THE PODIATRY CARE CENTER
www.thepodiatrycarecenter.com
12150 Annapolis Road, Suite 109 Glenn Dale, MD 20769
(301) 352-3668 Phone (301) 352-3669 Fax

NEW PATIENT INTAKE FORM: WELCOME TO OUR PRACTICE!!!

DATE: _____ REFERRED BY: PHYSICIAN: _____ FRIEND: _____ WEBSITE: _____

DEMOGRAPHIC INFORMATION:

PATIENT LAST NAME: _____

PATIENT MIDDLE NAME: _____

PATIENT FIRST NAME: _____

GENDER IDENTITY: _____ DATE OF BIRTH: _____ SS #: _____

HOME: _____ WORK: _____ CELL: _____

☐ I CONSENT TO RECEIVE AUTOMATED TEXT AND VOICE MESSAGES AT THE PHONE NUMBER(S) ABOVE.

E-MAIL: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PAYMENT INFORMATION:

PRIMARY INSURANCE: _____ POLICY #: _____

SECONDARY INSURANCE: _____ POLICY #: _____

TERTIARY INSURANCE: _____ POLICY #: _____

INSURANCE POLICY:

PATIENT RELATIONSHIP TO GUARANTOR: SELF: _____ SPOUSE: _____ PARENT: _____ OTHER: _____

GUARANTOR NAME_____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

GENDER IDENTITY: _____ DATE OF BIRTH: _____ SS #: _____

PRIMARY PHONE NUMBER: _____ SECONDARY PHONE NUMBER: _____

PRESCRIPTIONS:

PREFERRED PHARMACY: _____ PHONE: _____ CITY:_____

PREFERRED LANGUAGE: _____ **RACE:** _____

HISPANIC/LATINO:_____ NOT HISPANIC/LATINO:_____ DECLINED TO SPECIFY:_____

CARE TEAM: PRIMARY CARE PROVIDER: _____ PHONE NUMBER:_____

NEXT OF KIN:

NAME: _____ RELATIONSHIP TO PATIENT: _____ PHONE: _____

PODIATRY HISTORY:

REASON FOR VISIT: _____

DURATION: _____ **PRIOR TREATMENT:** _____

PERSONAL MEDICAL HISTORY: Please check all that apply:

	YES	NO		YES	NO		YES	NO		YES	NO
ANEMIA			GOUT			PSYCHIATRIC CARE			HEART VALVE		
STROKE			HEART DISEASE			RHEUMATIC FEVER			CANCER		
ARTHRITIS			HEMOPHILLA			SICKLE CELL			THYROID DISORDER		
ASTHMA			HEPATITIS/JAUNDICE			HIGH CHOLESTEROL			LIVER DISEASE		
LUPUS			EPILEPSY			STOMACH ULCERS			HIGH BLOOD PRESSURE		
						GLAUCOMA			CATARACT EYE DISORDER		
HIV			RAYNAUD'S			GAUCHER DISEASE			RHEUMATOID ARTHRITIS		
ALS			BLOOD CLOT			FOOT INJURY			VENOUS HYPERTENSION		
EDEMA			GUILLAIN BARRE			ANKLE INJURY			VENOUS INSUFFICIENCY		
ABSCESS			KIDNEY DISEASE			NEUROPATHY			PHLEBITIS/THROMBOSIS		
LEPROSY			LYMPHEDEMA			AMYLOIDOSIS			SPINAL MUSCLE ATROPHY		
SYPHILLIS			BLOOD THINNER			ATHEROSCLEROSIS			NEIMANN-PICK DISEASE		
CHARCOT			CELIAC DISEASE			MULTIPLE SCLEROSIS			PVD/POOR CIRCULATION		
CELLULITIS			VEIN DISORDER			POLYNEUROPATHY			FABRY-ANDERSON DISEASE		
DIABETES			ONYCHOMYCOSIS			RIBOFLAVIN DEFICIENCY			PERIPHERAL/CENTRAL		
LEG INJURY			NIACIN DEFICIENCY			VITAMIN B12 DEFICIENCY			NERVOUS SYSTEM		

