SOMERS FOOT & ANKLE

Patient Name:_____ _ _____DOB:_____ Age:_____

Address: _____

City: _____State: _____ Zip:_____

Cell Phone:_____ Home :_____ Work:_____

Social Security Number: _____

Marital Status: Married Single Widowed Divorced

Email Address: _____

Emergency Contact Name: _____ Relation:_____

Phone(s): _____

Family Physician/Internist: _____ Phone:_____

Pharmacy: _____ Pharmacy Phone: _____

INSURANCE INFORMATION

Insurance Company Name: Primary Insurance _____

Insurance Subscriber's Name: _____ Subscriber's DOB: _____

Secondary Insurance: _____ Subscriber Name & DOB: _____

Responsible Party (if other than patient) Name & DOB: _____

Responsible party's address (if different): _____

Do you have an HMO insurance? Yes No **If yes, you must have your referral or your appointment will need to be rescheduled.**

I authorize Dr. Jennifer Somers/ Somers Foot & Ankle, LLC to release any medical information necessary to process my insurance claim, and I authorize payment of medical benefits to be made to this practice for services rendered. I agree to pay all of my copays, coinsurance, deductibles, and any balance that is denied or in dispute by my insurance company.

SIGNATURE: _____ DATE: _____

Patient, parent, or responsible party

MEDICAL HISTORY

Anemia Y N	emphysema Y N	heart problems Y N	paralysis Y N
Arthritis (osteo) Y N	epilepsy Y N	Hepatitis A / B / C Y N	polio Y N
Asthma Y N	fibromyalgia Y N	hernia Y N	scoliosis Y N
Blood clots Y N	high blood pressure Y N	kidney problems Y N	seizures Y N
Blood transfusion Y N	head injury Y N	thyroid problem Y N	stroke Y N
Cancer Y N	hearing loss Y N	liver disease Y N	tuberculosis Y N
Diabetes Y N	heart attack Y N	meningitis Y N	foot/skin ulcers Y N
Cholesterol Y N	heart catheterization Y N	multiple sclerosis Y N	weakness Y N
Gall bladder problems Y N	migraines Y N	congestive heart failure (CHF) Y N	
Rheumatoid arthritis Y N		stomach/intestinal ulcer or bleeding Y N	

DO YOU HAVE ANY MEDICAL PROBLEMS NOT LISTED ABOVE? (Please list) _____

_____

_____

ALLERGIES: do you have any allergies to any medications? No **Yes:** please list _____

_____

Do you have allergies to adhesives? **Y N**

Do you have allergies to Betadine/iodine/shellfish? **Y N**

Do you have any other allergies not listed? No **YES** please list _____

SURGICAL HISTORY: please list the type of surgery and approximate year of your surgery/surgeries:

_____

_____

MEDICATIONS: please list all of your medications and dosage (or provide a list) , including OTC and herbal, etc.:

_____

_____

_____

_____

SOCIAL HISTORY

Is there any chance that you could be pregnant? Y N If female, date of last menstrual period: _____

Do you smoke? Y N If yes, how much? _____per day For how long? _____

Have you quit smoking? Y N When? _____

Do you drink alcohol? Y N If yes, how much/how often? _____

Do you live in a (check all that apply): ___1 story ___2+ story ___Alone ___with family ___with friends

Do you use any recreational drugs? Y N If yes, what type? _____

Do you use any assisted devices? ___cane ___walker ___wheelchair ___crutches

Occupation: _____ Are you currently working? Y N Reason not working: _____

What is your height? ___ft ___inches Weight? _____lbs. Shoe size? _____ Width? _____

FAMILY History: (please CHECK any condition(s) that your immediate family (grandparents, mother, father, siblings, children) suffer(ed) from and their relationship to you:

___ Diabetes _____ ___Blood clots _____ ___Blood disorder _____

___Heart disease _____ ___ Cancer (what type) _____ _____

CHIEF COMPLAINT: what is the reason that prompted you to make this appointment? _____

_____

_____

How long has this problem/symptom(s) been present? _____
Have you tried or received any prior treatment for this condition? No **Yes**, please explain:

_____

_____

Patient Name (Printed): _____

Patient Signature_____ Date: _____

NAME:_____**DOB:**_____

Do you <u>now</u> or have you <u>recently</u> had any problems related to the following systems? Circle YES or NO.

If you mark **YES** to any of the following, please indicate next to that problem the doctor that is treating you.

<u>If you haven't seen a physician yet, please contact your Internist or Family Physician to address those issues</u>.

Cardiovascular

Chest pain (recent) Y N
Irregular heartbeat Y N
Large varicose veins Y N
Other: _____

Constitutional Systems

Fever Y N
Chills Y N
Excessive fatigue Y N
Other: _____

Musculoskeletal

Neck pain Y N
Hip pain Y N
Back pain Y N
Knee pain Y N
Shoulder/elbow/hand pain Y N

Ear/Nose/Throat/Mouth

Ear problems Y N
Hearing loss Y N
Sinus problem Y N
Other: _____

Endocrine

Excessive thirst Y N
Tired/sluggish Y N
Other: _____

Genitourinary

Urine retention Y N
Painful urination Y N
Other:_____

Hematological/Lymphatic

Swollen glands Y N
Blood clotting problem Y N
Other: _____

Gastrointestinal

Abdominal pain Y N
Heartburn Y N
Vomiting Y N
Other: _____

Integumentary

Skin rash Y N
Boils Y N
Persistent skin itch Y N
Other: _____

Neurological

Seizures Y N
Tremors Y N
Paralysis Y N
Numbness/Tingling Y N
Other: _____

Psychological

Do you suffer from depression? Y N
Do you feel severely anxious or nervous? Y N
Other: _____

