Patient Information Sheet

Last Name:____ **First:**____ **MI:**________

Mailing Address:____

City:_________________________ **State:**______ **Zip:**_________

Home Phone #: (_______)_______________________________

Cell Phone #: (_______)_______________________________

Preferred Method of Contact: ☐ Cell Phone ☐ Home Phone

Reminders/Office Communication Preference: ☐ Call ☐ Text

Email: ____

Responsible Party (Minors Only)

Name:____

Mailing Address:____

City:_________________________ **State:**______ **Zip:**_________

Phone #: (_______)____________________________________

Primary Care Physician: ______________________________

How did you hear about the practice? ☐ Dr.______________

☐ Friend/Family_______________________ ☐ NFA Website

☐ Google ☐ Health Fair ☐ Other______________________

Date of Birth:_____________________ **Gender:** ☐ M ☐ F

Marital Status:☐ Married ☐ Widowed ☐ Single ☐ Divorced

Social Security Number #: ________-_______-_________

Race: _______________ **Hispanic/Latino?** ☐ Yes ☐ No

Language: ☐ English ☐ Spanish ☐ Other _____________

EMERGENCY CONTACT

Name: ____

Ph #: (_____)________________ **Relation:** _______________

Pharmacy Name:____ **Pharmacy Number:** (_____)__________________________

Pharmacy Address/Street:____

PRIMARY Insurance Company Information	SECONDARY Insurance Company Information
Insurance Name: _________________________________	**Insurance Name:** _________________________________
Policy ID: ________________________**Group #:**____________	**Policy ID:** ________________________ **Group #:**___________
Co-pay $: _____________ **Referral Required:** ☐ Yes ☐ No	**Co-pay $:** ____________ **Referral Required:** ☐ Yes ☐ No
Policy Holder Name: ___________________________________	**Policy Holder Name:** ___________________________________
Policy Holder Date of Birth: ____________________________	**Policy Holder Date of Birth:** ____________________________
Relationship to Policy Holder: ☐Self ☐Spouse ☐Child ☐Other	**Relationship to Policy Holder:** ☐Self ☐Spouse ☐Child ☐Other

Patient Signature ____ **Date**_____________________

(Parent or Guardian if patient is under 18 years old)

Patient Name: ____ **Date:** ______________________

Reason for your visit today: _____________________ **When did problem start?**_____________________

Previous treatments include (check all that apply):

- ☐ Pain Medication
- ☐ Injection
- ☐ X-rays
- ☐ Physical Therapy
- ☐ Antibiotics
- ☐ Surgery
- ☐ Bone Scan
- ☐ Ice/Stretching
- ☐ MRI
- ☐ CT Scan
- ☐ Hospitalization
- ☐ Other:________________________

►Current Medications

☐ None or ☐ See Attached List

____

____

____

►Patient Medical History

Have you been diagnosed with any of the following? If so, check all that apply.

- ☐ Anemia
- ☐ Arthritis
- ☐ Back Problems
- ☐ Blood Clots
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ HIV+/AIDS
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ Irregular Heartbeat
- ☐ Kidney Stones
- ☐ Kidney Disease
- ☐ Liver Disease (hepatitis) A B C
- ☐ Stomach Ulcers/Reflux
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Other_______________

►Allergies

☐ None or ☐ See Attached List

____

____

►Previous Surgeries

☐ None or Please list procedure and date performed:

____

____

►Family History

Has anyone in your family been diagnosed with any of the following? If so, check all that apply.

