North Scottsdale Podiatry Group
9755 N. 90th St, Suite C120
Scottsdale, AZ 85258

Patient Information Form

Date_____

Patient Name _____Home Phone _____ Fax:_____

Work Phone _____ Cell Phone _____ E-Mail_____

Birth date _____Social Security Number _____Age_____

Address_____City/State_____Zip_____

Male _____Female _____ Single _____Married _____Widowed _____

Language_____

Ethnicity: (Circle One) White, Hispanic, African American, American Indian, Asian, Native American

Employer Name & Number_____

Referring Physician _____Primary Physician_____

Primary Insurance Name _____Phone #_____

Name of Insured_____Relationship_____

Social Security Number_____Birthdate_____

ID#_____Group#_____

Secondary Insurance Name _____Phone#_____

ID#_____Group#_____

****

This office is required to keep your signature on file authorizing us to file claims to your insurance company and to release information to that payor for consideration. Please read and sign the following statement:

I authorize any holder of medical or other information about me to be released to the insurance company. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts the assignment. Regulations Pertaining to Medicare assignment of benefits apply.

Signature_____Date_____

PLEASE PAY YOUR COPAY THAT IS REQUIRED WHEN YOU ARRIVE & PRESENT YOUR INSURANCE CARDS TO BE COPIED. THANK YOU FOR CHOOSING THIS OFFICE TO ASSIST YOU.

MEDICAL HISTORY

Please fill in ALL sections of these forms as this information is required by the Doctor

Patient's Name: _____ Patient's Age:_____

Today's Date: _____ Who Referred You To Us: _____

Who is your Primary Care Physician: _____

When was your last visit with your Primary Physician: _____

Please Check Off ALL That Apply To You (PAST AND CURRENT):

	YES	NO		YES	NO
Allergies (Seasonal)			Kidney Disease		
Alzheimer's/Dementia			Leukemia		
Anemia			Lung Disease		
Anxiety and/or Depression (specify)			Migraines		
Arthritis			Neuropathy		
Asthma			Neurological Disease		
Blood Diseases			Osteoporosis		
Cancer (specify type):			Pacemaker		
Cholesterol			Parkinson's		
Circulatory Problems			Phlebitis		
Delayed Healing			Polio		
Diabetes (specify type):			Prone to Infection		
Diverticulitis/Diverticulosis			Prostate Issue		
Emphysema			Skin Disease		
Epilepsy			Spinal Disease		
Gall Bladder Removed			Stomach Disorders		
GERD			Stroke		
Gout			TB		
Heart Disease			Thyroid Disease		
Hernia (specify type):			Tumors/Growths		
High Blood Pressure			Ulcers (Legs/Feet)		
HIV/AIDS			Valley Fever		

Additional Medical Problems: _____

_____

MEDICAL HISTORY (continued)

FOR OFFICE USE ONLY:

BP: _____ /_____

Pulse:_____

WEIGHT: _____ HEIGHT: _____ SHOE SIZE: _____

IF YOU'RE A DIABETIC, what is your Most Recent A1C : _____

And your Current Fasting Blood Sugar : _____

IF YOU'RE ON A BLOODTHINNER (Warfarin, Coumadin, etc.), what is your Most Recent INR: _____

Do you Smoke? Yes _____ No _____ Daily Use: _____ Duration:_____

Do you drink Alcohol? Yes _____ No _____

What is your Occupation? _____

Do you Exercise and how often? _____

Are you currently pregnant, trying to get pregnant, or breast feeding? Yes _____ No _____

Have you had any previous Podiatry care? If so what did you have done and how long ago?

_____

FAMILY HISTORY : (Check Off and Circle Any That Apply To Your Immediate Family)

____ HYPERTENSION	Mother	Father	Grandparent	Sibling
____ HEART DISEASE	Mother	Father	Grandparent	Sibling
____ DIABETES	Mother	Father	Grandparent	Sibling
____ FOOT PROBLEMS	Mother	Father	Grandparent	Sibling
____ CANCER	Mother	Father	Grandparent	Sibling
____ OTHER	Mother	Father	Grandparent	Sibling

SURGICAL HISTORY/HOSPITALIZATIONS:

☐ None

☐ I have had the following surgeries or hospitalizations in the past:

_____Year: _____ _____Year: _____

_____Year: _____ _____Year: _____

MEDICAL HISTORY (continued)

LIST OF CURRENT MEDICATIONS:	
Please list any medications that you are now taking or provide us with a list. Include non-prescription medications & vitamins or supplements: NAME OF DRUG	DOSE (include strength & how many you take per day)
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Do you have any Drug Allergies? If so <u>Please Be Specific</u>:

_____

_____

Are You Allergic To: (check all that apply)	Yes	No
IODINE		
LOCAL ANESTHETICS		
ADHESIVE TAPE		
LATEX GLOVES		

MEDICAL HISTORY (continued)

What is the Reason for your Visit Today? (Please Be Specific)

_____

_____

Was this due to an Injury? (If Yes please explain)

_____

_____

How long have you had this problem?

