MYERS & MILLER PODIATRY,INC

Today's Date: ___________

PATIENT INFORMATION:
LAST NAME: __________________________ LEGAL FIRST NAME: __________________________ MI: _____
PREFERRED NAME: __________________________ DOB: __________ AGE: _____ GENDER: __________
SOCIAL SECURITY #: _________________________ MARITAL STATUS: ___________________
SPOUSE NAME: ________________________________
ADDRESS: ____
CITY: ____ STATE: ____________ ZIP CODE: _____________
PHONE (Number you wish for office to contact first): ______________________________
ALTERNATE PHONE: _______________________________
IF MINOR: PARENT(S) OR GUARDIAN(S) NAME: ____
EMAIL: ____
Will allow you to access your chart, request refills or ask questions using our secure portal
PLACE OF EMPLOYMENT: ____ PHONE: ___________________
POSITION: ____
EMERGENCY CONTACT NAME: _______________________________________ PHONE: ___________________
RELATIONSHIP: ______________________________

INSURANCE INFORMATION:
PRIMARY INSURANCE: _____________________________________ POLICY #: __________________________
GROUP #: ____________ SUBSCRIBER/POLICY HOLDER NAME: _____________________________________
SOCIAL SECURITY #: ____________________ DOB: _______________
PATIENT'S RELATIONSHIP TO SUBSCRIBER: _______________________________
SECONDARY INSURANCE: ___________________________________ POLICY #: __________________________
GROUP #: _____________ SUBSCRIBER/POLICY HOLDER NAME: ____________________________________
SOCIAL SECURITY #: ___________________ DOB: ________________
PATIENT'S RELATIONSHIP TO SUBSCRIBER: ______________________________

YOUR MEDICAL TEAM:
PRIMARY CARE PHYSICIAN: ____ DATE OF LAST VISIT: _________
CARDIOLOGIST: ____
ENDOCRINOLOGIST: ____
NEPHROLOGIST: ____

HOW DID YOU HEAR ABOUT OUR OFFICE? ____

REASON FOR TODAY'S VISIT: _____________________________ REFERRED BY: ___________________________
IF TODAY'S VISIT IS DUE TO INJURY:
DATE OF INJURY: ________ AFFECTED/INJURED BODY PART: _____________ SIDE: ________
XRAY OR MRI: ________ LOCATION: _________________________________
SHORT DESCRIPTION OF ACCIDENT/INJURY: ____
____

*****ALL BLANKS AND QUESTIONS MUST BE ANSWERED ON EACH PAGE*****

PAST/PRESENT MEDICAL HISTORY:
Check mark yes OR no for each medical condition

Yes	No	
___	___	Heart Attack/Myocardial Infarction
___	___	Heart Murmur
___	___	Heart Disease
___	___	Stroke/Cerebrovascular Accident
___	___	Mini Stroke/Transient Ischemic Attack/TIA
___	___	High Blood Pressure/Hypertension
___	___	High Cholesterol/Hypercholesterolemia
___	___	Blood Clot(s) Location: ___________________________________
___	___	Pacemaker Manufacturer: ____
		Our office will need a copy of the card
___	___	Asthma
___	___	Chronic Bronchitis
___	___	Emphysema
___	___	Chronic Pulmonary Disease/COPD
___	___	Sleep Apnea
___	___	Diabetes Mellitus Circle: Type I Type II Insulin Noninsulin
___	___	Cancer Type: _______________________________________
		Current - Remission - Cured
		Treatment: _____________________________________
___	___	Pancreatitis
___	___	Addison's Disease
___	___	Cushing's Disease
___	___	Glaucoma
___	___	Macular Degeneration
___	___	Cataracts
___	___	Gallbladder Problems
___	___	Liver Disease
___	___	Hernia Type: ____
___	___	Diverticulitis
___	___	Crohn's Disease
___	___	Ulcerative Colitis
___	___	Gastric Ulcers
___	___	Gastroesophagel Reflux Disease/GERD
___	___	Dementia Type: _______________________________________
___	___	Seizure Type: ____________________________________
___	___	Migraine Headaches
___	___	Neuropathy
___	___	Multiple Sclerosis
___	___	Depression
___	___	Anxiety
___	___	Chronic Fatigue Syndrome

