont'd)

I have read the above policy regarding my *financial responsibility* to Palmetto State Surgical Podiatry Associates, P.C. for medical services provided. I agree to pay Palmetto State Surgical Podiatry Associates, LLC any balance unpaid by my insurance carrier for myself or the below named person.

PRIVACY STATEMENT: 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 ACKNOWLEDGE OF NOTICE OF PRIVACY PRACTICES: By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices, and that I have (or had the opportunity to read if I so chose) and understand the Notice and agree to its terms.

Assignment of Benefits

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to **Palmetto State Surgical Podiatry Associates, LLC** all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, and/or non-covered services. 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.

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:

PRINT Patient Name: _____ Signature: _____

FINANCIALLY RESPONSIBLE PARTY:
PRINT Name: _____ Signature: _____
Relationship to Patient: _____ Date: _____

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Office Policies Regarding Managed Care Insurance Plans

We understand that the many changes in the health care system have made it quite confusing for our patients. The following are guidelines that have been established by the insurance companies to allow reimbursement for services we provide:

- You are responsible for obtaining and bringing referrals at the time service is rendered.
- Be aware that referrals may be for one visit or more. This is clearly indicated on the referral form
- Referrals do expire. Most are good for either sixty or ninety days. This is also indicated on the referral form.
- A consultation report will be sent to your primary care doctor after the first visit and follow-up reports will be provided as necessary.
- You are responsible for your co-pay at the time your treatment is rendered.
- If you do not have a referral for a visit, you are responsible for full payment.
- Primary care physicians have indicated that they can not be called with a patient in the office for a referral for that particular visit. Referrals must be obtained before your visit to our office. Primary care physicians often need several days to provide you with a referral.

We are always available to help you with any questions regarding your insurance and treatment in our office. Thank you.

Our Patient's Bill of Rights

As patient and physician, ours is more than a relationship, it's a partnership. To ensure this, we live by the following principles:

- A patient has the right to know what his or her condition is and what trouble it is likely to cause.
- A patient has a right to have the condition explained in real terms, not medical terms.
- A patient has the right to know our qualifications and experiences.
- A patient has the right to consult other doctors without us being insulted or angry that the patient wants another opinion.
- A patient has a right to understand our fees.
- We will spend a patient's money wisely as possible. We will look for and recommend the most cost effective way of solving our patient's problems.
- We will not recommend surgery unless the patient needs help that only surgery can provide.
- If a patient feels that we have not provided them with our best efforts, please make this known. We cannot guarantee results of treatment, but we can guarantee you our best efforts to treat you honestly and fairly.
- If a patient has financial problems, our office is committed to making arrangements so proper, necessary care is always provided.
- Considerate, respectful care at all times and under all circumstances with recognition of your personal dignity.
- Personal and informational privacy, within the law.
- Confidentiality of records and disclosures. Except when required by law, you have the right to approve or refuse the release of records.
- The opportunity to participate in decisions involving your health care, unless contraindicated by concerns about your health.
- Impartial access to treatment regardless of race, color, sex, national origin, religion, handicap or disability.
- Know the identity and professional status of individuals providing service to you.