



PATIENT NAME: _____

Current Problem: (Location, Duration, Onset, Aggravating Factors, Previous Treatment)

Length of time for current problem: _____ days weeks months years

Past Medical History

- | | | |
|---|---------------------------------------|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Asthma | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Depression | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Hypercholesterol | Other: _____ | |

Current Medication List

_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies **No Known Drug Allergies**

- | | | | | |
|--|--|----------------------------------|----------------------------------|---------------------------------|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Iodine |
| <input type="checkbox"/> Local Anesthetics | <input type="checkbox"/> General Anesthetics | <input type="checkbox"/> Latex | | |
| <input type="checkbox"/> Other | _____ | _____ | _____ | |

Previous Surgeries

**New Patient Consent to the Use and Disclosure of Health Information
For Treatment, Payment, or Healthcare Operations**

I, _____; understand that as part of my health care, Carolina Foot Specialists originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a **Notice of Information Practices** that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations

I understand that Carolina Foot Specialists is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Carolina Foot Specialists reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations, should Carolina Foot Specialists change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

Patient's signature

Date

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship: _____

Witnessed by: _____

FOR OFFICE USE ONLY

Consent received by _____
on _____

Consent refused by patient, and treatment refused as permitted.

Consent added to the patient's medical record on _____

A Financial Agreement and Understanding with Our Families

Thank you for choosing our office for your foot care. Our clinical and administrative staff works closely together to provide a positive environment for visits to the office and assistance with financial requirements. A clear understanding between all of us will help insure a happy result for all concerned.

We would like to encourage payment in full for all services at the time of the visit.

If you would like us to file your insurance claim for you, you will need to bring your insurance identification card and driver's license. We send out your form immediately. Without this information, we cannot file your insurance for payment. We have no control over your benefits – that's between you, your employer and the insurance company. Some of our families have very comprehensive coverage while other plans cover very little. We also have no control over the amount an insurance company reimburses for a particular service. In some cases, insurance companies use outdated fee schedules (the SC State Employees plan has not had a fee increase in many years) or require larger co-pay or deductibles from the family. For these reasons, we require you to pay 40% of covered services and full payment for non-covered services at each visit to take care of you deductibles, co-pays and non-covered services. Please remember, we do not have any control over what the insurance company will pay for services rendered. You will be billed for any balance remaining after the insurance payment is received.

We are happy to help our families who have insurance by continuing to accept their insurance. However, please understand that you always have the final responsibility for payment for any services rendered. If your insurance company does not respond, you are required to pay any amount owed no later than 45 days after the date the services are rendered. We send monthly statements of all current open balances, so that you will be aware of what credits/payments have been made to your account. We do not charge interest on the open balance amounts; however accounts with balances due over 30 days will receive a rebilling charge of \$3.00 per month. Unless specific arrangements are made with our Financial Department, all accounts with any balance due over 90 days will be referred to an outside collection agency. Any additional charges they make to collect the past due amount (about 35%) will be added to your balance due.

When necessary, we will work with you on an individual basis. We are happy to discuss other available payment options such as billing to your Visa or MasterCard.

As a reminder, we will try to contact you a day or two before the scheduled appointment. Please make sure we have the correct home and work numbers so we may confirm your appointment. A message left on your answering machine or voice mail will be considered a confirmation of the scheduled appointment. If your plans change or an emergency arises, please call us immediately. We can usually fill in your appointment given 48 hours notice, but a visit canceled on the day of the appointment or a "no-show" broken appointment cannot be filled.

Our staff is always available to discuss any questions and assist you. Your health depends upon the success of our partnership. Please feel free to ask for our assistance at any time.

Patient Signature

Date

Parent or Legal Guardian

Date