



**PATIENT INFORMATION**

(Please print clearly with full detail)

Date: \_\_\_/\_\_\_/\_\_\_ How were you referred to our office? \_\_\_\_\_

Patient's Last Name \_\_\_\_\_ Patient's First Name \_\_\_\_\_ Age \_\_\_\_\_

DOB \_\_\_\_\_ Male \_\_\_ Female \_\_\_ Social Security# \_\_\_/\_\_\_/\_\_\_ Marital Status S \_\_\_ M \_\_\_ W \_\_\_ D \_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZipCode \_\_\_\_\_

Home Phone(\_\_\_\_) \_\_\_\_\_ Work Phone(\_\_\_\_) \_\_\_\_\_ Cell Phone(\_\_\_\_) \_\_\_\_\_

Patient's Employer \_\_\_\_\_ Employer's Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Occupation \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Name/Number of friend/relative not living with you \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

Name/Number of an Emergency Contact \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

**RESPONSIBLE PARTY AND/OR SPOUSE'S INFORMATION**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Male \_\_\_ Female \_\_\_ Home Phone(\_\_\_\_) \_\_\_\_\_ Work Phone(\_\_\_\_) \_\_\_\_\_

Social Security# \_\_\_/\_\_\_/\_\_\_ Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**INSURANCE INFORMATION**

Insurance Company \_\_\_\_\_ Insurance Phone # \_\_\_\_\_

Subscriber/Medicare ID# \_\_\_\_\_ Group# \_\_\_\_\_ PPO \_\_\_ POS \_\_\_ EPO \_\_\_ HMO \_\_\_

Subscriber's  
Last Name \_\_\_\_\_, First Name \_\_\_\_\_ DOB \_\_\_\_\_

**ASSIGNMENT AND RELEASE**

**My signature below authorizes the doctor to release my medical information necessary to process my insurance claims. I authorize that any benefits due me be paid directly to my physicians. I understand payment is expected at time of service. I acknowledge that I was provided/offered a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understand the Notice.**

Responsible Person's Signature \_\_\_\_\_ Date \_\_\_\_\_

## MEDICAL HISTORY FORM

Dear Patient:

Patient Name: \_\_\_\_\_

It is a pleasure to welcome you to our office! In order to best serve your podiatric medical/surgical needs, please take a moment to complete this medical history form.

Are you in good health? \_\_\_\_\_

Are you now or have you been under a Physician's care during the past year? \_\_\_\_\_

If so, for what medical problem? \_\_\_\_\_

Do you have a family physician?    Y    N

Name: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Are you being treated by any specialty physicians?    Y    N

Name: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Are you currently taking any medications?    Y    N    If so, please list them:

\_\_\_\_\_

Daily Vitamins? \_\_\_\_\_ Daily Aspirin? \_\_\_\_\_

Do you have any allergies or have you ever had a negative reaction to **Penicillin, Sulfa, Codeine, Aspirin, Iodine, Novocain, metals, shellfish, adhesive tape, local anesthetics, pollen, molds, dust, materials, food, topical contactants, animals, soap, clothing, jewelry, cosmetics, or anything else?**

Please circle if you have ever been treated for any of the following conditions: **Heart Disease, Gout, High Blood Pressure, Diabetes, Blood Clots, Rheumatic Fever, TB, Cancer, Thyroid, Ulcers, Hepatitis, Asthma, Epilepsy, Stroke, Anemia, Phlebitis, Arthritis, AIDS, Depression, Bronchitis, Anxiety, Heart Murmur, Syphilis, Gonorrhea, Sickle Cell, Broken Bones, Prolonged Bleeding, Bowel, Bladder, Kidney, Liver or Lung problems, or any other medical concern:** \_\_\_\_\_

Have you ever been hospitalized for an illness, injury or have you ever had any surgery? \_\_\_\_\_

Do you have a family history of any of the following health disorders?    **Heart Disease, Diabetes, High Blood Pressure, Cancer, Sickle Cell Anemia, other:** \_\_\_\_\_



### MEDICAL HISTORY FORM

Do you smoke?      Y      N  
If so, how much? \_\_\_\_\_ How long? \_\_\_\_\_

Do you drink the following beverages?