_____

_____

ARE YOU CURRENTLY EXPERIENCING ANY OF THESE SYMPTOMS? (Check Off All That Apply)

Cardiovascular

___Leg Pain When Walking

___Chest Pain ___Chest Pressure/Angina

___Leg Swelling ___Cold Hands Or Feet

___Leg Cramps ___High Blood Pressure/Hypertension

Respiratory

___Chest Pain ___Difficulty Breathing

___Wheezing ___Coughing

___Shortness Of Breath

Integumentary

___Athletes Foot ___Nail Abnormalities

___Keloids ___Itchiness

___Dry, Scaly Skin ___Rash

___Lower Leg Ulcers

Musculoskeletal

___Back Pain ___ Joint Swelling/Pain

___Muscle Weakness ___Muscle Pain

___Neck Pain ___Sciatica

___ Joint Instability

General

___Nausea/Vomiting ___Fever

___Dizziness ___Chills

___Weight Gain/Weight Loss ___ Vision Problems

Endocrine

___Dry Hair ___Cold Intolerance

___Dry Eyes ___Weight Changes

___Thyroid Problems

Neurological

___Tingling ___Weakness

___Numbness ___Seizures

___Tremors ___Paralysis

Hematologic

___ Sickle Cell Disease ___Clotting Disorders

___Anemia ___Bleeding Problems

___Use Of Blood Thinners

Immunologic

___Chemotherapy ___Gout Attack

___Rheumatic Diease ___Arthritic Flare

NORTH SCOTTSDALE PODIATRY GROUP

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices by North Scottsdale Podiatry Group and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Patient Signature

AUTHORIZATION TO RELEASE MEDICAL LAB RESULTS OR ANY OTHER MEDICAL INFORMATION

I hereby authorize North Scottsdale Podiatry Group to release my protected medical information to the following listed individual(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____

Patient Signature Date

MAY THE OFFICE LEAVE A MESSAGE ON VOICEMAIL REGARDING YOUR TEST RESULTS? (please check one)

_____ Yes _____ No

NORTH SCOTTSDALE PODIATRY GROUP

PATIENT INSURANCE AGREEMENT

I hereby authorize the processing of the Medical Insurance either by electronic or manual method by North Scottsdale Podiatry Group. My signature authorizes payment of all major medical and/or surgical benefits to which I am entitled from the listed Insurer I have provided to pay North Scottsdale Podiatry Group. I further authorize North Scottsdale Podiatry Group to release all medical and/or insurance claim information necessary to secure the payment(s).

- **You are responsible for any co-payments, co-insurance, deductibles, out-of-network costs, and all non-covered services. Copayments are due at the time of service.**

You are responsible to know when you are eligible for services and to know your insurance coverage. It is your responsibility to notify us at the time of your visit if you need a referral, pre-authorization for any procedures, or specialist and if lab work needs to be sent to a special lab. Please understand that if we have not been advised in advance of your program's requirements and we provide a service or use a laboratory or hospital that is outside your program, **you will be responsible for the appropriate fees**. Your insurance carrier should have provided you with a phone number for you to use to obtain information about your coverage.

- **ROUTINE FOOT CARE MAY NOT BE COVERED BY YOUR PLAN**

Routine Foot Care Includes: The Cutting or Removal of Corns, Callouses or Nails; Trimming Of Nails, and Heel Fissures. So please be advised that the cost of these services will be your responsibility at the time of service if not covered under your insurance plan.

By signing below, I acknowledge that I have read and understand the above information and agree to all the terms listed above. This agreement will remain in effect until revoked by me in writing. A copy of this document will be considered valid as an original.

Printed Patients Name: _____

Patients Signature: _____

Date: _____

NORTH SCOTTSDALE PODIATRY GROUP
9755 N 90TH ST STE C120
SCOTTSDALE, AZ 85258
480-391-9193

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
1) Routine Nail Care	No Systemic Condition	1) 45.00
2) Corns and Callouses	No Systemic Condition	2) 45.00
3) Heel Fissures	No Systemic Codition	3) 45.00
4) Orthotics/Therapeutic Shoes	A narrow exception permits coverage of special shoes and inserts for certain patients with diabetes.	4) 250-500
5) Darco/Surgical Shoes		5) 25.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date: