MODERN PODIATRY
FOOT & ANKLE CLINIC

New Patient Form

Patient Name:_____ Date of Birth:_____ Sex: ☐M ☐F

Social Security #:_____ Employed:☐ Y ☐N Occupation:_____

Address: _____

Street City State Zip

Home#: _____ Work #:_____ ****Cell #**:_____

Email:_____

Emergency Contact: _____ Phone #:_____

Primary Physicians Name: _____

Physician Contact Number: _____ Date Last Seen: _____

Insurance Information

Primary Insurance Name: _____

Policy Holder's Name: _____ Social Security #: _____

Policy Holder's Date of Birth: _____ Patient's Relationship to Policy Holder: _____

Policy Holder's Employer: _____

☐Married ☐Single ☐Divorced ☐Widowed

How did you hear about us: (Please circle)

☐Physician ☐Internet ☐Newspaper ☐Social media ☐Insurance ☐Friend/Family

*Referring Doctor's name_____ *Referring Friend/Family's name_____

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Patients Name: _____ **Shoe Size:** _____

Pharmacy Information

Preferred Pharmacy: _____ **Address:** _____

Reason for your visit: _____ **Pain Level:** _____

Alcohol Intake: ☐Yes ☐No If yes, how often?_____ **Caffeine Intake**:☐Yes ☐No

Smoker: _____ pack(s)/day X _____ years **Previous smoker**: ☐Yes ☐No How much/long: _____

Height: _____ **Weight**: _____

Constitutional: Are you currently experiencing (please check): ☐Nausea ☐Vomiting ☐Fever ☐Chills ☐Night Sweats

Have you had a Flu shot this season? ☐YES ☐NO **Have you had the pneumonia vaccine?** ☐YES ☐NO

Medications: List current medications & dosage:

_____ _____

_____ _____

_____ _____

Past Medical History: If you now have or have ever had any of the following conditions, please check the box and be more specific in the blank space below:

☐Thyroid Problems ☐Hepatitis ☐Cancer ☐Ear Disorders ☐Multiple Sclerosis ☐Hearing Loss

☐Circulation Problems ☐Eye Disorders ☐Heart Disease ☐ADD/ADHD ☐Heart Burn/Reflux ☐Lymphedema

☐Bipolar Disorder ☐Anxiety ☐Back Problems ☐Alcohol/Drug Dependency ☐Anemia

☐Currently Pregnant ☐Depression ☐High Blood Pressure ☐Children/Pregnancies ☐Fibromyalgia

☐Asthma ☐Gout ☐High Cholesterol ☐Prostate Problems ☐Breathing Problems

☐HIV/AIDS ☐Lupus ☐Osteoarthritis ☐Pre-Diabetes ☐Diabetes: Type I or Type II

☐Current Kidney Dialysis ☐Osteoporosis/ bone density ☐Kidney Problems ☐Neuropathy ☐Parkinson's

☐Alzheimer's/ Dementia ☐Other:_____

Allergies: ☐Yes ☐No If yes, please list: _____

Family History: Please check off any medical conditions that run in your **family** and write which member(s) affected:

☐Diabetes _____ ☐Gout _____ ☐Heart Disease_____ ☐Circulation Problems _____

☐High Blood Pressure_____ ☐High Cholesterol_____ ☐Other_____

Surgeries: List all surgeries you have had. Begin with the most recent. Please give the year.

_____

If **diabetic**, who manages your diabetes?_____ Phone #:_____

Last A1C? _____ Performed by/Date: _____

**For those patients 65 years of age or older, do you have a living will or have someone to make decisions on your behalf? ☐YES ☐NO

POLICIES & DISCLOSURES

Below are our policies & disclosures. If you have any questions, please discuss them with our front office staff.