PAST/PRESENT MEDICAL HISTORY CONTINUED:

Yes	No	
___	___	Fibromyalgia
___	___	Rheumatoid Arthritis
___	___	Degenerative Joint Disease/Osteoarthritis
___	___	Gout
___	___	Fracture(s) Location: ______________________
___	___	Osteoporosis
___	___	Claustrophobia
___	___	Bladder Infections
___	___	Kidney Infections
___	___	Kidney Stones
___	___	Kidney Failure
___	___	Kidney Dialysis
___	___	Kidney Transplant Date: _________
___	___	Enlarged Prostate
___	___	Anemia
___	___	Hepatitis Type: _________
___	___	HIV Positive or AIDS
___	___	Sexually Transmitted Disease Type: _________________
___	___	Tuberculosis
___	___	Scarlet Fever
___	___	Thyroid Disease Type: _____________________________
___	___	Physical Disabilities Type: __________________________________
___	___	Mental Disabilities Type: _____________________________________
___	___	Bleeding Disorder(s) Type: ______________________________________
___	___	Chicken Pox/Varicella
___	___	Mumps
___	___	Polio
___	___	Rheumatic Fever
___	___	Mammogram Date: ___________
___	___	Flu Vaccine Date: ____________
___	___	Pneumonia Vaccine Date: _____________

List any other conditions, diseases or problems not listed above: ____
____

Height: ____ft ____in Weight: ______ Shoe size: ______

PHARMACY: LOCAL: ____ LOCATION: _____________________
MAIL IN: ____

MEDICATIONS: NONE   (circle if no medications or any type of vitamins/supplements)
Include all names of medication/vitamin/herbal/supplement, strength/dosage and frequency/how often taken needed

PRESCRIPTION MEDICATIONS:

____
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VITAMINS:

____
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____
____

SUPPLEMENTS:

____
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____

HERBALS:

____
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____

OVER THE COUNTER:

____
____
____
____
____

ALERGIES: No KNOWN ALLERGIES (circle if no allergies)
Please include medications, foods and environmental with reactions

____
____
____
____
____

SURGERIES: NONE (circle if no surgeries)
Include procedure, location of facility, doctor who performed procedure, date and outcome

____
____
____
____
____

SOCIAL HISTORY:
Check mark yes OR no and fill in blanks

Yes	No	
___	___	Alcohol use Average: ____ drinks per: day week month year (circle one)
___	___	Tobacco use Average: ___ /day How many years: _____
___	___	Former Tobacco use Quit: _____
		Form of Tobacco use:
		Cigarette: ___ Cigar: ___ Chewing Tobacco: ___ Snuff: ___
___	___	Illicit/Street/Recreational Drug use Type and how often: _____________
___	___	Caffeine use Average: ___/day
		Form of Caffeine:
		Coffee: ___ Pop/Soda: ___ Tea: ___

FAMILY HISTORY:
Please check all that applies to your Parents, Siblings, Children and Grandparents (maternal or paternal) NOT you

Yes	No		Relationship to You
___	___	Anxiety	_______________
___	___	Arthritis	_______________
___	___	Asthma	_______________
___	___	Bleeding Problems	_______________
___	___	Cancer Type: __________	_______________
___	___	Heart Attack/Myocardial Infarction	_______________
___	___	Hepatitis	_______________
___	___	Diabetes Mellitus	_______________
___	___	Depression	_______________
___	___	Seizures	_______________
___	___	Foot Problems	_______________
___	___	Gout	_______________
___	___	High Blood Pressure/Hypertension	_______________
___	___	High Cholesterol/Hypercholesterolemia	_______________

FAMILY HISTORY CONTINUED:

Yes	No		Relationship to You
___	___	HIV	_______________
___	___	Kidney Disease	_______________
___	___	Liver Disease	_______________
___	___	Osteoporosis	_______________
___	___	Stroke/Cerebrovascular Accident	_______________
___	___	Thyroid Problems	_______________
___	___	Tuberculosis	_______________

SYSTEM REVIEW:

