



Email: information@footclinicsc.com

New Patient Paperwork

General information

Last name _____ First name _____ MI _____

Preferred Name _____ Sex _____ DOB _____ Social Security _____

Mailing Address Street _____

Apartment # _____ City _____ Zip code _____

Home phone # _____ Cell _____

E-mail _____

Family Physician _____ When was your last appointment there? _____

Pharmacy name _____

Pharmacy address _____

Emergency Contact Name _____

Phone # _____ Relationship to emergency contact _____

How did you hear about us? (CIRCLE) *Doctor Friend Family Internet Insurance Other:*

Consent for Minors

Guardians First Name: _____ Last Name: _____ MI: _____

Contact number: _____ - _____ - _____ Relationship to patient: _____

Guardians Signature: _____

List ALL Medication (current and discontinued within the last year)

Name	Dosage	Name	Dosage

Do You have any allergies? (circle all that apply)

Penicillin Tape Lidocaine Codeine Latex Sulfa Betadine

other:_____

Medical History (circle all that apply)

AIDS/HIV High Blood Pressure Gout Bunions

Hepatitis Ingrown Diabetic (if yes, what was your last blood sugar? _____)

Other:_____

Past surgeries:

Height ____' ____ **Weight** ____ lbs **Shoe Size** _____

Do you smoke or use smokeless tobacco? _____

How long/how many packs per day ? _____

Do you drink alcohol? _____ If YES how often? _____

What's the reason for your visit?

Reason for today's visit? _____

How long have you had this issue? _____

Have you seen a podiatrist previously? _____

What treatments have you tried? _____

Have you received an X-ray in the last 3 months? _____

Patient **Name** _____



I acknowledge and agree that Foot Clinic of SC may: (CHECK ALL THAT APPLY)

- ☐ Leave a message regarding upcoming appointments.
- ☐ Leave a message regarding lab results/imaging studies/medication refills on my answering machine.
- ☐ Leave a message regarding billing questions on my home answering machine.

I acknowledge and agree that Foot Clinic of SC may disclose my protected health information and medical record information to the following individuals who are either, my family members, legal representatives, guardians, health care surrogates, or have power of attorney on my behalf:

Print name, relationship, and phone number

I have read and understand the information on this consent. I may receive a copy of this consent if I so choose and I am the patient or the authorized party to act on the behalf of the patient to sign this document verifying consent to the above terms.

Please Print Name

Patient's Signature or Authorized Representative

Date

E-PRESCRIBING CONSENT FORM

E-Prescribing is defined by a Physician's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an E-Prescribing program. These include:

Formulary and benefit transactions - gives the prescriber information about which drugs are covered by the drug benefit plan.

Medication history transactions – provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

I authorize Foot Clinic of SC, LLC to view my external prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies and pharmacy benefit managers may be viewable by my provider and staff a Foot Clinic of SC, LLC, and it may include prescriptions back in time for several years, and may include prescriptions to treat HIV, substance abuse and psychiatric conditions, if applicable. I understand that my prescription history will become part of my Foot Clinic of SC, LLC medical record.

Understanding all of the above, I hereby provide informed consent to Foot Clinic of SC, LLC to enroll me in the E-Prescribing program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction. This consent will remain in force until revoked or changed.

Please Print Name

Patient's Signature or Authorized Representative

Date



Patient Financial Policy

Thank you for choosing our practice for your Podiatric needs. We are committed to providing you with the best possible medical care. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

