Columbia Podiatry

(573) 443-2015 | Reception@ColumbiaPodiatryLLC.com | www.ColumbiaPodiatryLLC.com
R. Scott Foster, DPM • Terry Sanders, DPM • Sarah Newey, DPM

Patient Information

Name: FIRST _____ MI _____ LAST _____

DOB: _____ Age: _____ SSN: _____ MALE or FEMALE

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____

Email: _____

Ethnicity: _____ Non-Hispanic or Latino _____ Hispanic or Latino _____ Decline

Race: _____ African American _____ American Indian or Alaskan Native _____ Asian

_____ Pacific Islander _____ White _____ Decline

Marital Status: _____ Single _____ Married _____ Partner _____ Divorced _____ Widowed

Name of Spouse / Other: _____

Emergency Contact & Phone: _____

Name of Parent or Legal Guardian (if applicable): _____

Primary Physician: _____ Phone: _____

Address of PCP: _____

If Diabetic, diabetes physician: _____ Phone: _____

Ophthalmologist or Optometrist: _____

Date of most recent PCP exam: _____ Diabetes exam: _____ Eye exam: _____

Employer: _____ Occupation: _____

How did you hear about us: ____ Friend ____ Physician ____ Website ____ Magazine ____ Patient ____ Other

Who (so we can thank them): _____

Today's appointment date/time: _____

Doctor you will see today: _____ FOSTER _____ SANDERS _____ NEWEY

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Patient Name: _____ **Date:** _____ **DOB:** _____

Height: _____feet _____inches Weight: _____lbs. Shoe size: _____

Rate your general health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

What is your normal blood pressure? _____

Are you currently pregnant? ☐ NO ☐ YES

Date of most recent mammogram: _____ Date of most recent colonoscopy: _____

Date of most recent flu vaccine: _____ Date of most pneumonia vaccine: _____

Please list the reason for your visit today: _____

How and when did this begin? _____

Has this problem been treated before (if so, what treatment)? _____

What relieves the problem? _____

Are you having any pain today? ☐ NO ☐ YES (where) _____ If yes, please rate below:

0	1	2	3	4	5	6	7	8	9	10

No pain Moderate pain Worst pain possible

Do you have any allergies? (*check all that apply*)

☐ NONE ☐ Adhesive Tape ☐ Animals ☐ Aspirin

☐ Iodine ☐ Latex ☐Pollen/Mold ☐Tetanus

Antibiotics (*please list all*): _____

Anesthetics (*please list all*): _____

Foods (*please list all*): _____

Other (*please list all*): _____

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Patient Name: _____ **Date:** _____ **DOB:** _____

Current Medications: (*Please list all and dosages, including over the counter or attach a current list*):

Preferred Pharmacy: _____ Contact info: _____

Please list all hospitalizations and surgeries:

Hospitalization / Surgery	Year		Hospitalization / Surgery	Year

Habits: Do you currently / Have you formerly used (*answer yes/no*)

Tobacco: Current? ☐Y ☐N If yes, how many packs per day? _____

Former? ☐Y ☐N If yes, how long since last usage? _____

Alcohol: Current? ☐Y ☐N If yes, how many drinks per week? _____

Former? ☐Y ☐N If yes, how long since last usage? _____

Illicit Drugs: Current? ☐Y ☐N If yes, which ones? _____

Former? ☐Y ☐N If yes, how long since last usage? _____

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Patient Name: _____ **Date:** _____ **DOB:** _____

Past Medical History

Have you/a family member been treated for any of the following conditions? (Check all that apply)

CONDITION	YOU	FAMILY MEMBER (if so, who?)
Alcoholism		
Anemia		
Arthitis		
Asthma		
Bleeding Disorders		
Blood Clots / DVT		
Cardiac Disease		
Cancer (type)		
Cerebral Palsy		
Circulation Problems		
Depression / Psychiatric Disorder		
Diabetes		
Emphysema / COPD		
Gout		
High Blood Pressure		
High Cholesterol		
HIV		
Kidney Disease / Dialysis		
Liver Disease		
Multiple Sclerosis		
Neuropathy		
Osteroarthritis		
Pacemaker		
Paralysis		
Parkinson's Disease		
Peptic Ulcer / Reflux Disease		
Peripheral Vascular Disease		
Polio		
Rheumatoid Arthritis		
Seizures		
Stroke		
Thyroid Disease		
Ulcerative Colitis		
Varicose Veins		
Other (please list)		

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Review of Systems:

Do you have any of the following problems (check all that apply):

