Welcome to Partners In Foot Health. Please answer the following questions and know that all information is strictly confidential. Thank you for choosing our office.

Patient Name: _____ **Date of Birth:** ____/____/____
(First) (Middle) (Last)

Home Address: _____**City**_____**State:**_____ **Zip:** _____

Home Phone (**)** _____ **Cell Phone (** **)** _____ **Work Phone (** **)** _____

Social Security# _____ **Email Address:** _____

Age: _____ **Sex:** [] Male [] Female **Marital Status:** [] Single [] Married [] Divorced [] Widowed

Employer: _____ _____**Occupation** _____

Race: [] White [] Black/African American [] American Indian [] Asian [] Native Hawaiian

Ethnicity: [] Hispanic/ Latino [] Non Hispanic/ Latino

Spouse/Parent/Guardian Name: _____ **Phone (** **)** _____

Emergency Contact Person: _____ **Phone (** **)** _____

Primary or Referring Physician _____ **Phone (** **)** _____

Address_____

Who referred you to our office? **[] Doctor**_____ **[] Friend/Family**_____
[] Yellow Pages [] Internet [] Office Website [] Other_____

Primary Insurance: _____ **ID/Contract #**_____ **Group#**_____

Policy Holder: _____ Relationship to patient _____ Date of Birth _____

Secondary Insurance: _____ **ID/Contract #**_____ **Group#**_____

Policy Holder: _____ Relationship to patient _____ Date of Birth _____

It is your responsibility to inform us of any changes in your insurance. Failure to do so may result in claims not being paid and you being billed for the entire balance. If your insurance requires a referral to see a specialist this is your responsibility to provide one or you will be billed for the entire visit.

Assignment and Release
I, the undersigned, certify that I (or my dependant) have insurance coverage with the above plan (s) and hereby assign all insurance benefits, if any, otherwise payable to me, directly to Partners In Foot Health for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I also authorize the doctor to release all information necessary to secure the payment of benefits from my insurance company.

Consent for Treatment
I give permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet:

Patient/Guardian Signature: _____ Date: _____

PATIENT MEDICAL HISTORY

THANK YOU FOR VISITING OUR OFFICE. PLEASE FILL OUT THE FOLLOWING:

NAME_____ **AGE** _____ **DATE OF BIRTH:** _____

Please check all that apply to you: **[] I have no medical conditions**

[] Acid Reflux
[] Anemia
[] Anxiety
[] Arthritis
[] Asthma
[] Back Pain
[] Bladder Disease
[] Blood Clots
[] Blood Disorders (Sickle cell)
[] Bronchitis
[] Cancer (type) _____
[] Depression
[] Diabetes (How many years? _____)
[] Epilepsy
[] Gastric Ulcers
[] Gout
[] Heart Attack
[] Heart Disease
[] Hepatitis
[] High Cholesterol
[] HIV/AIDS
[] Hypertension
[] Kidney Disease
[] Liver Disease
[] Lung Disease
[] Seizures
[] Stroke
[] Thyroid Disease
[] Vascular Disease

Other Medical Conditions: _____

MEDICATIONS (Name only): **[] I take no medications** **[] Medication list provided by patient**

_____

_____

_____

Are you currently taking any herbal medications or vitamins? **[] I use no herbal medications or vitamins**

_____

_____

ALLERGIES: [] I **have no drug allergies**

[] Aspirin
[] Antibiotics (list below)
[] Anti-inflammatory
[] Iodine
[] Codeine
[] General Anesthesia
[] NSAIDS
[] Latex
[] Local Anesthesia
[] Sulfa
[] Pain Meds (list below)
[] Penicillin
[] Shellfish
[] Tape

Other Medication Allergies: _____

FAMILY HISTORY (Diabetes, Heart Disease, Gout, Cancer, Foot Problems or other):

Mother: _____
Father: _____
Siblings: _____
Grandparents: _____

SURGERIES AND HOSPITALIZATIONS (procedure, year and any complications)

_____

_____

_____

IMPLANTS/ARTIFICIAL JOINTS/PACEMAKER (Please list) _____

_____

HEIGHT: _____ **WEIGHT:** _____ **SHOE SIZE:** _____ [] Medium [] Narrow [] Wide

Do you consume alcohol? [] No [] Yes If so, how many drinks/beers in a week? _____
Do you smoke? [] No [] Yes If so, number of packs/day _____ for _____ years
Did you ever smoke? [] No [] Yes If so, how much? _____ packs/day for _____ years, quit in _____

I certify that the above information is true and correct to the best of my knowledge.

