# Focused Foot Care

| **Patient Information**/Informacion Del Paciente | | | |
|---|---|---|---|
| **Last Name** / Apellido | **First Name** / Nombre | | **M.I.** |
| **Address** / Direccion | **City** / Ciudad | **State** | **Zip Code** |
| **Home Phone** / Telefono de Casa | **Work Phone** / Telefono de Trabajo | **Cell Phone** / Celular | |
| ***Best phone number to contact me is:** **Home** **Work** **Cell** | | | |
| **Date of Birth** / Fecha de Nacimiento | **Age** / Edad | **Social Security #** / # de Seguro Social | **Sex**/Sexo **M** **F** |
| **Primary Care Physician** / Doctor Primario | | **Phone (Prim. Care Physician)** / Telefono Doctor Primario | |
| **Marital Status** / Empleador: □ **Single** / Soltero □ **Married** / Casado □ **Divorced** / Divorciado □ **Widowed** / Viudo | | | |
| **Occupation** / Ocupacion | | **Employer** / Empleador | |
| **Referred By** / Referido Por | | | |
| **My Email Address** / Mi Correo Electronico | | | |

| **Insurance Information** / Informacion de Seguro Medico | | |
|---|---|---|
| **Primary Insurance** / Seguro Primario | **Policy #** | **Group #** |
| **Secondary Insurance** / Seguro Secundario | **Policy #** | **Group #** |

| **Insured Information (If other than Patient)** / Informacion del Asegurado (Si no es el Paciente) | | |
|---|---|---|
| Insured ● **Last Name** | **First Name** | **M.I.** |
| **Date of Birth** | **Social Security #** | **Relationship to Patient** |

● **Insurance Assignment and Release:** I certify that I have insurance coverage (as shown above) and assign to Focused Foot Care (Eric Wee, D.P.M., Inc.) any insurance benefits for services rendered. Also, I authorize the use of my signature on all insurance claim submissions. ● I authorize Focused Foot Care to release any information to the above named Insurance Company(ies) related to payment for services or required in the course of evaluation and treatment.

**Signature** (of Beneficiary, Guardian, or Personal Representative) **Print Name** **Date**

## Podiatric History

| **Name** / Nombre | **Date of Birth** / Fecha de Nacimiento |
|---|---|

**What brought you to see the doctor?** / El Motivo de su visita al medico?

**When did your symptoms begin?** / Cuando empezaron los sintomas?

**What treatments have you tried?** / Que tratamientos ha tenido?

**Do you have any other problems with your feet or ankles?** / Tiene otras problemas con sus pies o tobillos?

## Medical History

**Please check what you have or have been treated for:** / Indique por lo que lo han tratado

| | | |
|---|---|---|
| ☐ **Diabetes ( Type I / Type II)** | ☐ **High Blood Pressure** | ☐ **Asthma** |
| ☐ **Poor Circulation** | ☐ **Low Blood Pressure** | ☐ **Cancer (Type: _____)** |
| ☐ **Arthritis / Gout** | ☐ **High Cholesterol** | ☐ **Osteoporosis** |
| ☐ **Bleeding Disorders** | | ☐ **Joint Replacement(s):_____** |
| ☐ **Anemia** | ☐ **Heart Disease** | |
| | ☐ **Heart Valve Replacement** | ☐ **Hepatitis / Jaundice** |
| ☐ **Liver Disease** | ☐ **Pacemaker** | ☐ **HIV / AIDS** |
| ☐ **Kidney Disease** | | |
| ☐ **Lung Disease** | | ☐ **Others:_____** |
| ☐ **Thyroid Disease** | | |

## Current Medications

| | |
|---|---|
| | |
| | |
| | |

## Allergies

| | |
|---|---|
| ☐ **Penicillin** | ☐ **Iodine** |
| ☐ **Sulfa** | ☐ **Adhesive / Tape** |
| ☐ **Local Anesthetics** | ☐ **Latex** |
| ☐ **Codeine / Demerol** | ☐ **Other: _____** |

## Past Surgical & Social History

| **Procedure** / Operacion | **Date** / Fecha | **Complications?** / Complicasiones? |
|---|---|---|
| **Procedure** | **Date** | **Complications?** |

**Do you smoke?** / Fuma? ☐ Yes ☐ No **If yes, how much?** Cuantos?

**Do you drink alcohol?** / Bebe alcohol? ☐ No ☐ Occasionally/Ocasional ☐ Moderate/Moderado

**Activities / Exercise?** / Ejercisios?

● **Treatment Consent and Notice of Privacy Practices:** I hereby consent and give my permission to administer treatments and/or procedures upon me as the doctor deems necessary. Also, I acknowledge that I have received and/or reviewed the Notice of Privacy Practices of Focused Foot Care.

**Signature** (of Beneficiary, Guardian, or Personal Representative) **Print Name** **Date**

# Focused Foot Care Patient Financial Policy

**Patient Name:** _____ **Birth Date:** _____

- Focused Foot Care appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure **payment in full of our fees**. We feel our fees are fair and reasonable for the quality of care and the personal attention you will receive.

- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf.

- If you have insurance coverage with a plan that Focused Foot Care has an agreement with to accept an assignment of benefits (**in-network**), we will bill your insurance company for the services rendered and will only require you to pay the co-pay/co-insurance/deductible for the services rendered. (**Focused Foot Care is in-network for MediCare.**)

- If you have insurance coverage with a plan with which we **do not** have a prior agreement (**out-of-network**), we will prepare and send the claim for you on an unassigned basis. This means your insurer may send the payment directly to you. Therefore, we require **50%** of the charges for your evaluation and treatment due at the time of service, with the remaining balance due after your insurance claim is processed. Any overpayment made to Focused Foot Care will be reimbursed to you.

- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for specialized services or medical equipment; however, you remain responsible for the charges.

- You must inform Focused Foot Care of all insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

- There are certain elective treatments and surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those.

- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due Focused Foot Care.

- There is a service fee of $25.00 for all returned checks.

**I have read the above policy regarding my financial responsibility to Focused Foot Care for providing evaluation/treatment services to me or the above named patient.**

**Signature** (of Beneficiary, Guardian, or Personal Representative) **Print Name** **Date**