	Yes		Yes		Yes
Constitutional / General		**Peripheral Vascular**		**Skin**	
General good health lately		Blood clots / DVT		Rash	
Fever / Chills		Peripheral edema / swelling		Itching / Burning	
Dizziness		Claudication		Eczema / Psoriasis	
Headaches		Leg pain when walking		Discoloration	
Weight loss or gain		Cold feet		Sores / Lesions	
Loss of appetite		**Respiratory**		Nail changes / fungus	
Fatigue		Shortness of breath		**Neurologic**	
Weakness		COPD / Emphysema		Seizures	
Eyes, Ears, Nose, Mouth		Asthma / Wheezing		Tremors	
Vision problems/Glasses/Contacts		Cough		Numbness / Tingling	
Blindness		Sleep Apnea / Snoring		Hypersensitivity	
Cataracts		**Gastrointestinal**		Paralysis	
Double vision		Frequent nausea / vomiting		Memory Loss	
Hearing problems / Hearing aids		Abdominal pain		Dizziness/ Vertigo/ Fainting	
Ringing in ears		Constipation / Diarrhea		**Psychological**	
Vertigo		Heartburn / Reflux		Anxiety	
Nasal congestion		Ulcers		Depression	
Nose bleeds		GI bleeding / bloody stools		Psychiatric Care	
Dental difficulties / Dentures		**Genitourinary**		Stress	
Throat, Neck		Painful Urination		Addiction	
Sore throat		Frequent Urination/Incontinence		**Hematologic / Lymphatic**	
Difficulty swallowing		Kidney Disease / Hemodialysis		Anemia	
Neck stiffness / Pain		**Musculoskeletal**		Bruise easily	
Swollen Glands		Joint pain / swelling / redness		Bleed easily	
Cardiovascular		Muscle cramps / pain / weakness		Enlarged lymph nodes	
Chest pain / Heart attack		Back pain		Cancer / type	
Congestive heart failure		Gout		**Allergic / Immunologic**	
High blood pressure		Arthritis		Seasonal allergies	
High cholesterol		**Endocrine**		Reactions to food	
Palpitations		Diabetes		Reactions to drugs	
Murmur		Thyroid		**Surgical concerns**	
Dizziness / Fainting		Loss of hair		Anesthesia problems	
Stroke		Heat / Cold Intolerance		Wound healing problems	

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COLUMBIA PODIATRY PAYMENT/INSURANCE POLICY

Our mission is to provide each patient with high-quality, compassionate, comprehensive foot care. Patients who carry insurance should be aware that although we will bill their charges to the insurance company of the insured's card that is provided on the day services are rendered, as an insured, you are ultimately responsible for this payment, not the insurance company. Any disputes with your insurance company or non-payment of claims are your responsibility to pursue with your insurance. We will be more than happy to provide any documentation needed to assist in processing your claims. All co-pays and/or deductibles are due at the time of service as well as any charges incurred for certain supplies purchased at the time of visit, such as: orthotics, lotions, creams, nail polish, etc.

If you have a Medicare replacement insurance plan, such as Essence, Coventry Gold Advantage, Humana, Advantra, etc., it is your responsibility to contact your primary care physician for a referral to authorize treatment with us in advance of your appointment date. Any charges incurred that are not pre-authorized will be billed to the patient.

If you have an insurance plan that was purchased through the Healthcare Exchange and is not an employer group policy, it is the responsibility of the patient to contact their insurance to make sure a pre-authorized referral is not needed to be seen at our facility, and if one is needed, that it has been sent to our facility.

If you are self-pay and do not either carry medical insurance or wish to pay out-of-pocket, the charge for services is due and payable the day of services. We accept cash, check, MasterCard, Visa, American Express, and Discover as forms of payment.

I hereby certify that all of the above information is understandable to me and the information I have provided on the previous pages is accurate and true to the best of my knowledge.

I authorize Columbia Podiatry to release any medical information required to process my charges today with my insurance company. I also assign R. Scott Foster, Terry A. Sanders, Sarah B. Newey, DPM the medical and/or surgical benefits to which I or my dependents are entitled under my medical insurance plan(s), including secondary insurance companies, if applicable.

I understand that I am financially responsible for all charges and payment is expected at the time of service.

Patient/Guarantor's Signature: _____

Date: _____

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Patient Name: _____ Date: _____ DOB: _____

SUMMARY OF NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please, review it carefully.

This is a *summary* of Notice of Privacy Practices. It is meant to summarize how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please, refer to the Notice of Privacy Practices booklets which are displayed throughout our office for further information.

Uses and Disclosures of Health Information – We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on your Authorization – In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care
- For certain limited research purposes
- For purposes of public health & safety
- To Government authorities to prevent child abuse or domestic violence
- To the FDA to report product defects or incidents
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders
- When required by court orders, search warrants, subpoenas and as otherwise required by the law

Patient Rights – As our patient, you have the following rights:

- ✓ To have access to and/or a copy of your health information
- ✓ To receive an accounting of certain disclosures we have made of your health information
- ✓ To request restrictions as to how your health information is used or disclosed
- ✓ To request that we communicate with you in confidence
- ✓ To request that we amend your health information
- ✓ To receive notice of our privacy practices

If you have a question, concern, or complaint regarding our privacy practices, please do not hesitate to ask to speak with our Office Manager/Privacy Officer.

Patient/Guarantor's Signature: _____

Date: _____

Patient Name: _____ Date: _____ DOB: _____

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NON-DISCRIMINATION STATEMENT

Columbia Podiatry complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex Columbia Podiatry does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Columbia Podiatry:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Office Manager.

If you believe that Columbia Podiatry has failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, or sex, you can file a grievance with:

Columbia Podiatry Office Manager
305 N. Keene St. suite 209
Columbia, MO 65201 573-443-2015
fax 573-449-5886
email at reception@columbiapodiatryllc.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Office Manager is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Authorization to Release Medical Information

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Date: _____

Patient Name: _____ DOB: _____

I hereby authorize and request you release any information, including the diagnosis, medical reports, XRays, and/or laboratory reports of any treatment or examination rendered to me from: _____ to _____.

I authorize release to:

Columbia Podiatry
305 N. Keene St., Suite 209
Columbia, MO 65201
573-443-2015 (office)
573-449-5886 (fax)
reception@columbiapodiatryllc.com

Patient signature: _____ Date: _____

Witness signature: _____ Date: _____