PODIATRY 1st
JAMES ANDERSON D.P.M.
NATALIE MOTA D.P.M.
JOHN LINDSAY D.P.M.

O'Fallon Office
717 Insight Ave.
Suite 100
O'Fallon, IL 62269

Columbia Office
1000 Eleven South
Suite 3A
Columbia, IL 62236

St. Louis Office
11710 Old Ballas Rd.
#100
St. Louis, MO 63141

Phone : 618-277-9533 | Fax : 618-277-9540

First Name: _____ M.I.: ____ Last Name:_____

Date of Birth: _____ /_____ / _____ Sex: _ Male _Female Preferred Phone: _____

Home Address: _____ City _____ State _____ Zip _____

Email Address: _____

How did you hear about us?

☐ Google/Internet Search ☐ Existing Patient/Friend/Family: _____
(please provide name so we can thank them)

☐ Physician Referral: _____ ☐ Other:_____

Race/Ethnicity (Optional)

Race: ☐ Caucasian ☐ African American ☐ Asian ☐ Hispanic ☐ American Indian ☐ Other ☐ Prefer Not to Answer

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Prefer Not to Answer

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employment Status: ☐ Employed FT ☐ Employed PT ☐ Unemployed ☐ Retired ☐ Disabled

Patient's Employer: _____ Occupation:_____

Insurance Information

Primary Insurance:_____ ID #:_____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Relationship to Patient:_____Insured Person's Phone #: _____

Do you have a secondary insurance? YES NO

Secondary Insurance:_____ ID #: _____

What is your preferred pharmacy? _____ Phone Number: _____

Location: Street:_____ City _____ Zip_____

Who is your family doctor? _____ Location: _____

Date you last saw your physician: _____ / _____ / _____

Emergency contact information

Name: _____ Relation: _____ Phone: _____

Patient Signature: _____ Date:_____

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REQUEST FOR CONFIDENTIAL INFORMATION

I hereby request Podiatry 1st to contact me by: (Please check all that apply)

[ ] Cell Phone May leave message: Yes_____ No_____

[ ] Home Phone May leave message: Yes_____ No_____

[ ] Work Phone May leave message: Yes_____ No_____

I also authorize Podiatry 1st to speak with the following people regarding my diagnosis and/or treatment options or any other related healthcare issues:

Name:_____ Relationship: _____Phone: _____

Name:_____ Relationship: _____Phone: _____

Name:_____ Relationship: _____ Phone: _____

I understand that Podiatry 1st is not required by law to agree to this request, but every attempt will be made to abide by my restrictions unless I need emergency treatment. This agreement is valid until revoked by me in writing.

SIGNATURE: _____ DATE:_____

INSURANCE AUTHORIZATION AND ASSIGNMENT GUARANTY OF PAYMENT OF MEDICAL SERVICES

I hereby authorize Podiatry 1st to furnish information to insurance carriers, other physicians and any other facilities involving the treatment/care of illness/injuries and for services provided as a patient of Podiatry 1st. I also hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I authorize payment of benefits to the physician or supplier. I understand that I am financially responsible for all medical and related charges incurred by me and/or my dependent in my/his/her medical treatment provided by my physician or other persons or facilities acting with or in the place of my physician, whether or not such charges are covered by insurance, including any and all collection fees, costs and attorney fees incurred by the physician or facility in collecting my or my dependent's medical bill. This authorization applies to all occasions of service until it is revoked by me in writing. I also hereby authorize photocopies of this authorization form to be as valid as the original.

SIGNATURE: _____ DATE:_____

NOTICE OF PRIVACY PRACTICES / PATIENT RIGHTS AND RESPONSIBILITIES ACKNOWLEDGMENT

I acknowledge that I am aware of Podiatry 1st's Notice of Privacy Practices and consent to the use of disclosure of my Protected Health Information (PHI) by Podiatry 1st for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, to conduct health care operations of Podiatry 1st and as required by law. I also acknowledge that I was offered the entire notice and that I understand I may obtain a full version of the notice at any time. I understand my rights as a patient of this practice concerning my PHI, as it is outlined in this notice and in addition I have received a copy of Podiatry 1st's Patient Rights and Responsibilities. I am aware that Podiatry 1st reserves the right to change the privacy practices that are described in this Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by contacting the office.

