

Thank you for scheduling an appointment at Laurel Podiatry, the office of Shawn P. Echard, DPM.

To ensure your visit goes smoothly, the enclosed paperwork must be completed prior to your appointment.

Unlike prior experiences you may have had at doctor's offices, your wait time with us is minimal. We do, however, ask that you arrive 15 minutes prior to your appointment so our office staff can process your paperwork in our electronic medical records system.

If your paperwork is not completed, you will be asked to reschedule. This process helps our schedule to run pretty much on time or with a minimal wait time. Please take the time to complete the paperwork and be as detailed as you can.

**Appointment Date:** \_\_\_\_\_

**Appointment Time:** \_\_\_\_\_

**Directions:**

**Greensburg Office 724-832-7880**

235 Humphrey Road  
Two Pineview Place, Suite 4

From the West: Route 30 E, take the Pleasant Unity Exit. At the stop light facing Sunoco, turn left onto Humphrey Road (also Route 130). Go up the road and we are on the right in the brown brick office buildings called Pineview Place. We are in Building 2, Suite 4. (Upper Level) Drive up around to the back.

From the East: Route 30 W past Westmoreland Mall. Stay on Business Route (far right lane), do not stay on the main highway. Go toward downtown Greensburg. Go 2 stop lights and turn left onto Humphrey Road (also Route 130). Go up the road and we are on the left as soon as you pass the Plumber's Equipment Co. We are the brown brick office buildings called Pineview Place. We are in Building 2, Suite 4. (Upper Level) Drive up around to the back.

**Mt. Pleasant Office 724-547-3668**

100 Bessemer Road, Suite B

Route 119 S to the Scottdale Exit. At the stop light at the end of the ramp, make a left. Go 2 stop lights and make a left onto Bank & Trust Road (between GetGo and the Scottdale Bank & Trust. At the intersection, make a right and the office will be on the left in the State Farm Building. Our office and parking are located in the back of the building.

or

Go through the back entrance of McDonald's in the Country Side Plaza. Make the first right at the State Farm Building. Our office and parking are located in the back of the building.

**Somerset Office 814-443-1524**

223 South Pleasant Avenue  
Med-Cor Central, Suite 201

From the turnpike: You will proceed through the toll booth, past Eat n' Park and Highland's Motorcycle. Take the by-pass around past Jenny Vacuum and Leiss Tool and Die. Do not turn. Go through the stoplight and then to the stop sign. CVS Pharmacy is on corner as well as The Medicine Shoppe. Med-Cor is on the left 1/2 block ahead.

From downtown Somerset: Proceed east on Patriot Street past the hospital. This ends in a "T." Turn right and go 1/2 block. We are on the left in Med-Cor Central.

Today's Date: \_\_\_\_\_

Patient's Name:		Birthday:		Age:		e-mail:	
Street address:				Home phone:			
City:			State:		Zip:		Work phone:
Patient Soc. Sec #				Primary Care Doctor:			
Who may we thank for referring you to us?							
<b>Insurance Information</b>		Please allow our office to copy your insurance cards.					
Primary Insurance Co.				ID #		Group #	
Subscriber's name:				Subscriber's birthday:		Relation:	
Subscriber's Soc. Sec. #							
Secondary Insurance Co.				ID #		Group #	
Subscriber's name:				Subscriber's birthday:		Relation:	
Subscriber's Soc. Sec. #							
<b>What are you seeing the doctor for today?</b>							
Please explain here:							
Where is your pain?				Does the pain prevent you from working?			
How long has it hurt?				Does the pain occur with shoes on?			
What does it feel like?				Does it hurt barefooted?			
Does it hurt everyday?				Is it getting worse?			
What do you do that makes it hurt?				Describe any injury.			
What have you done to treat the condition?							
On a scale from 0 through 10, rate your pain:      no pain      0 1 2 3 4 5 6 7 8 9 10      severe pain							
What are your expected goals of treatment?							

**Medical History**

Check the squares, circle or fill in the blanks

**List your Allergies:**     None

- |                                  |                                     |                                   |                                  |                                      |
|----------------------------------|-------------------------------------|-----------------------------------|----------------------------------|--------------------------------------|
| <input type="checkbox"/> Latex   | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Aspirin  | <input type="checkbox"/> IVP dye | <input type="checkbox"/> Environment |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa      | <input type="checkbox"/> Novocain | <input type="checkbox"/> Tape    | <input type="checkbox"/> Iodine      |

**What medications do you take?**     None     I have brought a list

- |          |          |          |
|----------|----------|----------|
| 1) _____ | 4) _____ | 7) _____ |
| 2) _____ | 5) _____ | 8) _____ |
| 3) _____ | 6) _____ | 9) _____ |

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**Mark any that apply**

ARE YOU A DIABETIC?  Yes  No      How many years? \_\_\_\_\_      Do you take pills?      Insulin?  
What is your blood sugar range? \_\_\_\_\_  Don't know      What is your HbA1c? \_\_\_\_\_  Don't know

**Past Medical Problems**

HEENT

Cataracts       Glaucoma       Migraines       Headaches

Cardiovascular

Angina       Abnormal beat       High blood press       Blood clots       Circulation prob  
 Coronary dx       Pacemaker       High cholesterol       Phlebitis       Cold feet  
 Heart attack       Mitral v prolapse       Anemia       DVT      Have you ever had a blood transfusion?  
 Congestive heart dx       Heart valve dx       Leukemia       Bleeding disease       Yes       No

Endocrine/GI/GU

Thyroid disease       GERD       Stomach ulcer       Gall bladder       Hiatal hernia       Prostate  
 Incontinence       Irritable bowel       Hepatitis       Liver disease       Kidney disease       Dialysis

Respiratory

Asthma       COPD       Bronchitis       Sleep apnea  
 TB       Emphysema       Pneumonia      Do you use oxygen?       Yes       No

Neurological

Depression       Anxiety       Bipolar       Seizures       Cerebral palsy       MS  
 Stroke       Dementia       Down syndrome       Alzheimer's       Mental disability

Musculoskeletal

Hip prosthesis       Low back pain       Osteoarthritis       Osteoporosis       Rheumatoid Dx       Fibromyalgia  
 Knee prosthesis       Other implants       Amputation

Hospitalizations

Reason \_\_\_\_\_      Reason \_\_\_\_\_      Reason \_\_\_\_\_  
Date \_\_\_\_\_      Date \_\_\_\_\_      Date \_\_\_\_\_

Family History

In your immediate family (mother,father,brothers,sisters,grandparents), is there a history of any medical problems listed above?

