

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  
 Congestive heart dx  Heart valve dx  Leukemia  Bleeding disease  
Have you ever had a blood transfusion?  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 doctors make 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 provider.

However, we cannot render services on 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-insurances, or ineligible services. Many insurance companies require a referral form to allow treatment.

***It is the policy of this office to have that referral form within 24 hours of the treatment date. Your carrier will refuse payment, so the charges for that day will be patient charges.***

All insurance forms processed by this office, prior to payment in full, are assigned to this practice. Your cooperation in complying with this matter 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 to date to accomplish this. Any additional changes need to be reported at subsequent visits.

**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 their 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