SOCIAL HISTORY:

Do you SMOKE? YES NO If Yes, how many per day? _____ How many years? _____
Do you DRINK? YES NO If Yes, how frequent? _____ How much? _____
Do you EXERCISE? YES NO If Yes, how often? _____ How many days a week? _____
OCCUPATION: _____ How long are you on your feet during the day? _____

SURGERIES: Please list all surgeries that you have had and the date performed.

Type of Surgery	Date	Type of Surgery	Date
1.		4.	
2.		5.	
3.		6.	

Did you experience any major complications? If yes, explain: _____
Do you form keloids or excessive scars after surgery of an injury?: _____

FAMILY MEDICAL HISTORY: Please indicate all that apply.

Medical Condition	Family Member	Medical Condition	Family Member	Medical Condition	Family Member
Diabetes		Arthritis		Stroke	
Hypertension		Cancer		Heart Disease	
Poor Circulation		Foot Disorder			

ALLERGIES: Please indicate as it applies to you.

Allergy	NO	YES-If Yes, what was the reaction?	Allergy	NO	YES –If Yes, what was the reaction?
Adhesive Tape			Betadine		
Latex			Codeine		
Penicillin			Aspirin		
Sulfa			Iodine		
Other					

MEDICATIONS: List medications you are currently talking-include if taking **COUMADIN, ASPIRIN, PLAVIX & PREDNISONE.**

Name of Medication	Daily Dosage	Name of Medication	Daily Dosage
1.		4.	
2.		5.	
3.		6.	

CONSENT: I certify that the above information is true and correct. I give my permission to The Podiatry Care Center, LLC to administer and perform such procedures as deemed necessary for the diagnosis and/or treatment of my feet and/or ankles. I authorize payment of medical benefits to The Podiatry Care Center for professional services rendered. I authorize the release of any medical or other information necessary to process my insurance claims. I understand that I am financially responsible for all charges not covered by my insurance; including the balance remaining after payment of insurance benefits, coinsurance and/or deductible.

Patient/Guardian Signature: _____ **Date**:_____

THANK YOU FOR CHOOSING THE PODIATRY CARE CENTER, LLC

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CONSENT TO TREAT AND ASSIGNAMENT OF BENEFITS

Release of Information:

~ All information provided herein is true and correct.
~ I hereby consent to treatment.
~ I give permission to The Podiatry Care Center, LLC to release information, verbal and written contained in my medical record and other related information to my insurance company, related healthcare provider, case manager, attorney, school, employer, assignees and/or beneficiaries and all other related persons as it relates to my treatment.
~ I authorize The Podiatry Care Center, LLC to obtain medical records and/or professional information from my physician and other medical professionals as it relates to my treatment.
~ Information without patient identifiers may be used for quality assurance purposes.

Assignment of Benefits:

~ I authorize payment directly to The Podiatry Care Center, LLC
~ This is a direct assignment of my rights and benefits under this policy
~ A copy of this assignment shall be considered as effective and valid as the original

Notice of Privacy (HIPAA Acknowledgment/Consent)

~ I hereby acknowledge that I have received a copy of and I understand the Notice of Privacy Practices for The Podiatry Care Center, LLC
~ In addition, I hereby consent to the use and disclosure of my personal health information for the purpose of treatment, payment and healthcare operations.

Payment Guarantee

~ I agree to pay The Podiatry Care Center, LLC for the services sand/or products provided to me or the party names above. If by law, such as workers' compensation or insurance contracts prohibits payment for these services and/or products I will cooperate and assist in the provision of information, authorizations, releases or any other type of information necessary to allow for speedy collection from my payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances.