	Arthritis	Cancer	Diabetes	High Blood Pressure	Stroke
Mother	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐
Sister	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐
Other_________	☐	☐	☐	☐	☐

►Social History

Please answer the following:

Occupation: ____

Use of Alcohol? □ No □ Yes (If yes, how much?) ______________________________________

Use of Tobacco? □ No □ Yes (If yes, how much?) ______________________________________

Use of Drugs? □ No □ Yes (If yes, how much?) ______________________________________

►Review of Systems

(Please check all conditions and symptoms that you currently have)

General	__Fever	__Chills	__Weight loss/gain	__Appetite loss
Eyes	__Blurry vision	__Double vision	__Poor vision	__Glasses
Ear/Nose/Throat	__Ringing ears	__Sinus congestion	__Hearing Loss	__Sore throat
Heart	__Chest pain	__Irreg. heart beat	__Leg cramps w/ walking	__Murmur
Lungs	__Cough	__Shortness of breath	__Difficulty breathing	__Snoring
Digestive	__Nausea	__Stomach ulcer	__Constipation	__Diarrhea
Urinary	__Burning	__Frequent urination	__Incontinence	__Impotence
Musculoskeletal	__Joint pain	__Muscle weakness	__Joint stiffness	__Deformity
Skin	__Rash	__Sores/Ulcers	__Abnormal scar	__Dry skin
Neurological	__Numbness	__Tingling feet	__Poor balance	__Sciatica
Psychiatric	__Depression	__Mood swings	__Anxiety	__Nervousness
Peripheral Vasc	__Varicose veins	__Leg/foot swelling	__foot pain with sleeping	__Leg cramps
Endocrine	__Hair loss	__Excessive thirst	__Fatigue	__Frequent Urination
Hematological	__Leg swelling	__Bleeding tendency	__Bruise easily	__Slow to heal
OB/GYN	__Pregnant	__Birth control pills	__Hormone therapy	__Menopausal

► Last Date Seen by Primary Care Doctor: ____

► Weight: ____________________ Height: __________________ Shoe Size: _________________

(Office Use ONLY: BP __________________________ P_________________)

►Authorization to Treat

I hereby consent to be treated by the physicians and staff at Neuhaus Foot and Ankle to render medical treatment and evaluation of foot and ankle injuries needed for myself or the patient mentioned above for who I am responsible. I further authorize the order of x-rays, injections, casting, or other diagnostic tests and treatment that may be necessary to diagnose and treat my illness or injury. I acknowledge that no guarantees have been made as to the nature of examination and/or procedures recommended or performed. Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees. I understand it is my decision whether to proceed with the testing recommended after it has been fully explained to me by the physician. In order to maintain an accurate and up to date medical record, I give Neuhaus Foot and Ankle permission to import my medication history from an external source.

I fully understand that this consent is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing. Written revocation of consent must be sent to the physician's office, Attn: Administration.

Patient Signature ____ Date_____________________

(Parent or Guardian if patient is under 18 years old)

Financial Policy

Physicians/Providers at Neuhaus Foot and Ankle are committed to providing you with the best possible medical care. In order to achieve this goal, we need your assistance and your understanding of our payment policy. It is vital to your care for you to have a clear understanding of our expectations regarding your billing and payment for services.

Please initial each policy below:

______ **Insurance/Self-Pay.** I certify that I (or my dependent) have insurance coverage with the above mentioned insurance carrier. I acknowledge full financial responsibility for services rendered by Neuhaus Foot and Ankle. I understand that I will be held responsible for any costs, which are not covered by my insurance carrier, including any co-pay, deductible, co-insurance, denial, or uncovered services, and payment for these costs are expected at the time of service. I understand I am responsible for prompt payment of any amounts not collected at the time of my visit. I also consent that payment of authorized Medicare and any other insurance benefits may be made on my behalf directly to Neuhaus Foot and Ankle for any medical treatment rendered. I understand that if I (or my dependent) does not have active insurance coverage, I will be considered a self-pay patient. I understand I will be financially responsible at the time all services rendered to my dependents or myself.

______ **Referrals.** I understand I am required to know whether or not my insurance plan requires a referral, and to obtain one prior to my scheduled appointment. I understand I will not be seen without a referral if it is required. I also understand that a referral is not a guarantee of coverage from the insurance carrier.