SIGNATURE: _____ DATE:_____

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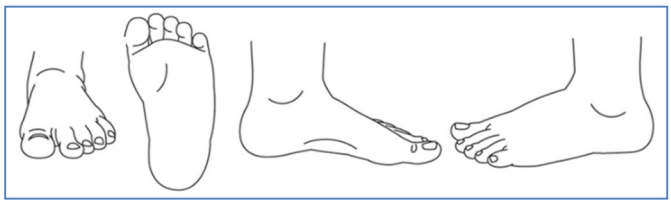
Reason for your visit today

Please describe the issue(s) / concern(s) that brings you to our office today?

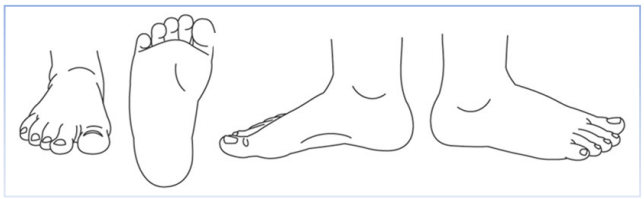
_____

_____

Where is the pain/problem located? ***Please MARK on the pictures below.***



Left Foot



Right Foot

How long ago did this problem start? _____

Onset of condition: ☐ Suddenly ☐ Gradually

Is there any known injury related to the condition? ☐ No ☐ Yes (Date of Injury:_____)

Did you sustain an injury at work? Yes No

Are your injuries auto accident related? Yes No

Briefly describe details of injury: _____

Describe your pain? ☐ No Pain ☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Electrical

☐ Other: _____

How would you rate your pain on a scale from 0 to 10? (please circle)

No Pain* = 0** 1 2 3 4 5 6 7 8 9 **10 = *Worst Pain Imaginable

Since your pain or problem(s) began, has it: ☐ Worsened ☐ Improved ☐ Unchanged

What tends to worsen the condition or pain? ☐ Shoes ☐ Not wearing shoes ☐ Dress shoes / heels ☐ Prolonged standing / walking ☐ Running ☐ Other: _____

What seems to improve or make your condition feel better?

☐ Not wearing shoes ☐ Wearing shoes ☐ Getting off feet ☐ Elevating feet

☐ Other: _____

What treatments have you had / tried for this problem? ☐ None ☐ Injections

☐ Medication _____ ☐ Other: _____

How has this problem affected your lifestyle or ability to work? ☐ It has not affected me

☐ Reduced physical activity ☐ Unable to work ☐ Depression

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Medications

Please list all current prescriptions, over-the-counter medications, and herbal or dietary supplements.

□ **No Current Prescription Medications, over the counter Medicines, or herbal or dietary supplements**
□ **Please see attached list, or**
Medication Name: _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Past Medical History

□ **No Past Medical History or Conditions**

- ☐ Atrial Fibrillation (A-fib)
- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ **Blood Clot** (DVT)
- ☐ **Cancer**
  type: _____
- ☐ Charcot Arthropathy
- ☐ Charcot Marie Tooth (CMT)
- ☐ Coronary Artery Dis. (CAD)
- ☐ Depression
- ☐ **Diabetes**
  - **Age when diagnosed:** _____
  - **Last A1C (if known):** _____
  - **Take Insulin?**_____
- ☐ Dialysis
- ☐ Epilepsy
- ☐ GERD/Reflux
- ☐ **Gout**
- ☐ HIV or AIDS
- ☐ Heart Attack (MI)
- ☐ Heart Failure (CHF)
- ☐ Hepatitis
- ☐ Hernia
- ☐ High Cholesterol
- ☐ High blood pressure
- ☐ **Kidney Disease**
- ☐ **Liver Disease**
- ☐ Lung Disease
- ☐ Migraines
- ☐ **Neuropathy of feet**
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ **PAD**
- ☐ Pneumonia
- ☐ Polio
- ☐ Pulmonary Embolism
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Stroke (CVA / TIA)
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Vein problems
- ☐ **Wounds** (nonhealing leg / foot)
- ☐ Other: _____

Allergies

□ **NO Allergies or adverse reactions**

□Penicillin □Sulfa □Codeine □Morphine □Ciprofloxacin □Keflex

□Vicodin □Iodine □Erythromycin □Aspirin □Contrast Dye □Latex

□NSAIDS □Adhesive Tape □Anesthetics (□Local □General)