Yes	No	
___	___	Are you in good general health
___	___	Swollen glands in neck
___	___	Sore throat or mouth sores
___	___	Chronic sinus problems/Rhinitis
___	___	Bleeding or bruising tendency
___	___	Change in mole Location: ___________
___	___	Frequent/recurring headaches
___	___	Light headed
___	___	Depression
___	___	Dizziness/loss of balance
___	___	Anxiety
___	___	Claustrophobia
___	___	Shortness of breath
___	___	Joint stiffness/pain
___	___	Weakness of muscles/joints
___	___	Back pain
___	___	Excessive thirst
___	___	Heat intolerance
___	___	Cold intolerance

Yes	No	
___	___	Chest pain
___	___	Leg swelling
___	___	Leg cramps
___	___	Frequent diarrhea
___	___	Constipation
___	___	Blood in stool
___	___	Black tarry stool
___	___	Frequent heartburn/stomach upset
___	___	Spitting up blood
___	___	Chronic/frequent cough
___	___	Nausea
___	___	Frequent urination
___	___	Blood in urine
___	___	Incontinence/dribbling
___	___	Wheezing

*****ALL BLANKS AND QUESTIONS MUST BE ANSWERED ON EACH AND EVERY FORM*****

All information given on all pages is current and correct to the best of my knowledge.

Patient/Guardian Signature: _________________________________ Date: _______

MYERS & MILLER PODIATRY, INC

Effective September 15, 2014

Due to the cost of the practice with patients who “no show” or cancel with less than a 24 hour notice combined with the long list of patients that are scheduled out 4-5 weeks who could be scheduled earlier, we have implemented a new policy. A charge will occur for any “no show” appointments.

“No show” is defined as a patient that has an appointment and does not cancel or is not present at their scheduled appointment time.

$45.00 charge for any new patient who “no shows” or cancels with less than a 24 hour notice

$25.00 charge for any established patient who “no shows”

$15.00 charge for any established patient that cancels with less than a 24 hour notice

These charges may be waived at the discretion of the practice due to emergency situations. The charges are the responsibility of the patient and cannot be submitted to the patient’s insurance.

The above charges will need to be paid before the missed appointment may be rescheduled.

MYERS & MILLER PODIATRY, INC.

PATIENT AUTHORIZATION

I hereby give Myers & Miller Podiatry, Inc. permission to examine and treat my feet. I authorize Myers & Miller Podiatry, Inc. to submit any and all health care information to any health insurance program for their review and payment. I authorize payment of medical benefits to the practice. I further understand and agree to pay for services or amounts applied to my annual deductible, co-payments as well as charges denied by my insurance program or considered not medically necessary. Examples of these denied charges may include injections, routine medical care not due to an illness or condition and any other service specified in my health insurance contract.

____ _____________

Signature of patient (Parent or Guardian of Minor) Date

MEDICARE BENEFICIARIES

I request that payments made by Medicare be payable on my behalf to Myers & Miller Podiatry, Inc. for any service(s) furnished to me by any of these physicians. I authorize any holder of medical information about me to be released to the Health Care Finance Administration and its agents of any information needed to determine these benefits payable to related services.

I understand my signature request that payment be made to Myers & Miller Podiatry, Inc. and authorizes release of medical information necessary to pay the claim. If the appropriate item of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer for agency shown. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the remaining amount between Medicare's payment and the Medicare allowed charge, any deductibles, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

____ _____________

Signature of patient Date

MYERS & MILLER PODIATRY, INC.

FINANCIAL POLICY:
We are pleased to provide your podiatric care. Please understand that payment is part of your treatment. The following is a statement of our Financial Policy which you need to read and sign.
Patients or their legal representative shall complete an information sheet which requests current insurance information before seeing the doctor.

- -If self pay, full payment is due at the time of service
- -Co payments are due at the time of service
- -Co insurance amounts are due at the time of service
- -If you have insurance, your claim will be sent to your insurance company and any remaining balance due after their portion is paid will be your responsibility
- -We accept cash, checks and major credit cards. Returned checks will be subject to a $25.00 fee.

If you are unable to make timely payments due to financial hardship please contact our office for assistance with this matter.

