Modern Podiatry Patient Information

Patient Name: _____ Nickname: _____DOB:_____

Home Address: _____ Apartment:_____

City: _____ State: _____ Zip Code: _____

Home Phone: _____Cell Phone: _____

Email Address: _____

Preferred Methods of Communication: □ Home □ Cell □ Email □ Text □ Other_____

Sex: □ Male □ Female □ Decline to specify Preferred Language: _____

Marital Status: □ Single □ Married □ Widowed □ Divorced □ Separated □ Other

Ethnicity: □ Hispanic/Latino □ Not Hispanic/Latino □ Unreported/Refused to Report

Race: □ American Indian or Alaska Native □ Asian □ Black or African American □ More than one race

□ Native Hawaiian □ Pacific Islander □ White □ Unreported/Refused to Report

Primary Physician: _____Phone: _____

Specialty Doctors:_____

Pharmacy: _____ Phone: _____

Emergency Contact _____ Emergency Phone _____

Disclosure to Designated Family, Friends or Caregivers

I allow Modern Podiatry to disclose medical information as needed to the following designed individual(s) involved with my health care. I understand that I am not required to list anyone. I also understand that I may change my list in writing at any time.

Print Name: _____ Relationship: _____Phone #: _____

Print Name: _____ Relationship: _____Phone #: _____

Insurance Information

Do you have a specialist copay?_____Do you require a referral?_____

Primary Insurance _____ Group # _____ ID #_____

Person Responsible for Account _____

Relationship to Patient _____ D.O.B _____ SSN _____

Address (if different from patient) _____

Secondary Insurance _____ Group _____ ID # _____

Person Responsible for Account _____

Relationship to Patient _____ D.O.B _____ SSN _____

Is this a compensation or work-related case? □ Y □ N Date of Injury _____

Review of Systems

Shoe Size: _____ Height: _____ Weight:_____

- What is your chief complaint you are here to address today?_____

_____

- Description of Pain (dull, sharp, aching, etc.): _____
- Aggravating Factors (when is the pain at its worst?) _____
- How long has this bothered you? _____Days _____Weeks _____Months _____Years
- Relieving Factors: □ Rest □ Ice □ Heat □ Medications □ Home Remedies □ Stretching □ Other:_____
- Does your foot pain limit your activities? □ Yes □ No Do you have difficultly/pain walking? □ Yes □ No
- Have you had any previous treatment for this problem? □ Yes □ No

If yes, please explain: _____

- Please indicate which foot problems you now have or have had in the past:

□ Ankle Pain
□ Ankle Instability (Easy Twisting Injuries)
□ Ankle Swelling or Stiffness
□ Achilles Tendon Pain
□ Pale or Blue Discoloration of the Feet
□ Swelling in Feet or Ankles
□ Ingrown Toenails
□ Athlete's Foot
□ Corns/Calluses
□ Plantar Wart
□ Heel or Arch Pain
□ Cramps in Feet or Legs
□ Leg Pain
□ Tired Feet
□ Bunions
□ Flat Feet
□ Numbness in Feet/Toes or Legs
□ "Toe-in"or"Toe-out" Gait (Walking)
□ Pain or Fatigue of Feet or Legs During Activity or Exercise
□ Non/Poor Healing Sore, Ulcer or Gangrene on the Leg or Foot

Medication List

Please list current medications prescribed by a doctor, including over the counter medications, vitamins, and supplements. Please include dosage and strength._____

_____

_____

_____

_____

_____

_____

□ I will be bringing my medication list to my appointment.