Social History

Do you smoke?       Yes       No      Do you consider yourself sight impaired?       Yes       No  
How many packs per day? \_\_\_\_\_      Do you consider yourself hearing impaired?       Yes       No  
How long have you smoked? \_\_\_\_\_      Are you physically handicapped?       Yes       No

Tell us about your work habits: \_\_\_\_\_

Tell us about your leisure activities: \_\_\_\_\_

Are you pregnant?  Yes  No  DNA      How many children do you have? \_\_\_\_\_      Are you an organ donor?  Yes  No

Do you have an advanced directive?       Yes       No      What type?       Living Will      Power of Attorney \_\_\_\_\_

Sex:       Male       Female       Single       Married       Widowed       Divorced

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Shoe size: \_\_\_\_\_ Do you use any device to help you walk?  No  Cane  Walker

*Your signature verifies that the medical information that has been provided above is accurate to the best of your knowledge. Further, your signature acknowledges that Laurel Podiatry Associates, LLC has given you the opportunity to read the HIPAA privacy policies, practices and procedures that are used in this office and required by federal law. It is understood that a separate consent is needed for disclosure of your private health information. It is also understood that by seeking foot care to be provided by this office, that you give consent for those examinations and/or treatments that are commonly performed in this office. This includes, but is not limited treatment for toenail and skin conditions, circulation problems, neurological problems and deformities of the foot. This may include surgical procedures, x-rays, vascular tests, gait analysis or injections.*

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**Our Office Policy**  
**Laurel Podiatry Associates, LLC**

Our doctor makes every effort to participate with any third party insurance carrier. In fact, this practice accepts almost all insurance contracts. We reserve the right to refuse assignment of benefits when this office doesn't have a contractual provider relationship with your carrier.

However, we cannot render services on the assumption that your charges will be paid entirely and solely by your insurance company. Certain insurance plans require the patient to pay the deductibles, co-insurance, or ineligible services. Some insurance companies require a referral form to allow treatment.

***It is the policy of this office is to have the referral prior to your appointment. Your carrier will refuse payment, so the charges for that day will be your responsibility.***

All insurance forms processed by this office, prior to payment in full, are assigned to this practice. Your cooperation in complying with this assignment will be greatly appreciated. **MOST MISUNDERSTANDINGS ABOUT INSURANCE CAN BE AVOIDED IF YOU UNDERSTAND WHAT YOUR POLICY PROVIDES.**

***If your carrier refuses payment, then that balance is your responsibility.***

Further, the information that has to be obtained for treatment and billing purposes has to be accurate. We require that all patients provide all relevant medical and demographic data to accomplish this. The changes to that information need to be reported at subsequent visits.

**OUR OFFICE CHARGES A \$30.00 FEE FOR ANY MISSED OR "NO SHOW" APPOINTMENTS AND FOR APPOINTMENTS THAT ARE NOT CANCELLED OR RESCHEDULED WITHIN 24 HOURS OF YOUR SCHEDULED APPOINTMENT. WE WILL PROVIDE REMINDER CALLS THE BUSINESS DAY PRIOR TO YOUR APPOINTMENT.**

**ASSIGNMENT OF BENEFITS:**

I hereby authorize, Laurel Podiatry Associates to release any information to insurance carriers necessary to process this and any future insurance claims. I hereby assign to, Laurel Podiatry Associates, direct payment of medical benefits for all medical charges incurred by me or my dependents for services rendered by Laurel Podiatry Associates, LLC (Shawn P. Echard, DPM) or under his supervision. **I understand that I am responsible for any amount not covered by my insurance plan.**

My signature below acknowledges that I am aware of and understand the above described practice of Laurel Podiatry Associates, and that I agree to be legally bound to the terms of this practice policy.

**Authorization:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*Photocopy of these assignments shall be valid as the original.*

This is the policy of the office regardless of your authorization. The authorization above simply indicates that we have explained the office policy to you and not necessarily your acceptance.

**LAUREL PODIATRY ASSOCIATES, LLC**

**PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I hereby give my consent for Laurel Podiatry Associates, LLC to use and disclose protected health information (PHI) about me to carry out treatment, and payment and healthcare operations (TPO). (Laurel Podiatry Associates, LLC's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing the consent. Laurel Podiatry Associates, LLC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Laurel Podiatry Associates, LLC Privacy Officer at 235 Humphrey Road, Two Pineview Place Suite #4, Greensburg, PA 1560.

With this consent, Laurel Podiatry Associates, LLC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice carrying out TPO. Such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Laurel Podiatry Associates, LLC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they marked Personal and Confidential.

With this consent, Laurel Podiatry Associates, LLC may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Laurel Podiatry Associates, LLC restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to LAUREL PODIATRY ASSOCIATES, LLC's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior to consent. If I do not sign this consent, or later revoke it, LAUREL PODIATRY ASSOCIATES, LLC may decline to provide treatment to me.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Print Name of Patient or Legal Guardian

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date