



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 _____ Zip Code _____

Home Phone(____) _____ Work Phone(____) _____ Cell Phone(____) _____

Patient's Employer _____ Employer's Address _____

City _____ State _____ Zip Code _____ Occupation _____

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

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.

Signature of Patient or Guardian - Date

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: _____