~ I acknowledge that the benefit verification form is only an explanation of coverage obtained from my insurance company and its's not a guarantee of coverage. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, or that coverage is insufficient, I will be responsible for payment of any unpaid portion of payment for any and all services and/or products received from The Podiatry Care Center, LLC. I further acknowledge that the insurance information I provide is accurate and up-to-date at the time of all services rendered. If it is determined that this is not the case I will be responsible for all charges incurred for that date of service.

~ I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatment unless agreed to in writing by myself and a representative of The Podiatry Care Center, LLC.

~ I understand that monies owed which are my responsibility to pay exceed 90 days of delinquency additional fees may/will be applied for collection services, attorney fees, court costs and any other costs for collection.

I have read the above and understand the information provided. I authorize treatment and the release of information as explained. I approve of the Assignment of Benefits, acknowledge I have received the HIPPA Notice of Privacy Practices and guarantee payment.

Patient/Guardian Signature: _____ **Date**:_____

Printed Patient Name: _____

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please read carefully.

Rules and Disclosures of your protected health information (PHI):

Treatment: Your information will be disclosed to additional healthcare providers involved in your care.

Payment: Included are the disclosures of your PHI for payment to insurance companies. At times insurance companies require information regarding your medical procedures and treatment to determine that your treatment was a medically necessary.

Health Care Operations: Information will be utilized to improve the quality and cost of care delivered. This may include business management, professional peer review and evaluation of performance.

Appointment and Services: Includes the use of your email address and phone number for appointment reminders or information about your treatment or other health related benefits and services. If you would like us to refrain from using this information please submit your request in writing and we will accommodate this request.

Other Uses and Disclosures Permitted/Required by Law:
~ Public health activities such as required reporting of disease, injury, birth and death or required public health Investigations
~ If we receive reports of abuse, neglect or domestic violence
~ To your employers when we provide care to you at the request of your employer
~ To a government agency conducting audits, investigations, civil or criminal proceedings
~ Court subpoena or law enforcement officials as required by law
~ To funeral director/coroners as consistent with law
~ To worker compensation agencies for benefit determination

Your Privacy Rights: You have the right to request restrictions on uses and disclosures of your PHI for treatment, payment or healthcare operations. We will attempt to accommodate reasonable requests when appropriate.
~ If you believe your privacy rights have been violated you can file a complaint in writing without retaliation. If you have questions or need further assistance regarding this Notice you may contact us at:

The Podiatry Care Center, LLC
12150 Annapolis Road, Suite 109
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301-352-3668

I acknowledge that I have received a copy of this privacy notice and a comprehensive notice was made available.

Patient/Guardian Signature: _____ **Date**:_____

Printed Patient Name: _____

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APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to The Podiatry Care Center, LLC. When you schedule an appointment with The Podiatry Care Center, LLC we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

~Effective February 1, 2018 any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24-hour notice** will be considered a No Show and charged a **$50.00 fee**.

~ Any established patient who fails to show or cancels/reschedules an appointment without **24-hour notice for a second time** may be charged a **$65.00 fee.**

~ If a **third** No Show or Cancellation/Reschedule without 24-hour notice should occur the patient may be dismissed from The Podiatry Care Center, LLC.

~ Any new patient who fails to show for their initial visit on more than one occasion **will not be given another appointment,** but they may be seen on a future date as our schedule allows.

~ The No Show/Reschedule fee is charged to the patient, not the insurance company, and is **due at the time of the patient's next office visit.**

~ As a courtesy we send a reminder email, phone call and/or text message to remind you of your upcoming appointment. If you do not receive a reminder email, phone call or text message the above Policy will remain in effect.

You may contact The Podiatry Care Center, LLC during business hours at the number above. Should it be after regular business hours or a weekend, you may leave a message. Messages left are acceptable as timely cancellation methods.

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

Signature (Patient/Legal Guardian)	**Relationship to Patient**
Printed Name	**Date**