Name _____Date of Birth: _____

Home Address _____ City _____ State _____Zip _____

Email Address _____ Male____ Female____ Marital Status: _____

Home Phone _____ Work Phone _____ Cell Phone _____

Occupation and Employer_____

Emergency Contact _____ Relationship _____ Phone# _____

Primary Care Physician Name and Phone Number _____

Pharmacy Name, Address & Phone Number _____

Primary Language _____ Ethnicity: ___ Hispanic or Latino ___ Not Hispanic or Latino ___ Other

Race: __ African American __Caucasian ___Multi-Racial __Asian __Native American __Native Hawaiian/Pacific _____Other

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(If patient is a child or dependent adult, please give name of responsible party for finances and billing)

Responsible Party _____ Date of Birth _____/_____/_____

Address _____

Phone Number _____ Relationship to Patient _____

Insurance Information

_____ Check here if NO health insurance Primary Care Referral Needed? _____Yes _____No

Primary Carrier _____Policy# _____ Group# _____

Policy Holder (if other than patient) _____Date of Birth _____/_____/_____

Secondary Carrier _____ Policy# _____ Group# _____

Secondary Carrier Policy Holder _____Date of Birth _____/_____/_____

Are you interested in Laser Treatment for Toenail Fungus? Yes _____No _____ Maybe _____

Are you interested in MLS Laser Treatment for Pain and other issues? Yes_____ No_____ Maybe _____

How did you hear about our office? _____

All treatment options will be discussed prior to any service(s) being performed. Once verbal and/or written consent is given, I authorize Dr. Kelly Geoghan to administer the necessary treatment in order to diagnose and treat as needed.

Signature _____ Date _____

Dr. Kelly L. Geoghan •1447 York Road • Suite 504 • Lutherville, MD 21093
(410)753-4422 • (410)753-4660(fax) • www.flawlessfeet.net • info@flawlessfeet.net

Kelly L. Geoghan DPM

PATIENT NAME: _____ DOB: _____AGE: _____

Height _____Weight _____ Shoe Size: _____

What type of foot and/or ankle problem are you having?

_____

Medications and Strength

NO MEDICATIONS: _____

Include prescriptions, over the counter medication & and vitamins.***If you have a list we can copy it****

_____
_____
_____
_____
_____

Allergies: Please list your reaction to each allergy

NO ALLERGIES: _____

___Adhesive/Tape _____
___Anticoagulant _____
___ Aspirin _____
___ Codeine _____
___ Demerol _____
___ Local Anesthetics_____
___ Latex _____

____Other _____
___ Food_____
___ Novocaine_____
___ Penicillin_____
___ Sulfa_____
___ Iodine_____

Cigarette Smoking History

____Current Every Day ___ Current Occasional ____Heavy Smoker
____Light Tobacco Smoker ___ Former Smoker ____Never Smoker
____Unknown

If you currently or previously smoked: When did you start smoking? _____
If you quit, when did you stop smoking? _____ How much did/do you smoke per day? _____

Do you Vape or Chew Tobacco? _____Yes _____No If yes, when did you start? _____

Past Medical History (please check all that applies) NO PAST MEDICAL HISTORY _____

__Anxiety
__Arthritis
__Asthma
__Bleeding Disorder
__Circulation Problems
__Diabetes
__Depression
__Gout
__Heart Disease
__Hepatitis
__High Cholesterol
__HIV/AIDS
__Hypertension (High B/P)
__Kidney Disease
__Liver Disease
__Nervousness
__Rheumatic Fever
__Seizures/Epilepsy
__Sickle Cell Disease
__Skin Problems
__Stomach Ulcer
__Stroke
__Thyroid Disease
__Other _____
_____COVID-19

Past Surgical History

Surgery _____Date _____
Surgery _____Date _____
Surgery _____Date _____

Social History:

Alcohol Use ___Non-Drinker ___Occasional ___Social ___Moderate ___Heavy
Illegal Drug Use ___Yes ___No **Exercise:** ___Never __Less than 3 times a week ___More than 3 times a week
Family Medical History (diabetes, cardiac, pulmonary, cancer, other)

Acknowledgement of Receipt of Notice of Privacy Practice

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have reviewed, read and understand the Notice of Privacy Practices document containing a more complete description of the uses and disclosures of my health information. I understand that Kelly L. Geoghan, DPM, LLC has the right to change their Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below for a current copy of the Notice of Privacy Practice.

