

PATIENT INFORMATION FOR FAMILY FOOT CARE LLC

Patient Name: _____ Patient Sex: Male ___ Female ___

Patient SSN: _____ Patient Date of Birth: _____ Age: _____

Race: _____ Ethnicity _____ Primary Language _____

Patients Address: _____

City _____ State _____ Zip _____ + _____

Home Phone Number: _____ Work: _____ Cell: _____

Occupation: _____ Patients Employer: _____

Please Circle: Divorced Partner Married Separated Single Widowed

Spouses Name: _____ Spouses Date of Birth: _____

Spouses SSN: _____ Spouses Work or Cell Number: _____

Spouses Employer: _____

*****If patient is a child:**

Mothers Name: _____ Date of Birth: _____

Mothers SSN: _____ Mothers Work or Cell Number: _____

Mothers Employer: _____

Fathers Name: _____ Date of Birth: _____

Fathers SSN: _____ Fathers Work or Cell Number: _____

Fathers Employer: _____

Primary Insurance Company Name: _____

Policyholders Name: _____

Secondary Insurance Company Name: _____

Policyholders Name: _____

Third Insurance Company Name: _____

Policyholders Name: _____

*****Patients Primary Care Doctor/Pediatrician:** _____

Referred to our office by: _____

Patients Pharmacy: _____

Pharmacy Phone Number: _____

PATIENT MEDICAL INFORMATION

Patient Name: _____

Please list the reason(s) for seeing the doctor today: _____

How long have you had the current problem you are being seen for today? _____

Is your visit related to an injury or accident? Yes or No

If YES please provide work comp information before being seen or we will NOT bill today or any future visit(s) to the work comp company unless you provide proper information today. We also cannot go back and refile past visits to work comp.

Please list all current medications: _____

Allergies: Please circle Yes (Y) or No (N).

Penicillin: Y N Sulfa: Y N Codeine: Y N Aspirin: Y N

Adhesive Tape: Y N Latex: Y N Local Anesthesia: Y N

Other: _____

Height: _____ **Weight:** _____ **Shoe Size:** _____ **Width:** _____

Do you smoke? _____ How much and how often? _____

Do you drink alcohol? _____ How much and how often? _____

Are you pregnant? _____ (We ask this of our female patients as there is often a need for X-rays to be taken.)

Medical Status: Please circle Yes (Y) or No (N).

Diabetic: Y N Arthritis: Y N Rheumatoid Arthritis: Y N

High Blood Pressure: Y N Hepatitis: Y N If yes which one _____

HIV/Aids: Y N Kidney Problems: Y N Heart Problems: Y N

Cancer: Y N Bleeding Disorders: Y N Liver Problems: Y N

Gout: Y N Are you on any blood thinners or taking aspirin? Y N

Please list any previous surgeries: _____

FAMILY FOOT CARES' FINANCIAL INFORMATION

Please **read and initial** each statement below. If you have any questions, please ask.

I, _____, authorize Family Foot Care LLC/Dr. Sophie Liu/Dr. Steven Frank to release information regarding my medical history and treatments to my insurance company in order for them to be paid. I, also, authorize payments for services to be paid directly to Family Foot Care LLC/Dr. Sophie Liu/Dr. Steven Frank from my insurance company. _____

I will ensure that Family Foot Care LLC/Dr. Sophie Liu/Dr. Steven Frank has my current insurance information and any referral I may need. ***If I do not provide current insurance information or a current referral, I understand that I will be responsible** for that day and any days charges forward until I provide current information, within a timely manner, so that my claim(s) can be processed by my insurance company. Failure to supply information in a timely manner, will lead to my or my legal guardians full responsibility. _____

I understand that any copays or self pay amounts are due at the time of service. I understand that at any time during or before my treatment I can ask and will receive an answer on the cost(s) of any treatment that is being performed or going to be performed on me. I understand there will be finance charges, late charges and a 25% attorney fee on any unpaid account. _____

I understand that the staff and/or Dr's of Family Foot Care **are not aware** of my personal insurance companies deductibles, coinsurance and or copays for my plan. It is my responsibility to find out that information. _____

I understand that if a custom DME product is ordered for me, such as **orthotics or special shoes**, or I receive an **air cast, nite splint, ankle brace, Dyna-Flex Plate or powersteps**, that they are **non-refundable and non-returnable**. If my insurance denies them for **any** reason, I understand it is ultimately my responsibility and I will pay for the product(s) I have received. _____

I understand that there is a fee for copies of medical records and X-rays. I also acknowledge that there are fees associated with any forms filled out by our office for my absence from work due to a surgery or a Family Medical Leave. _____

I understand that **if I am a Medicare patient** and I am eligible for Diabetic shoes and inserts that they are **not** "free". Medicare will pay 80% of the allowed amount and then my secondary will pay the remaining 20% - **IF** I have the benefit. I understand there is a possibility that I may owe the 20% if my secondary does not cover it. _____

I acknowledge by signing my name below as the patient or guardian of the patient that I have read and initialed all of the above financial disclosures and understand and will comply. I have asked questions, if necessary, and I have had those questions answered and I understand.

Please note that Family Foot Care's financial policy is in effect for the entire time you are a patient of ours not just for the date that you sign the policy. If we have any changes we will have you fill out a new form at that time.

Patient or Legal Guardian Signature: _____ **Date:** _____

**Office of Dr. Sophie Liu and Dr. Steven Frank
Family Foot Care**

Authorization of Medical Information

Please read the following questions carefully and sign at the bottom of the page. You have the right to review our privacy practices at any time. Please refer to our **HIPAA** notice located in our reception area and/or on our web page at www.Familyfootcaremo.com.

____ I have read and understand the HIPAA notice.

____ I decline reading the HIPAA notice but, am fully aware that it is always available to me.

Please **CIRCLE** where we may leave a message if necessary:

HOME ANSWERING MACHINE WORK CELL PHONE

May we discuss the patients medical condition with members of your family or friends?

YES _____ **NO** _____

If **YES**, please list below the name of that person and their relationship to the patient.

NAME	RELATIONSHIP TO PATIENT	PHONE NUMBER
-------------	--------------------------------	---------------------

Please list **ANY** information from your medical record at Family Foot Care that you would **NOT** wish to have disclosed:

--

I give permission to Family Foot Care to release information, either verbal or written regarding my medical condition only, for the purpose of medical management.

(Print Name of Patient)

(Signature of Patient/Legal Guardian)

(Date)

This release may be rescinded at any time in writing from the patient/legal guardian. ***Please note that Family Foot Care's HIPAA policy is in effect for the entire time you are a patient of ours not just for the date that you sign the policy. If we have any changes we will have you fill out a new form at that time.***