REGARDING INSURANCE:
Your insurance is a contract between you and your insurance company. It is <u>your</u> responsibility to contact your insurance to confirm network status of the physician prior to your visit. Should the doctor have an agreement with your insurance company, we will bill the insurance <u>if</u> it is a covered service.
Not all services are a covered benefit. It is <u>your</u> responsibility to check with your insurance company prior to your visit regarding what services will and will not be covered. If the service is a non covered service you will be responsible for payment at the time of service.
If a patient is covered by both Medicare and Medicaid we will assume the patient is experiencing financial hardship in which case non covered fees will be waived.
We are sure that you have heard of “identity theft”. As our practice continues to grow, it is one of our top priorities to keep our patients personal information safe. As a result we will need to review your insurance card at each visit.

MINOR PATIENTS:
The child’s parent or guardian is responsible for payment at the time of service.

NEW PATIENTS:
New patients are to arrive at our office 45 minutes in advance of their appointment time to fill out necessary paperwork. If all of your paperwork is not complete by your appointment time, we reserve the right to reschedule you.

MISSED APPOINTMENTS:
As courtesy, please contact our office to cancel an appointment 24 hours in advance. If an established patient fails to show for 3 appointments without calling to cancel, the patient will be terminated. New patients failing to cancel their initial appointment will not be rescheduled a second time. Missed appointments are subject to a fee.

ARRIVING LATE:
If you arrive 10 minutes late for your scheduled appointment, we reserve the right to reschedule you.

I, the patient or legal guardian, understand that by signing this form I accept full financial responsibility of this account.

______________________________	________________	__________
Signature of patient, parent or guardian	Relationship	Date

MYERS & MILLER PODIATRY

ACKNOWLEDGMENT OF RECEIPT

I, _______________________________, acknowledge that I have been offered or received the Notice of Privacy Practices issued by Myers & Miller Podiatry.

I, _______________________________, authorize Myers & Miller Podiatry to discuss my health information with the following persons:

List phone numbers with the names.

Spouse: ____

Children: ____

____

Parent: ____

____

Other: ____

____

_______ Check if you do not authorize anyone.

____ __________________

Signature of patient, parent or legal guardian Date

MYERS & MILLER PODIATRY, INC.

PRESCRIPTION OF AGREEMENT AND CONTROLLED SUBSTANCE CONTRACT

Patient Name: ___________________________________ DOB: _______________

I agree to the following provisions to continue to receive controlled substance(s) for my condition. I have been informed of the potential dangers and risks associated with controlled medications use. I understand that compliance with the following guidelines is important to the continuation of treatment by my doctors. I also agree to comply with all my scheduled appointments. I will not request controlled substances or any other pain medication form prescribers other the doctor listed below.
I also agree to consent to random drug testing. Results of this testing may be released to other agencies if requested. I released the physician from any damages or liability failure to comply with testing may result in denial of prescription.

THE DO'S AND DON'TS EDUCATION HIGHLIGHTS

DO:

-Read the Medication Guide
-Take your medicine exactly as prescribed
-Store your medicine away from children and in a safe place
-Flush unused medicine down the toilet
-Call your healthcare provider for medical advice about side effects
-You may report side effects to the FDA at 1-800-FDA-1088
-Call 911 or your local emergency service immediately if you take too much medicine, have trouble breathing or shortness of breath
-Call 911 if a child has taken this medicine

DON'TS:

-Do not give your medicine to others
-Do not take medicine unless it was prescribed to you
-Do not stop taking your medicine without talking to your healthcare provider
-Do not break, chew, crush, dissolve or inject your medicine. If you cannot swallow your medicine whole talk to your healthcare provider
-Do not drink alcohol while taking this medicine

TALK TO YOUR HEALTHCARE PROVIDER:

-If the dose you are taking does not control your pain
-About any side effects you may be having
-About all medicines you take including over the counter medicines, vitamins and dietary supplements

I understand that failing to follow this agreement may result in discontinuation of all narcotic or controlled substance prescriptions being prescribed from this provider and could potentially result in care being terminated by the physician listed below.

I have read and understand the agreement.

ARE YOU CURRENTLY A PATIENT AT A PAIN CLINIC? YES ___ NO ____ IF YES- WHERE? ____________________
(I understand that it is my responsibility to inform Myers & Miller Podiatry, Inc. if I become a patient of a pain clinic in the future)

____ ________________
Signature of patient, parent or legal guardian Date

____ ________________
Signature of Myers & Miller Podiatry physician Date