CLAREMORE PODIATRY

PATIENT INFORMATION

(PLEASE PRINT)

Who may we thank for referring you to our office? _____

NAME _____

ADDRESS _____ CITY _____ ZIP _____

HOME PHONE _____ CELL _____ EMAIL _____

SOCIAL SEC NO. _____ DATE OF BIRTH _____ AGE _____ MARITAL STATUS S M D W (circle)

RACE _____ (optional) ETHNIC GROUP _____ (optional) PREFERRED CONTACT METHOD: Cell / Work / Home (circle)

PHARMACY _____

PATIENT'S EMPLOYER _____ POSITION _____

BUSINESS ADDRESS _____ BUSINESS PHONE _____

SPOUSE'S NAME _____ SPOUSE'S SOC NO. _____ SPOUSE'S DOB _____

SPOUSE'S EMPLOYER _____ SPOUSE'S WORK PHONE _____

PERSON RESPONSIBLE FOR BILL

(IF OTHER THAN ABOVE)

NAME _____ RELATIONSHIP _____

SSN _____ DATE OF BIRTH _____

ADDRESS _____ CITY _____ ZIP _____

HOME PHONE _____ CELL _____

EMPLOYER _____ POSITION _____

BUS. ADDRESS _____ BUS. PHONE _____

NEAREST RELATIVE TO NOTIFY IN AN EMERGENCY

(IF NOT ALREADY LISTED)

NAME _____ RELATIONSHIP _____

HOME PHONE _____ BUS. PHONE _____

AUTHORIZATIONS

BENEFITS TO PHYSICIAN:

☐ YES ☐ NO I hereby authorize payments directly to the physician of the surgical and/or medical benefits.

☐ YES ☐ NO I also understand I am responsible for any portion of my bill not covered by my insurance company.

RELEASE OF INFORMATION:

☐ YES ☐ NO I hereby authorize the release of information for insurance claim purposes.

☐ YES ☐ NO May we contact you on your work or cell phone?

I understand all of the above and hereby state that the information is correct to the best of my knowledge.

Signed _____ Date _____

CLAREMORE PODIATRY

MEDICAL INFORMATION

THIS INFORMATION IS IMPORTANT FOR OUR RECORDS AND YOUR HEALTH

Describe your foot problem: _____

_____

How long has it bothered you? _____

Any treatments you have tried? _____

PATIENT MEDICAL HISTORY:

Current weight: _____ Shoe size: _____ Height: _____

Primary Physician: _____

Date you last saw this doctor: _____

Other Treating Physicians (and condition being treated): _____

_____

Have you ever been treated for any of the following illnesses: (If yes, please check)

____ Diabetes (if yes, for how long? _____ Avg. blood sugar: _____ Recent HgA1C _____)

____ Anemia
____ Amputation
____ Arthritis
____ Back Pain
____ Blood Clots/Bleeding
____ Cancer
____ Circulation Problems
____ Depression/Anxiety
____ Emphysema/Bronchitis/Asthma
____ Epilepsy/Seizures
____ Cramping in legs with walking or at night
____ Fibromyalgia
____ Frequent Infections
____ Gout
____ Heart Disease/Heart Attack
____ Hepatitis
____ High Blood Pressure
____ Immunodeficiency Disease/HIV
____ Joint Replacements
____ Keloids/Big Scars
____ Kidney Disease
____ Liver Disease
____ Loss of Balance
____ Neurological Disorder
____ Pacemaker
____ Problems Healing
____ Stomach Ulcers
____ Stroke
____ TB
____ Thyroid Problems
____ Weight Loss/Gain

Please comment on any illness checked or any not listed above: _____

_____

_____

Name: _____

MEDICATIONS: (prescription, over the counter medications, supplements, herbal or homeopathic remedies): _____

_____

_____

_____

ALLERGIES: (i.e., Tape, iodine, metal, antibiotics, pain medications, etc.): _____

_____

PREVIOUS HOSPITALIZATIONS AND/OR SURGERIES: (Please list dates and any complications):

_____

_____

_____

SOCIAL HISTORY:

I live: _____ Alone _____ With Someone

Daily lifestyle: _____ Sits at job _____Stands at job _____ Stands and Walks _____ Retired

Exercise regimen: Type: (ie., Bike, walk, run, swim, etc.) _____

How much/How often? _____

Tobacco Use? _____ Yes _____ No # Packs per day _____

Previous Smoker? _____ # of years _____ When did you quit? _____

Alcohol Use? _____ Yes _____ No

# of drinks per week? _____

Recreational Drug use? _____ Yes _____ No Type? _____

FAMILY HISTORY:

Do you have a family history of Diabetes? _____ Yes _____ No Who? _____

Is there a family (blood relative) history of:

____ Arthritis	____ Bunions	____ Hammertoes
____ Amputation	____ Bleeding Disorder	____ Heart Disease
____ Anemia	____ Cancer	____ Kidney Disease

Mother: Alive or Deceased (please circle one)

If Deceased, cause and age of death: _____

Father: Alive or Deceased (please circle one)

If Deceased, cause and age of death: _____

REVIEW OF SYMPTOMS: (Please note if you have experienced any of the following in the past 6 months)

____ Fever	____ Chills	____ Nausea	____ Recent weight loss/gain
____ Chest Pain	____ Back Pain	____ Numbness of feet	____ Unstable on feet
____ Skin Rash	____ Wounds	____ Itching	____ Redness of feet or legs
____ Calf cramps when walking		____ Calf Cramps at night	____ Pregnant
____ Foot pain with first few steps in morning		____ Stiffness or pain in the morning	____ Gout
____ Swelling of foot or ankle			

Reviewed by Dr. _____

CLAREMORE PODIATRY
Tel: 918.341.6821

We are required by law to maintain the privacy of, and provide individuals with, a notice of our legal duties and privacy practices with respect to your protected health information. If you have any objections to our privacy practices please ask to speak with our HIPAA Compliance Officer in person or by phone at the number listed above.