Coffee:	frequently	occasionally	never
Soda:	frequently	occasionally	never
Alcohol:	frequently	occasionally	never

Do you take birth control pills? \_\_\_\_\_ How long? \_\_\_\_\_

Are you now or is there a possibility that you are pregnant? \_\_\_\_\_

Are you breast feeding? \_\_\_\_\_

Do you take any recreational drugs? \_\_\_\_\_

Have you ever been treated for or diagnosed with AIDS or HIV carrier? \_\_\_\_\_

Do you heal well? \_\_\_\_\_

Do you tend to bruise or scar easily? \_\_\_\_\_

Are you currently involved in a sport or exercise program on a regular basis? \_\_\_\_\_

What kind of shoes do you wear the most? \_\_\_\_\_

What is your shoe size? \_\_\_\_\_ Width? \_\_\_\_\_

What is your weight? \_\_\_\_\_ Height? \_\_\_\_\_

Were you ever treated for foot disorders as a child? \_\_\_\_\_

Were you ever treated for foot disorders as an adult? \_\_\_\_\_

Do you wear custom insoles (prescription orthotics)? \_\_\_\_\_

**What is the foot or ankle problem that brought you to the office? (Please be specific)** \_\_\_\_\_

How long have you had this problem? \_\_\_\_\_

What makes it better? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

Thank you for taking the time to answer these questions. Your answers will enable us to give you the kind of care that is best for your foot health needs. If you have any other medical concerns not listed above, please list them below or discuss them with the doctor. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



## OFFICE & FINANCIAL POLICIES

Welcome and thank you for choosing *Dr. Robert E. Neville & Associates* for your foot health concerns. We are committed to providing you with the highest quality medical care in an efficient, timely, and cost effective manner. We hope that by providing you with our policies in advance, we can prevent any misunderstanding or frustration at the time of your visit.

**Initial \_\_\_\_\_ Insurance:** When making an appointment with one of our physicians, it is your responsibility to confirm with your insurance company that the physician is currently under contract with your plan. If your plan requires that you have a referral prior to seeing a specialist, please contact your primary physician so that you have the referral in hand at the time of your appointment. We do accept faxed referrals, however, we advise you to call prior to your appointment time to be sure we have your referral. If we do not have a referral at your appointment time, we will need to reschedule your visit, unless you choose to be seen without using your insurance benefits and pay for your visit in full. *If your insurance should happen to change, we require that you notify our office 24 hours prior to your appointment time.*

**Initial \_\_\_\_\_ The patient is responsible for knowing their benefit coverage for specialist visits.** We will gladly file your insurance claim on your behalf. We allow 45 days from date the claim was filed for the insurance company to pay. If your carrier does **NOT** pay within this time, you could be responsible for the entire balance. We will not become involved in disputes between you and your insurance company regarding coverage and/or policy benefit criteria, i.e. deductibles, non-covered services, co-insurance, coordination of benefits, pre-existing conditions or reasonable and customary charges, etc, other than to supply factual information when necessary.

**Initial \_\_\_\_\_ You are responsible for deductibles, co-insurance, non-covered services, and any other charges your insurance may not cover.** You will be sent statements on a monthly basis regarding any monies owed by you, the patient. If the same balance becomes more than 3 months past due, you will then be charged a finance charge of \$10.00 each month thereafter until the balance is paid in full. If your account should ever have to be turned over to a collection agency, a \$25.00 fee will also be added to your account.

**Initial \_\_\_\_\_ Check-In:** Please arrive for your appointment a few minutes early so that all paperwork may be completed before you see the physician. Please bring your current insurance card with you to **EACH VISIT**. On follow-up visits, you will be asked to verify demographic/insurance information so that our records remain up-to-date.