□Other allergies:_____

Height_____ Weight_____

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Prior Foot / Ankle Surgery

☐ **NO Prior Foot or Ankle Surgeries**

☐ **YES** (Type of Procedure Performed) _____

Prior Vascular Surgery

☐ **NO Prior Vascular Surgery**

☐ **YES** (Type of Procedure Performed) _____

_____

Prior Cardiac Surgery

☐ **NO Prior Cardiac Surgery**

☐ **YES** (Type of Procedure Performed) _____

_____

Family Medical History *(mother, father, siblings):*

☐ **NO Family Medical History**

☐ Diabetes ☐ Blood Clots or Bleeding Disorders ☐ Other_____

☐ Gout ☐ Psoriasis _____

☐ Rheumatoid Arthritis ☐ Cancer (type: _____) _____

Social History

Tobacco: ☐ Never smoke ☐ Quit: How Long Ago? _____

☐ Current smoker ⇨ #_____ packs/day for _____years

Recreational Drugs: ☐ Never ☐ Occasional ☐ Weekly ☐ Daily

☐ Marijuana ☐ Meth ☐ Cocaine ☐ Other _____

Alcohol Use: ☐ Never ☐ Social ☐ Daily ☐ Approx Drinks/Week_____

Exercise: ☐ Sedentary ☐ Moderate ☐ Active

Living With: ☐ Alone ☐ Spouse ☐ Partner ☐ Family ☐ Friends

Occupation: Current or former Position Held: _____

Status: ☐ work FT ☐ work PT ☐ Retired ☐ Unemployed.

☐ Disabled: due to what medical condition? _____

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Systems Review

(check any symptoms below experienced in past 1-2 months)

☐ **None**

General	☐ Nausea, fever chills	☐ Unexplained loss or gain of weight
	☐ Unexplained fatigue / lack of energy	☐ Recent fall
Peripheral Vascular	☐ fatigue in calf muscle with walking	☐ pain, swelling or feeling of tightness in leg
	☐ toes turn blue, painful with cold weather	☐ frequent or chronic swelling of legs
Neurological	☐ dizziness, lightheaded or fainting	☐ difficulty with balance
	☐ weakness or paralysis	
Peripheral Neurological	☐ burning, tingling, stinging of feet	☐ weakness of foot / feet
	☐ numbness of foot /feet	
Gastro-intestinal	☐ abdominal pain	☐ frequent heartburn
	☐ bloody stool	☐ frequent nausea or vomiting
Skin	☐ excessive sweating of feet or hands	☐ non healing skin lesions
	☐ chronic or recurrent skin rash	☐ tendency to form thick scars (keloids)
Musculo-skeletal	☐ low back pain	☐ knee pain
	☐ hip pain	☐ swelling / stiffness - joints of hands or feet
Endocrine	☐ delayed healing of wounds	☐ excessive thirst
	☐ intolerance to cold or heat	☐ frequent urination
Hematology / oncology	☐ anemia	☐ bleed or bruise easily
	☐ anticoagulant use	

Patient Signature _____

Date _____

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Cancel, Reschedule, and No-Show Policy

Thank you for trusting Podiatry 1st with your foot and ankle medical care. When you schedule an appointment with Podiatry 1st, we set aside enough time to provide you with quality care. In the event you would need to cancel or reschedule an appointment, please contact our office as soon as possible, and **no later than 24 hours prior to your appointment**. This will give our office adequate time to schedule other patients who may be waiting for an appointment. Please see our Cancellation/No Show Policy below:

• Effective February 1st, 2018, established patients who fail to show or cancels/reschedules an appointment and has not contacted our office without **at least 24-hour notice** will be considered a No Show and may be required to put a credit card on file to make another appointment to be charged a $35.00 no show fee in the event of a consecutive occurrence.

• Any established patient who fails to show or cancels/reschedules an appointment without a **24-hour advance notice** may be charged a $35.00 fee after a second occurrence.

• If a third No Show or cancellation/reschedule with **no 24-hour notice** should occur the patient may be dismissed from Podiatry 1st.