Respiratory

Wheezing Y N
Frequent cough Y N
Frequent shortness of breath Y N
Other:_____

Patient's Signature_____ Date_____

Authorized Representative's Signature _____ Date_____
(if applicable)

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

1. Acknowledgement of Practice's Notice of Privacy Practices:
   By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

   _____ _____ _____
   Name of Patient Date of Birth Signature of Patient/Parent/Guardian

2. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:
   I agree that the practice may disclose certain of my health information to a Personal Representative of my choosing, since such a person is involved with my health care or payment relating to my health care. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

   Print name: _____ Phone number_____

   Print name: _____ Phone number _____

   Print name: _____ Phone number _____
   `

3. Request to Receive Confidential Communications by Alternative Means:
   As provided by Privacy Rule Section 154.522(b), I hereby request that Practice make all communications to me by the alternative means that I have listed below.
   Home Telephone Number: _____
   _____ Okay to leave message with detailed information
   _____ Okay to leave message with call back numbers only
   Written Communication Address: _____
   _____ Okay to mail to address listed above ___E-mail me at_____
   Work Telephone Number: _____
   _____ Okay to leave message with detailed information
   _____ Okay to leave message with call back numbers only
   Fax communication Address: _____
   _____ Okay to Fax at the number listed above ___ E-mail me at _____

   Other Instructions _____
   _____

   _____ _____
   Name of Patient (Printed Signature of Patient Date
   Witness: _____

Financial Policy for Somers Foot & Ankle, LLC
Dr. Jennifer Somers

Thank you for choosing our office as part of your health care team. In our effort to provide personalized care in the most efficient and economical manner possible, we are providing to all of our patients this copy of our Financial Policy. We ask that you take a few moments to read our Financial Policy and sign below.

Insurance Coverage

- Your insurance policy is a contract that exists between you and your insurance company. Our relationship is with you, the patient, and not the insurance company. If you have questions about your policy, please call the phone number provided on the back of your insurance card.
- New insurance companies are continually forming and existing insurance companies are rapidly changing. It is your responsibility to know the specifics of your policy (referral requirements, in and out of network physicians and facilities, etc.). Most policies now have deductibles, copayments, coinsurances, maximums and limitations (out of pocket expenses). After your claim has come back from the insurance a statement will be sent reflecting any additional monies owed following response from your insurance carrier.
- We rely on you to inform us of all insurances in effect and to notify the office immediately of any changes with your insurance**.** ***If you do not inform us of changes, you will be responsible for the services rendered.*** When multiple policies exist, it is the patient's responsibility to inform us which policy is the primary plan. ***If we are not provided ALL insurance information at the time of service, you will be responsible for paying Somers Foot & Ankle, LLC directly and then submitting for reimbursement from your insurance company.***

Appointment Charges

- All charges are the responsibility of the patient. We will bill your insurance company, but any services not covered are the patient's responsibility. If you have no insurance, you are responsible for all services rendered. Co-pays will be collected at the time of the appointment (as required by insurance companies). For new patients, we will make every attempt to contact your insurance company to determine your office visit copayment, if any. Existing patients should notify us of any changes related to copayment amount right away.
- Costs can vary, depending on the type of insurance coverage you have and the treatment for your particular condition(s.) Cost/payment by your insurance company cannot be guaranteed by our staff. If you have any concerns, we advise you to contact your insurance company.
- If you miss an appointment, or cancel an appointment less than 24 hours of the appointment time, you may be assessed a $25 fee, as we have reserved that time slot just for you. Missed appointment fees are the responsibility of the patient.
- A $25 fee will be assessed on all returned checks.
- Balances/Collection Fees: If balances are not received within 30 days from the postmark date of a mailed statement, a $12 rebilling fee will be added to each additional statement sent due to the unpaid balance. Past due accounts, more than 90 days, will be turned over to our collection agency and a $35 administrative fee will be added to the account balance.

I have read and understand the Financial Policy of Somers Foot & Ankle, LLC.

Patient's Name (print):_____Date of Birth:_____

Patient's/Guardian's Signature:_____

Date: _____

Do I Need a Test for PAD

Dear Patient,

We want to make sure you are aware of a condition that may affect you. As many as 12 million Americans have Peripheral Arterial Disease (PAD) and many go dangerously unrecognized. It is a condition in which the arteries that carry blood to the muscles of the legs become narrowed due to the buildup of plaque. This is the same disease process that causes blockages of the heart.

Poor Circulation may result in the legs when the blood flow becomes sluggish or even blocked. It can result in leg pain or "fatigue", which can limit your physical activity. Having PAD may also increase your risk of heart attack or stroke if untreated.

Please take a moment to answer the questions below so that we may briefly screen you for PAD. If you have any questions or concerns regarding PAD and your risk, or would like more information please do not hesitate to ask.

Do you have a history of or taken medication for any of the following?

☐Diabetes ☐Smoking

☐ High Blood Pressure ☐ High Cholesterol

Do you have any discomfort or aching in your legs when you walk that is relieved by rest?

☐ Yes ☐No

Do your legs ever feel fatigued or heavy when walking or are active?

☐Yes ☐No

Do you experience any pain at rest in your lower leg(s) of feet?

☐Yes ☐No

Are you bothered at night with burning, pain, or coldness in your feet or toes?

☐Yes ☐No

Do you ever need to stop and rest when walking or have difficulty keeping up with others?

☐Yes ☐No

Have you noticed any changes in the color of temperature of your feet?

☐Yes ☐No

Have you experienced poor healing o wounds, cuts or ulcers on your feet?

☐Yes ☐No

Patient Signature:_____ **Date:**_____

Physician Signature:_____ **Date:**_____

Notes:_____