**Initial \_\_\_\_\_ Check-Out:** Please be prepared to pay for the current visit as well as any past balances on your account. Payment of co-pays, deductibles, supplies or any non-covered services will be required at the time of service. Estimated patient responsibilities for surgical procedures and office care will be determined by insurance benefit coverage and collected at time of service. Paying at time of service does not mean you will not get a bill, fees are only estimated. **We only accept CHECKS, MASTERCARD, VISA, DISCOVER, AND DEBIT.**

**Initial \_\_\_\_\_ Late Arrivals:** If you arrive more than 15 minutes past your appointment time, you will be rescheduled so that other patients are not inconvenienced.

**Initial \_\_\_\_\_ No-Shows and Late Cancellations:** We require a 24-hour notice if you must cancel your appointment. If you cancel the same day as your appointment, you will be considered a **NO-SHOW** for that visit. A \$25.00 charge is charged to your account for each **NO-SHOW**. You will be expected to pay that charge and any others that may occur at the time of your next visit.

**Initial \_\_\_\_\_ Non-Covered Services:** An "Insurance Waiver" may be required to acknowledge understanding of your responsibility for paying non-covered services.

**Initial \_\_\_\_\_ Minors:** The parent(s) or guardian(s) accompanying a minor are responsible for providing current insurance information for the minor and/or payment in full for services provided. Unaccompanied minors must have a written authorization for medical treatment signed by the parent or guardian before treatment can be released.

**I have read, understand and agree to the above office and financial policies. I hereby attest that I have given and agree to provide current demographic and insurance information and authorize release of information necessary for insurance filing and pre-certification by signing this statement.**

Responsible Person's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_



## PATIENT CONSENT FORM

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Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- X Protected health information may be disclosed or used for treatment, payment or health care operations.
- X The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- X The Practice reserves the right to change the Notice of Privacy Policies.
- X The patient may revoke this Consent in writing at any time and all future disclosures will then cease.

I authorize that your office may contact me in the following manner (check all that apply).

**Home telephone:**

9 Ok to leave message on machine with detailed message, including normal lab results or benign pathology results.

9 Ok to leave message with call-back number only.

9 Ok to leave message with family member (Please specify who \_\_\_\_\_).

**Work telephone:**

9 Ok to leave message on machine with detailed message, including normal lab results or benign pathology results.

9 Ok to leave message with call-back number only.

9 Ok to leave message with co-worker (Please specify who \_\_\_\_\_).

**Cellular telephone:**

9 Ok to leave message on voicemail with detailed message, including normal lab results or benign pathology results.

9 Ok to leave message with call-back number only.

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Signature of Patient or Guardian - Date

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Witness (Practice Representative)

**DR ROBERT E NEVILLE AND ASSOC., PA AUTHORIZATION FOR  
TREATMENT  
AND RELEASE OF MEDICAL INFORMATION**

**AUTHORIZATION OF TREATMENT**

I the undersigned hereby authorize Dr. Robert E. Neville and Associates, PA to render treatment and/or therapy to myself that he deems medically necessary in order to treat the condition and or conditions I have requested from himself and his staff.

SIGNATURE OF PATIENT/ GUARDIAN: \_\_\_\_\_

RELATIONSHIP OF GUARDIAN TO MINOR CHILD: \_\_\_\_\_

**LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS**

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the enclosed captioned, and hereby assign and convey directly to **Dr. Robert E. Neville and Associates, PA** all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments and understand that these balances are due within 90 days from the date of insurance payment and/or denial and if outside collection attempts are necessary, I will also be responsible for all collection and legal fees. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

\_\_\_\_\_  
**SIGNATURE OF INSURED/ GUARDIAN**

\_\_\_\_\_  
**DATE**

**RELATIONSHIP OF GUARDIAN TO MINOR CHILD:** \_\_\_\_\_