• Any new patient who fails to show for their initial visit will be required to put a credit card on file to make another appointment. Any new patient who fails to show for initial appointment for a second time will not be able to reschedule.

• The fee is charged to the patient, not the insurance company, and is due at the time of the patient's next office visit.

• As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our Office Manager. You may contact Podiatry 1st 24 hours a day, 7 days a week at the numbers below. Should it be after regular business hours Monday through Friday, or a weekend, you may leave a message. Messages left at either location are acceptable.

Podiatry 1st - O'Fallon, Columbia, and St. Louis - (618)277-9533

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

_____ _____

Signature Relationship to Patient

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Prescription Consent Form

Consent to Obtain Patient Medication History. Patient Medication history is a list of prescription medicines that our practice providers, or other providers, have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system (EHR/EMR) and becomes part of your personal medical record. Medication history is very important in helping healthcare providers treat your symptoms and/or illness properly and in avoiding potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make drug history information available, and your drug history might not include drugs purchased without using your health insurance. Also, over-the-counter drugs, supplements, or herbal remedies that patients take on their own may not be included.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

_____ _____

Patient/Parent/Guardian Signature Date

_____

Printed Patient/Parent/Gaurdian Name

By signing this consent form, you are giving your healthcare provider permission to collect and giving your pharmacy and your health insurer permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.

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FINANCIAL POLICY

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skilled and high-quality care. The medical services and products provided by our office are services and products you have chosen to receive which may imply financial responsibility on your part.

INSURANCE: We participate in most insurance plans. If you are not insured by a plan we participate in, **payment in full is expected at each visit**. If you are insured by a plan that we participate in but do not have an up-to-date insurance card, **payment in full is required for each visit** until we can verify your coverage. **Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage**.

SELF PAY: Payment in full is due at the time of service if you do not have health insurance.

NON-COVERED SERVICES: Please be aware that some services you may elect to receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. **You are responsible for payment of these services.**

MEDICARE: We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. However, that does not mean that all services are covered. **Patients are responsible for paying their annual deductible if it has not been met. You are also responsible for any coinsurance and copayments.**

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or an explanation of benefits (EOB) is received from your primary insurance company.

COPAYMENTS AND DEDUCTIBLES: All co-payments and deductible must be paid at the time of service. This arrangement is part of the contract between you and your insurance company. Failure on our part to collect copayments and deductibles from patients can be considered fraud. Please help us uphold the law by paying your copayment at each visit.

REFERRALS/AUTHORIZATIONS: We are **required** to follow the guidelines of your managed care plan which mandates that when you visit a specialist such as Podiatry 1st, **you must have a referral from your primary care physician prior to seeking specialty care. Therefore, unless you present a referral at the time of visit, you are financially responsible for the services received.** Payment in full is due upon completion of the visit. You also have the option to reschedule your appointment.

CLAIM SUBMISSION: We will submit your claims to your insurance and will assist you in any way we can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of the claim is your responsibility whether your insurance company pays your claim or not. Your insurance benefit is a contract between you and your insurance company.

PODIATRY 1st

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PATIENT BILLING: You will be sent up to three notices for your financial responsibility (coinsurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After the third and last notice, your account may be forwarded to collections. Please let the billing office know if you have any difficulties resolving your bill. Payment arrangements can be made on a case-by-case basis. We accept the following payment methods: Cash, Check or Credit Card (VISA, MasterCard, American Express or Discover). A returned check fee of $25.00 will be added to your statement if a check is returned for insufficient funds. If your insurance company happens to send payment to you, the patient, we expect that you will forward it to our office to be applied to your balance.

I have read the above policy regarding my *financial responsibility* to C. James Anderson, DPM, LLC, for medical services provided. I agree to pay C. James Anderson, DPM, LLC any balance unpaid by my insurance carrier for myself or the below named person.

PRIVACY STATEMENT: Any information disclosed in your records will remain confidential and will not be used for any other reason except for providing quality care and treatment as well as to submit your claim to your insurance company and contact you as needed.

Assignment of Benefits

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to **C. James Anderson, DPM, LLC,** all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, copayments, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information.

PRINT Patient Name: _____ Signature: _____

Date: _____

FINANCIALLY RESPONSIBLE PARTY:

PRINT Name: _____ Signature: _____

Relationship to Patient: _____ Date: _____