- Payment for all services provided by our practice is due in full at the time services rendered. Exclusion to this policy are those patients who are members of a managed care insurance plan with which our practice participates.
- If our practice has a contractual agreement with your insurance plan, co-payments will be required at the time you check-in and any unmet deductible amounts will be required at the time you check out. We will verify your insurance benefits prior to the day of service unless you make an appointment same day.
- If our practice does not have a contractual agreement with your insurance plan, you will be considered self-pay and are responsible for the full payment at the time services are rendered.
- All patients are responsible for any non-covered services and will be asked to sign an Advanced Beneficiary Notice (ABN) for any non-covered services or supplies prior to the service. You will be responsible for your deductible, co-pays, and any service deemed medically unnecessary and all non-covered services or supplies.
- This practice will not file any secondary insurance to Medicare unless it is an e-crossover from Medicare, or a plan in which we participate. In this case, Medicare patients will be responsible for their co-payments and/or deductibles.
- This practice accepts Cash, Personal checks, MasterCard, and Visa as payment for services.
- A \$30 Return Check Fee will be assessed to your account for every check returned to this practice. No checks will be re-deposited.
- Some insurance plans require prior authorization from your primary care provider in order for our physicians to see you and receive payment from your insurance plan. While we make every effort to obtain this prior to the date of service, if we do not have this authorization number, we may need to reschedule your appointment. The member is ultimately responsible for the authorization, not our office nor the Primary Care Provider.
- If you are scheduled to have a procedure/surgery performed, we will conduct a pre-operative benefits check with your primary insurance company to determine as accurately as possible what your patient responsible amount will be after insurance pays. Payment is expected to be paid in full at the time of your pre-operative appointment, prior to the date your procedure will be rendered.
- Refunds will be issued (when applicable) monthly, if payment is made with credit/debit card the refund will be issued back to the payment card. If payment is made in cash, refunds will be issued via paper check. Account credits \$20 and under will not be automatically issued, the account credit will only be issued upon verbal request from the patient.
- If you do not give us 24 hours' notice of an appointment cancellation, you may be subject to a \$50 cancellation fee.
- It is our policy to send to the patient three consecutive monthly statements with any balance owed to the practice by the patient. Once all attempts at collections are exhausted, the patient's account is then placed with an outside collection agency with management's approval. After that time, the patient agrees to pay the cost of collection including a reasonable attorney's fee, if this account should be placed in the hands of an attorney for collections.
- We realize that temporary financial problems may affect timely payment of your account, if such problems do arise, we encourage you to contact us promptly for assistance in making payment arrangements.
- If you have any questions regarding our financial policies, please feel free to speak with our Financial Counselor or Office Manager. We will make every effort available to you to clarify any misunderstanding you have regarding your account.

PLEASE READ THE ABOVE INFORMATION CAREFULLY BEFORE SIGNING. By signing below, I acknowledge that I have read, understand, and agree to the terms of this policy. I also request that payment of authorized benefits be made to Foot Clinic of SC, LLC. I authorize them to release medical information to my insurance plan and its agents any information needed to determine these benefits or the benefits payable to related services. The undersigned certifies that they are either the patient or is duly authorized by the patient as the patient's general agent to execute the above and accept the terms.

Please Print Name

Patient's Signature or Authorized Representative

Date

A. Notifier: Foot Clinic of South Carolina, LLC

B. Patient Name & Date of Birth:

C. Patient SSN:

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If your insurance company doesn't pay for **D.** below, you may have to pay. Your insurance company does not pay for everything, even some care that you or your health care provider has good reason to think you need. We expect your insurance company may not pay for the **D.** below.

D.		E. Reason Your Insurance Company May Not Pay:	F. Estimated Cost
Office Visit	Orthotics	Insurance companies may not deem medically necessary	Up to \$3000
Nail Trimming	Callous Trim		
Ulcer Debridment	Nail Biopsy		
Injections	X-rays		
Ingrown Toenails	Wart Treatment		
Nerve Biopsy	DME		

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** listed above.

Note: If you choose Option 1 we may help you to use any other insurance that you might have, but your insurance company cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

- ☐ **OPTION 1.** I want **D.** listed above. I may be asked to pay now but also want my insurance company billed for an official decision on payment, which is sent as an explanation of benefits (EOB). I understand that if my insurance company doesn't pay, I am responsible for payment, but **I can appeal to my insurance company** by following the directions on the EOB. If my insurance company does pay, you will refund any payments I made to you, less co-pays or deductibles.
- ☐ **OPTION 2.** I want **D.** listed above, but do not bill my insurance company. You may ask to be paid now as I am responsible for payment. **I cannot appeal if my insurance company is not billed.**
- ☐ **OPTION 3.** I don't want **D.** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if my insurance company would pay.**

H. Additional Information:

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:
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