- At Modern podiatry, we strive to answer any benefit related questions as accurately as possible. However, due to rising numbers of different plans within insurance companies and discrepancies in coverage information provided from their agents, it is ultimately the patient's responsibility to call and verify that we are in-network and that your plans are active at the time of their visit.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check.
- You must inform the office of all insurance changes and referral/authorization requirements. If you have a plan that requires a referral, it is your responsibility to make sure we have the referral before seeing our provider. In an event that the office is not informed or your insurance fails to cover your services, it will be your responsibility to pay any charges denied.
- Please understand that any FMLA, work forms, short term/long term disability, or a formalized doctor's letter needed, there will be a charge of $50. There is also a $15 fee for any medical record request.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctors. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within 60 days, you will receive a bill.
- We accept medicare. However, there is an initial yearly deductible and a 20% co-insurance. Federal law requires that physicians collect this amount. If you have a secondary insurance to cover the 20%, we will submit to the secondary insurance. Please note that you may still owe your yearly deductible.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due to the office. Patients who are 90 days past due on their balance will be sent to collections, unless a payment plan has been put into place.
- Any durable medical goods or non-covered services/products purchased, there is a no refund policy.
- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.
- In fairness to all of our patients, we understand that emergencies occur, but repeated no shows or cancellations with less than 24 hours' notice will result in a fee of $25.00. You might be asked to pay before you are seen by the doctor.

- Patients who come to the office 15 minutes later than scheduled appointment might be asked to reschedule.
- Surgery cancellation or a request for reschedule, there will be a $150 fee.
- In case you need narcotic pain medications to be prescribed by our doctor to control your pain, you must promise not to give pills to others, use illegal drugs, or seek controlled medications from health care providers. In addition, you must agree to use the medication as prescribed and to come to the clinic for drug testing and pill counts. Patients acknowledge that if they violate the opioid treatment agreement (OTA), they may no longer receive controlled medications.
- Modern Podiatry discloses that your physician has a financial interest in Medical City of Frisco Surgery Center and Vascular Institute of North Texas. You are always given an option to use an alternative health care facility for your care.
- You certify, warrant, and represent that the phone number you have provided to us is your contact number. You are authorizing Modern Podiatry to contact you via text for appointment reminders and a form of communication in case we are unable to reach you by the phone.
- Please note that our text messages are used for reminders only and you may not seek medical advice or consultation via text. If you wish to not receive texts, please indicate here and let one of our front staff know.
- Your physician may take photographs or video recordings during your appointment as long as your name or your identity is not shared with anyone. Modern Podiatry does not allow any photographs or video recordings during your appointment from patients and their family members without informed consent to protect the privacy of our patients and medical staff.

☐ Please check the box that you understand and agree with the policies stated above.

Signature of Patient/ Responsible Party:_____ Date:_____

Printed Name of Patient/ Responsible Party:_____ Date:_____

EXPLANATION OF PAYMENT POLICY & PRIVACY(HIPAA) POLICY

At Modern Podiatry, we do our best to obtain the most accurate information possible from your insurance for your benefit and coverage. However, discrepancies can happen as payment is not guaranteed from the insurance provider. It is ultimately your responsibility to follow up if any refund or payment is owed from either of the parties. Once explanation of benefit (EOB) is received, you can follow up with your questions or concerns. Also, if you have a separate account like a medical reimbursement account (MRA), once payment has been processed please contact us with the EOB and we are able to refund any overpayment amounts accordingly.

I hereby authorize Modern Podiatry to release medical information pertinent to the filing of insurance claims for me. I authorize my insurance carrier to pay benefits directly to Modern Podiatry on any unpaid services filed on my behalf. I understand that I AM RESPONSIBLE for payment to Modern Podiatry for charges for the above patient regardless of my insurance coverage. I also understand that Modern Podiatry is not ultimately responsible for collecting my insurance or negotiating settlements of claims. I acknowledge that I understand Notice of Privacy Practices and that I have had the opportunity to read and understand the Notice. I also hereby give Modern Podiatry permission to diagnose and administer treatment for my foot and/or ankle condition and authorize any release of information obtained in the course of my treatment. **I allow Modern Podiatry to receive and release my personal and medical information that may be pertaining to my treatment, medical history and also diagnosis.**

Patient's Signature: _____ Date: _____

You can also print/e-mail completed forms to hello@modpodiatry.com*