My signature below is only an acknowledgement that I have been notified of Claremore Podiatry's Privacy Policies and Practices. I am aware that a copy of said practices is available upon my request.

Signature_____ Date_____

In addition to those parties listed in Claremore Podiatry's Privacy Practices, and those required by law (i.e. medical care providers and insurance carriers) I give my permission for Claremore Podiatry to speak with and/or release my medical care and treatment information to the following individual(s):

Release To: _____ Relationship: _____

_____ _____

_____ _____

I understand that I may revoke this consent at any time prior to the 12 month automatic expiration date of my signature. However, my revocation cannot be applied retroactively once my PHI has been released in good faith. I understand that Claremore Podiatry and its staff, employees, officers and directors cannot be responsible for the confidentiality of information disclosed after said information has been released pursuant to this authorization, and I hereby release them from any liability arising from such disclosure and from all legal responsibility or liability that may arise from this authorization.

Patient/Legal Guardian Signature: _____ Date: _____

Relationship to Patient: _____ Patient Date of Birth: _____

Witness Signature: _____ Date: _____

CLAREMORE PODIATRY

_____ (please check)

I _____ **give** consent to Claremore Podiatry to review my pharmaceutical history through RX Hub. This allows our office to access all your prescribed medications from all doctors.

Signature _____ Date _____

_____ (please check)

I _____ **do not** give consent to Claremore Podiatry to view my pharmaceutical history through RX Hub.

Signature _____ Date _____

CLAREMORE PODIATRY

FINANCIAL POLICY

Thank you for choosing us as your Foot and Ankle Care Specialists. It is our goal to provide you with the highest quality of care at the most reasonable prices. The following is our financial policy. We invite you to discuss with us any questions you have regarding our services or payment policies. The best health services are based on mutual understanding between provider and patient.

Patients or their guardian are responsible for their financial obligations incurred for medical services received. In the case of divorced parents, the parent bringing the under age child in is responsible for any balance incurred. As a courtesy we are happy to file your claim, however, final payment is the patient's or guardian's responsibility.

Claremore Podiatry is not a bank or financial institution. We do not extend credit or carry balances on accounts. We except Cash, Checks, Check Cards, MasterCard, Visa and Discover Card.

In order for you to be well informed, it is important that you understand:

1. **Insurance.** Your insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company. ALL CHARGES ARE YOUR RESPONSIBILITY, WHETHER YOU'RE INSURANCE PAYS OR NOT.
2. **Medicare Patients:** We would like you to understand that taking ASSIGNMENT means that YOU are responsible for the **YEARLY DEDUCTIBLE** for the **20% CO-INSURANCE** of what Medicare allows. If you have a secondary and your secondary does not pay your deductible or co-insurance, you are responsible for it.
3. **Co-payments, deductibles and co-insurance.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-pays and deductibles from patient can be considered fraud. Please help us in upholding the law by paying your part at each visit. Co-insurance is calculated and collected at the time of service also.
4. **Non-covered Services.** You are responsible for any non-covered services you choose to receive. Please be aware that some, and perhaps all, of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for the services in full at the time of your visit.
5. **Proof of Insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your current valid insurance. If you fail to provide us with your correct insurance information in a timely manner, you may be responsible for the balance of a claim. If required, obtaining the proper referral from your Primary Care Physician is your responsibility.
6. **Non-Payment.** Any balance that is not paid within 90 days will be subject to a $20.00 rebilling fee for each outstanding month until paid. At the end of 120 days, the account will be turned over for collections. All collection fees, legal fees and court costs will be added to the patient balance, this is in addition to the balance due this office. Please be aware that if a balance remains unpaid, you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by mail that you have 30 days to find alternate podiatric care. During that 30-day period, our physician will only be able to treat you on an emergency basis.
7. **Missed appointments.** Our policy is to charge $30.00 for missed appointments not canceled within a reasonable amount of time or for an understandable reason. These charges will be your responsibility and billed directly to you. Please help us serve you better by keeping your regularly scheduled appointment.
8. **Insufficient funds checks.** Restitution for returned checks is required within five (5) working days with cash, money order or credit card and will be subject to a $25.00 returned check fee.

I authorize Claremore Podiatry to contact me via current and any future cellular phone number(s), email address, or wireless device(s) regarding my delinquent account(s) I owe to Claremore Podiatry or to receive general information from Claremore Podiatry. I also authorize its agents, representatives and attorneys (including collection agencies) to use automated telephone dialing equipment and artificial or pre-recorded voice messages and personal calls, in their effort to contact me for purposes of collecting any portion of my account which is past due. I understand that I may withdraw my consent to call my cellular phone by submitting my request in writing to Claremore Podiatry or its agents.

I have read, understood and have received a copy of the payment policy and I agree to abide by its guidelines/terms described above.

Responsible Party Signature	Print Name of Responsible Party	Date