Medical History

Please indicate with a (X) any of the medical conditions below that pertain to you

□ AIDS/HIV	□ Congestive Heart Failure	□ Hearing/Ear Problems	□ Neuropathy
□ Allergies (Seasonal)	□ COPD	□ Heart Disease/MI	□ Osteoporosis
□ Anxiety	□ CVA (Stroke)	□ Hepatitis	□ Rheumatic Arthritis
□ Arthritis	□ Depression	□ High Cholesterol	□ Sciatica
□ Asthma	□ Diabetes	□ Hypertension	□ Skin Disorder
□ Atrial Fibrillation	□ Edema	□ Keloids/Thick Scars	□ Sleep Apnea
□ Back Problems	□ Epilepsy	□ Kidney Disease	□ Stomach Ulcers
□ Blood Disorder	□ Fibromyalgia	□ Liver Disease	□ Syncope
□ Blood Clots/DVT/PE	□ GERD	□ Lung Disease	□ Thyroid Disease
□ Cancer	□ Glaucoma	□ Lyme's Disease	□ Tuberculosis
□ Circulation Problems	□ Gout	□ Mitral Valve Prolapse	□ Vascular Disease

□ Other: _____

_____

_____

Surgical History

□ Amputation of Foot or Toes	□ Foot Surgery	□ Open Heart Surgery
□ Ankle Surgery	□ Fracture Orthopedic Surgery	□ Organ Transplant
□ Bariatric Surgery	□ Hammertoe Surgery	□ Pacemaker/Defibrillator
□ Bunion Surgery	□ Hip Surgery/Replacement	□ Vascular Surgery
□ Colon Surgery	□ Knee Surgery/Replacement	□ Other

Please list all other surgeries: _____

Allergies

Are you allergic or sensitive to any of the following: □ *No Known Drug Allergies*

□ Penicillin □ Sulfa □ Tape □ Latex □ Betadine (iodine) □ Aspirin □ Tylenol

□ Ibuprofen □ Vicodin □ Codeine □ Local or General Anesthesia □ Other _____

_____

_____

Social History

Please indicate with a (X) any of the responses below that pertain to you.

- Tobacco Use: Cigarettes: □ Never Smoked
  □ Current Smoker _____Packs per day _____Number of Years
  □ Former Smoker _____Number of Years _____Quit Date
  Other Tobacco: □ Vape □ Pipe □ Cigar □ Snuff □ Chew
  Are you interested in quitting? □ Not Ready to Quit □ Thinking about Quitting □ Ready to Quit
- Alcohol Use: □ None □ Rarely □ Moderate □ Quit
- Recreational Drug Use: □ Yes □ No
- Exercise Level: Do you exercise daily regularly: □ Yes □ No
  List activities:_____

Family History

Please indicate with a (X) for any responses below that pertain to your family members.

Medical Condition	Father	Mother	Siblings	Children
Living				
Deceased				
Blood Clots				
Cancer				
Depression				
Diabetes				
Heart Disease				
High Blood Pressure				
High Cholesterol				
Heart Disease				
Mental Illness				
Rheumatoid/Autoimmune				
Stroke				
Vascular Disease				
Other				

Acknowledgement and Agreement

Authorization to Access Electronic Prescription Records

I authorize Modern Podiatry and Dr. Christopher Blakeslee to view my external prescription history via electronic prescribing services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies and pharmacy benefit managers may be viewable by my provider and staff here. It may include prescriptions back in time for several years and may include prescriptions to treat HIV, substance abuse and psychiatric conditions, if applicable. I understand that my prescription history will become part of my Jackson Family Foot & Ankle Care medical record.

_____I agree to allow access to my electronic prescriptions

Health Information Exchange (HIE)

Modern Podiatry also participates in electronic health information exchanges (HIEs) with hospitals and various other health care providers. I authorize Modern Podiatry and the HIEs with which it participates to share my health information, through the HIE networks, for purposes permitted by law, including my treatment and coordination of my care, with all health care providers that are authorized under the HIEs' policies and applicable law to access my information. I understand and agree that the information about me that may be shared and accessed through the HIEs may include information about HIV/AIDS status, sexually transmitted diseases, family planning, mental health treatment, genetic test results, use of alcohol and other substances and other sensitive categories of my health information. I understand that I have the right to "opt-out" of having my information shared through HIEs.

