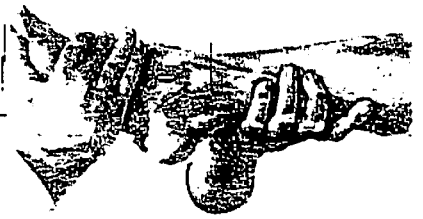
Blue Ridge Foot Center

Daniel L. Waldman, DPM, FACFAS



Gentle, advanced relief for your lifelong foot health

PATIENT INFORMATION FORM

Date: _____ Social Security #: _____

Patients First Name _____ Middle _____ Last_____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Nickname or Preferred Name: _____

Telephone Cell: _____ Home: _____ Work: _____

Marital Status: M S D W Date of Birth: ____/____/_____ Sex: M F

Email Address: _____

Primary Care Physician: _____ Date Last Seen: ____/____/_____

Physician Address: _____

Referral Source – How did you hear about our office? _____

Ethnicity: _____

Employer: _____ Occupation: _____

Preferred Pharmacy and Address: _____

Emergency Contact: _____ Telephone number: _____Relationship:_____

Please note:

We do not make payment arrangements. All co-pays and deductibles are due at the time of service. It is the patient/guardian's responsibility to understand the individual health insurance coverage.

Blue Ridge Podiatry Associates, PA will make every effort to remind patients of their appointments at least one day in advance. This is done as a *courtesy*. Patients are ultimately responsible for remembering to keep their appointments. Our office requires at least 24 hours notice prior to canceling an appointment. If less than 24 hours notice is given (this includes appointments missed without any notice or appointments canceled on the same day as they are made), our office reserves the right to charge a cancelation or no-show fee to the patient's account.

By signing below I affirm that I have had read and understood BRPA's privacy policy.

Patient (or Guardian) Signature: _____Date: _____

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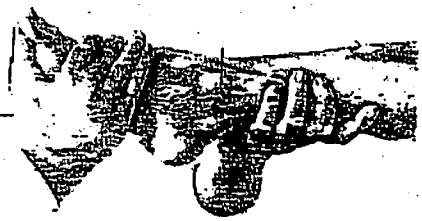

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FINANCIAL POLICY

Thank you for choosing our practice! It is our belief that establishing a written financial policy is mutually beneficial to all parties. It is our goal to avoid any miscommunication or concerns regarding financial matters in order to focus our energies on providing excellent healthcare services to our patients.

As a courtesy to you we will file your insurance for you. Each insurance plan has different benefits for you as well as different financial obligations. Not all insurance policies cover all services. It is ultimately your responsibility to check with your insurance company to determine covered benefits.

The following are our policies relative to financial responsibility:

- Payment is required at the time services are rendered. This includes co-pays, deductibles, and co-insurance, as well as payment for any non-covered or over the counter items.
- Please present your insurance card at your initial visit and any time you change insurance carriers/plans.
- You may be charged a "no-show" fee of $35.00 for any appointments missed, not canceled or rescheduled with *at least 24 hours notice.*
- Balances on your account must be paid in full within 30 days unless other arrangements are made in advance and in writing with the office manager.
- Accounts may be turned over to a collection agency for any balances past due 60 days or more.
- A service charge of $35.00 will be assessed for returned checks, refilling of insurance due to incomplete or incorrect information given at the time of the appointment or for accounts turned over to collection agencies.
- A fee of $25.00 will be assessed for the completion of any disability, Family Medical Leave Act (FMLA), attending physician statements (APS) or any other miscellaneous forms.
- Interest in the amount of 1.5% monthly (18% annually) may be added to any balances older than 60 days.
- In the case of services provided to patients under the age of 18, the parent, guardian or legal representative who initiates the services for the minor will be responsible for payment. We do not bill another individual or estranged spouse for payment.

I hereby authorize Blue Ridge Podiatry Associates, PA ("BRPA") to file all medical claims with any and all insurances. I hereby authorize payment of insurance benefits to be made to BRPA. I further understand that if my insurance company denies any or all medical services as "non-covered", "coverage terminated", "pre-existing" or "not a covered member", I will be responsible for full payment within 30 days of said denial(s), or within 30 days of the first billing statement sent by BRFC following the receipt of said denial(s). I understand that BRFC will not file any claims for non-covered or over the counter items.

I understand I will be legally responsible for all collection costs associated with the collection of this account including court costs, reasonable attorney fees, and all other expenses incurred with collection if I default on any unpaid balance.

I fully understand the above policies and agree to be financially responsible for any and all incurred charges resulting from medical services rendered.