______ **Past Due Accounts.** I understand that if my account becomes sixty (60) days past due, further steps to collect this debt may be taken. If we have to refer your account to a collection agency, I agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, I agree to pay all lawyer fees which we incur plus all court costs. In case of suit, I agree the venue shall be Davidson County, Tennessee. In addition, we reserve the right to deny future non-emergency treatment for any and all debtor-related unpaid account balances.

______ **Returned Checks.** I understand returned checks are subject to a $40.00 service charge. I will also lose the privilege to write checks to our office in the future.

______ **Missed Appointments.** I understand there is a $50.00 charge for any appointment not canceled within 24 hours. Multiple late cancellations or no shows may result in discharge from our practice.

______ **Medical Records.** I understand there is a $20.00 charge for medical records and a $5.00 charge for a CD of x-rays. Medical records take approximately 48 hours once payment is received.

______ **FMLA/Disability Forms.** FMLA/disability forms take approximately 3-5 business days to complete. There is a $20.00 fee per packet completed.

______ **Photographs and Videos.** Voluntarily, without compensation, I authorize Neuhaus Foot and Ankle to take and use pictures and/or videos of my foot for educational and advertising purposes which may include office screen savers, websites, social media or other promotional materials. These photographs are property of Neuhaus Foot and Ankle.

By signing below, I read, understand and agree to all the terms and conditions within this financial agreement. Please note, a photocopy of this consent shall be considered as valid as the original.

Patient Signature ____ **Date**_____________________

(Parent or Guardian if patient is under 18 years old)

Acknowledgement of Notice of Privacy Practices

Neuhaus Foot and Ankle wants to assure you that your personal health information (PHI) is secure. This Notice contains information regarding how we insure that your information remains private. By law, Neuhaus Foot and Ankle is required to provide you with our Notice of Privacy Practices. This Notice describes how your medical information may be used and disclosed by us. This Notice also tells you how you can obtain access to your PHI.

As a patient, you have the following rights:
- You have the right to have access and/or a copy of your health information.
- You have the right to request corrections to your health information.
- You have the right to request restrictions as to how your information is disclosed.
- You have the right to request confidential communications.
- You have the right to a report of disclosures to your information.
- You have the right to receive a copy of our privacy practices.

I authorize my physician and his/her staff to contact me by the designated means noted below:

☐ Home Phone/Home Answering Machine ☐ Cell Phone/Voicemail ☐ Email

I authorize the physicians of Neuhaus Foot and Ankle, PC or their staff to release information on file regarding my medical bills and/or my medical treatment to the person(s) listed below. I understand that by signing this release, the designated person(s) will be able to speak with any staff member of Neuhaus Foot and Ankle, PC regarding my protected healthcare information (PHI).

I understand that Neuhaus Foot and Ankle cannot be held liable for any information the below stated person(s) may obtain regarding my medical care. I understand that revocation of this authorization must be provided to Neuhaus Foot and Ankle, PC in writing. Written revocation of consent must be sent to the physician's office, Attn: Administration.

Neuhaus Foot and Ankle, PC may release medical and billing information to the following specified persons other than myself:

◦ To my Spouse _______________________________________ ☐ Yes ☐ No

◦ To my Family Member ________________________________ ☐ Yes ☐ No

◦ Other____ ☐ Yes ☐ No

Relationship _________________________________

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read) and understand the Notice. I understand that if I have questions or complaints regarding my privacy rights that I may contact the Privacy Officer at (615) 220-8788. I understand that Neuhaus Foot and Ankle reserves the right to change its privacy practices that are described in the Notice of Privacy Practices. I also understand that any revised notice will be posted on Neuhaus Foot and Ankle's website, available at each office, or mailed upon request.

Patient Signature ___________________________________ **Date**____________________

(Parent or Guardian if patient is under 18 years old)

Print Name ____ **Date** __________________