

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name _____

First Name _____ Middle Initial _____

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____ Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Employer/School Address _____

Employer/School Phone (____) _____

Spouse's Name _____

Birthdate _____ SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

PHONE NUMBERS

Home Phone (____) _____

Cell Phone (____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (____) _____

Work Phone (____) _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Dr. _____
all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to _____
Name of

_____ for any services furnished to me by that provider.
Doctor or Clinic

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

Signature of Beneficiary, Guardian or Personal Representative

Please print name of Beneficiary, Guardian or Personal Representative

Date _____ Relationship to Beneficiary _____

PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints.)

Have you ever been to a Podiatrist before?
☐ Yes ☐ No

If yes, please list.

Name _____

Last visit _____

Is there any personal or family history of diabetes?

☐ Yes ☐ No

Your occupation _____

Cigarette/Tobacco use _____

Years smoked _____

Athletic activities in which you participate (please list and indicate frequency)

Please indicate which foot problems you now have or have had in the past.

Ankle Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Athlete's Foot	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bunions	<input type="checkbox"/> Yes <input type="checkbox"/> No
Corns and Calluses	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cramps or Numbness in Feet or Legs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Flat Feet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Foot or Leg Cramps	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heel Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ingrown Toenails	<input type="checkbox"/> Yes <input type="checkbox"/> No
Plantar Warts	<input type="checkbox"/> Yes <input type="checkbox"/> No
Swelling in Ankles or Feet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tired Feet	<input type="checkbox"/> Yes <input type="checkbox"/> No

MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies to Anesthetics	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eye Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies to Medicine or Drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Foot or Leg Cramps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves or Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling in Ankles, Feet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis or Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tired Feet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Varicose Veins	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neuropathy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Phlebitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss, unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Ear Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Surgeries you have had _____

Hospitalization other than for the surgeries listed _____

Family physician _____ Last visit date _____

Are you now, or have you been, under any other doctor's care for any reason over the past two years? ☐ Yes ☐ No

If yes, please explain _____

MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins _____

Pharmacy Name(s) _____

Pharmacy Phone(s) (_____) _____

Do you take oral contraceptives? ☐ Yes ☐ No

ALLERGIES

<input type="checkbox"/> Adhesive/Tape	<input type="checkbox"/> Local Anesthetics
<input type="checkbox"/> Anticoagulant Therapy	<input type="checkbox"/> Novocaine
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Codeine	<input type="checkbox"/> Seafoods
<input type="checkbox"/> Demerol	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Iodine	
Other _____	

TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

HIPAA (Health Insurance Portability and Accountability Act)

I acknowledge that I have been made aware of the location of our Notice of our Privacy Practices and may receive a written copy upon request:

Print Name: _____

Name of Designee(s) able to obtain your PHI

Signature: _____

Date: _____



*Why spend more money in fees
to collect your A/R delinquencies?*

**It's like sending good
money down the drain.**

**Williams, Alexander & Associates has a great collections program
that makes your debtors pay our fees -- you get 100% of your money**

*Fee-added accounts enjoy a **ZERO PERCENT** contingency rate. This means that our collection fees are passed on to your debtor. If your debt is \$100, you will be paid the full \$100 — we get our fees from the debtor.*

To be a fee-added account with Williams, Alexander & Associates, your member/client/patient must agree at the point of service or sale that if the account becomes delinquent, they will pay collection costs and legal fees. The typical wording for the **debtor's signed statement** that is included in the contract or membership application or patient sign-up sheet is as follows: (Keep in mind, they are not debtors at this point.)

***I hereby authorize and guarantee
payment for all services rendered.***

***Although fees for services are due and
payment expected at the time services
are rendered, if I have been granted a
grace period for payment of fees, I ac-
knowledge that payment is due and ex-
pected at the time the billing statement
is received.***

***In the event that my account becomes
delinquent for more than 30 days, I also
agree to pay a finance charge of 1.5%
per month on any balance due, as well
as all reasonable collection costs not
to exceed 50%, court costs, attorney
fees and interest fees accrued with the
collection of this account.***

Responsible Party

Date

Both a SIGNATURE and a DATE are important elements of this agreement, because it indicates that the person knew what the terms were from the beginning. It also allows you to charge interest on a delinquent account until it is turned over for collections — you don't HAVE to charge interest, but you have protected and reserved your right to do so. When you send us your claims, just include a copy of the **debtor's signed statement** that allows us to pass along these fees to the debtor.

We are very successful in our recovery, but obviously, not every debt can be recovered and our contingency fees will not be collected in every case — we estimate that we can get the full amount for you about **90%** of the time on those debts which we collect.

***Some of your debts will have become delinquent
PRIOR to implementing your signed statements -- or
some items didn't have a signed statement attached.
No problem! We'll process the debts under the ap-
propriate program.***

Working together with you, Williams Alexander & Associates has created this fee-added program which places the accountability for delinquencies directly back in the lap of the person who caused the problem -- the debtor.

**For additional information,
call 800-394-2655**



**WILLIAMS, ALEXANDER
& ASSOCIATES**

*Collections and Debt
Management Services*

PO Box 2148, Wayne, NJ 07474

Member, American Collectors Association