Patient/Guardian Signature _____ Date _____

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Comprehensive Patient Medical History

Patient Name: _____ Date of Birth: ___/___/_____

Shoe size: _____ Height: _____ Weight: _____ Age: _____

Chief Complaint: _____

Have you ever been treated for:

___Corns/calluses	___warts	___athlete's foot	___leg/foot ulcers
___broken foot bones	___lower back pain	___bunions	___arch pain
___hammer/mallet toes	___fungal nails	___knee pain	___flat feet
___cramps in legs/feet	___heel pain	___childhood foot problems	___rash
___neuroma	___broken ankle	___toe walking	___in-toeing
___ingrown toenails	___foot numbness	___ankle sprain	___high arch feet
___gait (walking) problems			

Did you previously or do you now wear:

☐shoe inserts - still using them? ____ Do or did they help? ____

☐orthotics - still using them? ____ Do or did they help? ____Orthotics were obtained through _____

Are your first steps out of bed painful? Y N .....then subsides? Y N

Do you get leg cramps...during the day? Y N .....at night? Y N

Percent of waking hours spent on your feet? _____%

List the sports or type of dance you are active in: _____

Does foot pain limit your activities? Y N Do you have difficulty walking? Y N

Any pain in calves or buttocks when walking? Y N Is the pain relieved by stopping & standing still? Y N

Do you have or have been treated for:

___Stroke	___Heart Attack	___ High Blood Pressure	___Phlebitis
___Vascular disease	___A heart condition	___Anemia	___Poor circulation
___Diabetes	___Kidney disease	___Eyes: Glaucoma/Mac Deg	___Keloid/Thick Scar
___Gout	___Osteoporosis	___Alzheimer's	___Sciatica
___Lyme's Disease	___Rheumatic fever	___Arthritis	___Headaches
___Epilepsy	___Nerve Disorder	___Hearing/ear disorder	___Asthma
___Lung disease	___Tuberculosis	___Psychiatric disorder	___Hepatitis
___Liver disease	___Thyroid problem	___Dark urine	___Cancer
___Stomach ulcer	___Chronic light stool	___Unexplained weight loss	

___Other: _____

Do you have vascular grafts? Y N Do you have joint implants? Y N

Do you have replacement heart valves? Y N Are you now under active chemotherapy? Y N

Have you had any other serious illness? (list below) Y N Have you had any surgery? (list below) Y N

Have you ever been hospitalized or been under medical care over 24 hours? (list below) Y N

Illness/surgery:	Date:	Complications:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List relationship to you of family members who have had:

Diabetes _____ Foot problems _____ Cancer _____

Arthritis _____ Stroke _____ Heart Attack _____

High Blood Pressure _____ Birth Defects _____

Are you pregnant now? Y N # of childbirths _____

Are you slow to heal after cuts? Y N Any abnormal bruising, bleeding, scarring? Y N

Do you smoke now? Y N Packs/day _____ Years _____

Did you ever smoke? Y N Packs/day _____ Years _____

If you quit, when did you do so? _____

Alcoholic beverages? None Rarely Moderately Daily Quit

Recreational drugs? None Rarely Moderately Daily Quit Type: _____

Please mark if you take vitamins or supplements that contain:

___garlic ___gingko biloba ___echinacea ___ginseng ___St Johns wort

List other supplements you take:

_____

_____

List any medications, including insulin you currently taking below along with dosage and frequency:

_____

_____

_____

_____

_____

_____

_____

Allergies: Is there a history of skin reaction or other outward reaction or sickness following and injection, oral or topical administration of:

		If yes, what happens?
Latex, Adhesive tape	Y N	_____
Penicillin	Y N	_____
Other antibiotics	Y N	_____
Empirin, Tylenol	Y N	_____
Aspirin, Advil, Aleve	Y N	_____
Celebrex	Y N	_____
Other pain remedies	Y N	_____
Morphine	Y N	_____
Codeine	Y N	_____
Demerol	Y N	_____
Other narcotics	Y N	_____
Novacaine	Y N	_____
Other anesthetics	Y N	_____
Sulfa Drugs	Y N	_____
Shrimp, Iodine, Merthiolate	Y N	_____

Others: _____

Is there anything else that you want to tell the doctor?

_____

_____

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Required

Attention Patients

We would like to notify you of our policy that simplifies the way you pay for your Foot Care Services.

As a courtesy, Blue Ridge Podiatry Associates, PA will file your Insurance for services rendered. Patients are responsible for co-pay or deductible at the time of the visit. Co-insurance and/or other deductible balances due after the insurance has processed your claim will be collected via a credit card. This will eliminate the confusion of multiple billing statements being received after your visit, telephone call reminders about your balance and potential of being turned over to a collection agency.

The benefit of this policy is that you can use a credit card (Visa, Master Card, American Express, or Discover). This is kept securely on file in your electronic chart.

Blue Ridge Podiatry Associates, PA is authorized by me to charge the following credit or debit card up to $500.00 of the balance due on the card indicated below. For balances greater than $500.00 we will notify you before charging your card.

Visa MasterCard American Express Discover

Credit Card Number Expiration Date CVC Code

Signature Today's Date

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