Patient Name: _____ Date of Birth: _____

Signature: _____ **Relationship to patient**: SELF: _____

Date signed: _____ PARENT: _____

Do we have your permission to? GUARDIAN: _____

Leave a message on your answering machine/voicemail? _____YES _____ NO

Leave a message with whomever answers your phone to confirm appointments? _____ YES _____ NO

Send you an email? _____YES _____NO

Speak with any household members, guardians or whoever is listed below regarding your care: _____ YES _____ NO

Name and relationship who we can specifically speak with:

_____

_____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, however, acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgments

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Kelly L. Geoghan DPM

1. Insurance. We participate in most insurance plans but it is the patient's responsibility to verify participation. If you are not insured by an insurance plan that we participate with, payment in full is due at the time of service. If you are insured by a plan we participate with but you do not have a valid insurance card present, payment in full is required. If your insurance changes, please notify us before your next visit so we can update your records. We will need to copy your updated insurance card too. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your benefits.
2. Co-payments and deductibles. In accordance with your insurance guidelines, all co-payments and deductibles must be paid at the time of service. Most follow up visits are a billed service and are subject to a copay/deductible according to your insurance guidelines including orthotic fittings/follow up appointments and minor office procedures.
3. Non-covered services. Please be aware that some, and perhaps all, of the services you receive may be not covered or considered medically necessary by your insurance carrier. You must pay for these services in full at the time of service. We will not bill your insurance or supply any correspondence for any non-covered services.
4. Forms. All patients must complete all forms provided before seeing the doctor. We require you to provide a current/valid photo ID and current valid insurance to provide proof of insurance. We will make a copy of this information for our records. Periodically, we may need you to update your forms. We will get a copy of your insurance card yearly.
5. Claims. A claim will be sent to your insurance carrier for all covered services. Your insurance company may need you to supply information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company processes your claim. Your insurance benefit is a contract between you and your insurance company. We follow insurance guidelines.
6. Referrals. It is the patient's responsibility to ensure the office receives valid referrals prior to your appointment. Failure to do so may result in your appointment being rescheduled. Our office does not keep track of referrals. Please make sure any referral on file is valid prior to your appointment or you may be responsible for the visit.
7. Overdue balance. If your account is over 90 days past due, you will receive a letter requesting immediate payment. Partial payments will not be accepted unless approved by our Billing Department. Please be aware that if a balance remains unpaid, your account may be sent to a Collection Agency and/or Small Claims Court. If you have a balance that is 90 days overdue or more, we will only treat you for emergency care until your bill is paid in full. You will not be seen for any non-emergency services until your balance is paid in full.
8. Cancellation Policy. Our office requires at least 24 hours' notice for all appointment cancellations. If you are unable to provide 24 hours' notice, you may be charged $25.00 for the missed appointment. We will work with you for emergencies.
9. Requests for Medical Records. If a patient requests a copy of their medical records, there may be a fee. Also, we require a signed medical release before sending the records.
10. Returned Checks. There is a fee of $30.00 for all returned checks which will be added to your balance.
11. Treatment of Minor: The patient must be accompanied by their legal guardian or have a signed note for treatment.
12. **HSA and Flex Spending payment**: We accept this form of payment but it is your responsibility to know and follow their guidelines. We do not know the details about your Health Savings Account or Flex Spending benefits. We cannot refund any payment type to then apply to an HSA or Flex Spending Card after the date of service.
13. Benefits. As a courtesy, we may check your benefits for a specific service. Please be advised that benefits given are a quote and not a guarantee of payment. Your insurance carrier may not inform us that some services are diagnosis driven, need pre-certification and are only covered if considered medically necessary. We provide you with the information they relay to our office. If your claim is denied, even after a quote is given, you will be responsible for the services. We advise you to verify your coverage and can supply you with any codes necessary to check your benefits.
14. Reminder calls: When reminding patients about their appointments we may leave appointment information on the voicemail or leave a message with whomever answers the telephone.
15. **Forms**: There may be a $10.00 per form fee for the completion of forms (disability, work forms etc.)

Assignment and Release: I hereby authorize my insurance benefits to be paid directly to the physician. I am legally responsible for any amount which is not paid by my insurance even if my physician is participating with my insurance company. I also authorize the physician to release any information required to process the claim. I understand that accounts are considered past due if no payment is received within 30 days of billing. If payment is not made within 90 days from the time services are rendered, I agree to pay any and all necessary cost of collections, including but not limited to attorney's fees of 35% on the balance outstanding, court cost and service of processing fees.

My signature below is my acceptance of this agreement.

Signature: _____DOB: _____ Date: _____

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