_____I agree to allow access to my health information exchange (HIE)

Consent to Treat

I, the underlying, voluntarily consent to and authorize Dr. Christopher Blakeslee and the employees of Modern Podiatry to provide such podiatric care and examinations, on a continuing basis, and to administer such routine diagnostic, radiological and/or therapeutic procedures, test and treatments as are considered necessary or advisable, in my diagnosis, care and treatment, in the judgement of Dr. Christopher Blakeslee, including, but not limited to, collecting and testing specimens, and administration of pharmaceutical products. I acknowledge that no guarantees have been made to me about the results of any examination or treatment.

_____I agree to treatment as described above.

Notice of Privacy Practices Receipt Modern Podiatry

I acknowledge receiving or viewing the Modern Podiatry Notice of Privacy Practices. I also acknowledge that current notice and future revisions of this notice will be available on the Modern Podiatry website www.ModernPodiatryNJ.com or upon request.

_____I acknowledge receipt of the Notice of Privacy Practices.

I have read and understand this form.

Patient Name:_____Signature:_____

Authorized Representative

Print Name:_____Signature:_____

Relationship to Patient:_____Date:_____

Acknowledgement of Financial Responsibility

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

Insurance Coverage

- We participated 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.
- We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed on your behalf. However, that does not mean that all services are covered. You are responsible for any deductible amount or non-covered services or co-insurance amount.
- 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.
- Please be aware that some of the services that 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.

Insurance Changes

- If you have had any changes in your insurance coverage, please notify us. Failure to do so may result in a claim denial and you will be billed.

Co-Payments, Co-Insurance, Deductibles and Self Pay

- Co-insurance and co-payments are the patient's/guarantor's responsibility. Co-payments are due at the time of the visit.
- Deductibles are the patient's/guarantor's responsibility. The deductible is determined by the contract you have with your health insurance carrier.
- Failure on our part to collect copayments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your copayment at each visit.
- Payments in full is due at time of service if you do not have health insurance.

Referrals

- Some insurances require a referral. We are required to follow the guidelines of your insurance which mandates us to have a referral from your primary care physician prior to seeking specialty care. If you are unsure if you need a referral, it is the patient responsibility to reach out to their insurance company.
- If you do not have a referral at time of visit, you will be financially responsible for all services received due in full upon completion of the visit.

Insurance Requests

- We will submit your claims and assist you in any way we reasonably can to help get your claim paid. Your insurance company may need you to supply certain information directly.
- You are responsible for responding to insurance company requests for further information. Failure to do so may result in a claim denial and you will be billed.
- 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

- Patient Statements will be mailed after we have received the explanation of benefits from your insurance company. If a second or third statement is required, a $10 rebilling fee will be added to your account for each subsequent statement.
- If your payment is not received after the third statement, your account will incur a $50 collection fee and will be forwarded to collections where additional fees may apply.

Acknowledgement of Financial Responsibility

- Bounced check fee - $50
- We accept the following payment methods: Cash, Check or Visa/MasterCard/Amex and Discover.
- In the event 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.

Medical Record Fees:

- The fees the practice may charge according to New Jersey Board of Medical Examiners:
  - The doctor may charge you to copy your records. The cost may not be greater than $1.00 per page or $100.00 for the entire record, whichever is less. If your records are no more than 10 pages, the doctor may charge $10.00.
  - The fees apply regardless of whether the practice provides the copies directly to the patient, electronic or paper.
- When records are mailed, we will charge the actual cost of the postage or shipping.
- A search fee of no more than $10.00 per patient per request. The search fee is permitted even though no medical record is found as a result of the search.

Missed/Canceled Appointments

- If 24-hour notice is not giving for any cancellation or missed appointment, you will be subject to a $25 fee.

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.

Assignment of Benefits

- I certify that I (or my dependent) have coverage with my insurance as presented and assign directly to Jackson Family Foot and Ankle Care DBA: Modern Podiatry all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, copayments and/or non-covered services rendered. 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 by physicians to provide continuity of care. I authorize the use of this signature on all insurance submissions.

I have read and understand the terms of this Financial Responsibility form. I agree to pay Modern Podiatry any balances unpaid by my insurance carrier for myself or the below nae person.

Patient Name:_____ Signature:_____

Financially Responsible Party

Print Name:_____ Signature:_____

Relationship to Patient:_____ Date:_____