Patient/Guardian signature: _____ **Date:** _____

Patient/Guardian signature: _____ **Date:** _____

PARTNERS IN FOOT HEALTH, P.C.
3976 Dix Hwy
Lincoln Park, MI 48146

Dear Patient:

For your convenience and safety, our office utilizes a computerized prescription program that allows both the accuracy and convenience of prescribing medications. This program allows for the electronic transmission of most of your prescriptions directly to your pharmacy.

To use this program we need to collect some information from you on the pharmacy of your choice.

We understand that you may not have the complete pharmacy information with you today. Please provide any information possible regarding the location (street, city, phone, fax) since any information provided will be helpful.

Thank You

Patient Name: _____ **Date of Birth:** _____

☐ **No allergies to Medications**

Drug allergies:

_____

_____

Main Pharmacy:

Name: (i.e. CVS, Rite-Aid, Walgreens, etc..) _____
Street Name and City: _____
Phone: _____ Fax: _____

Secondary Pharmacy: (you would like kept on file)

Name: (i.e. CVS, Rite-Aid, Walgreens, etc..) _____
Street Name and City: _____
Phone: _____ Fax: _____

At this time we do not electronically transmit to Mail Order Pharmacies. If you need to use this type of pharmacy we can print the Rx for you to take with you.

PARTNERS IN FOOT HEALTH

PATIENT FINANCIAL POLICY

Your understanding of our financial policy is an essential element of your care and treatment. If you have any questions, please discuss them with our office staff.

- We must emphasize that as a health care provider, our relationship is with you, our patient, and not with your insurance company. As a courtesy to you and per our contract with your insurance company, we will bill them directly assuming you have given us all your insurance information. We charge what is usual and customary by our area. The patient is responsible for any remaining unpaid charges as determined by your insurance company.

- ***You are responsible for knowing what your insurance benefits are, with regards to what insurance will and will not pay for. If you are in doubt, please contact your insurance carrier. This office assumes no responsibility for your lack of knowledge regarding your insurance benefits. We will attempt to verify benefits for some special services; however, you remain responsible for charges to any service rendered. Please understand that payment of your bill is considered part of your treatment.***

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office. If no authorization/referral is provided at the time of service you are responsible for all charges and payments due at time of service.

- We require all co-pays, office visit charges and non-covered insurance charges to be paid at the time services are rendered as indicated in our contract (and yours) with your insurance carrier. We accept Visa, MasterCard, Discover, American Express as well as debit cards, cash and personal checks.

- We do offer payment plans for outstanding balances due, not for co-payments. Please call our billing department to work that out. Our office will send out two (2) courtesy statements before sending the account to collections. (see below)

- Financial hardship cases are determined on an individual basis and should be directed to the doctor.

- **Our office uses GreenFlag Profit Recovery a division of Transworld Systems for our collection accounts. Collection fees, and court fees shall become your responsibility in addition to the balance due this office if collection proceedings are taken.**

We thank you for understanding our financial policies. Our goal is to make your visit with us as pleasant and professional as we can. If you have any questions, please feel free to ask or call our office for assistance at (313) 386-5750.

I understand these policies and agree to be bound by their terms. I also understand that such terms are subject to change or be amended and I will be notified of any such changes or amendments.

_____ _____

Patient/Guardian or Parent Date

_____ Patient initials to indicate copy received

ACKNOWLEDGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I will be offered a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so Chose) and understood the Notice.

_____ _____

Patient Name (please print) Date

_____

Parent of Authorized Representative (if applicable)

_____

Signature