# Healthy Steps Podiatry Center, PLLC

1529 E Chocolate Ave
Hershey, PA 17033
717-533-5937

Dear Patient:

We would like to extend a very warm welcome to you! We sincerely appreciate you choosing us for your Podiatry care and we look forward to getting to know you. If there is anything we can ever do to improve your experience with us, please don't hesitate to ask. This Welcome Packet includes several important documents to read and complete. Please remember to fill out the Patient Information Forms and bring them with you to your first visit. Also, bring any insurance information (member cards) you wish to use along with your driver's license or personal identification card. Thank you and we look forward to seeing you soon!

Sincerely,

Diane Bray, DPM Amanda Crowell, DPM

# Healthy Steps Podiatry Center, PLLC

Name:_____ Date:_____

Address:_____

Phone (Home):_____ DOB:_____Age:_____SSN:_____Shoe Size:_____

Phone (Cell):_____Phone (Work):_____Height:_____Weight:_____

How did you hear about us?:_____

Chief Complaint (why are you being seen today): _____

_____

Current problem is a result of: Check all that apply
Is your injury the result of an automobile accident? Yes ___ No ___
Is your injury job related? Yes ___ No ___
Are you currently involved in a lawsuit as a result of your foot/ankle injury? Yes ___ No ___
Do you plan to file a lawsuit because of your foot/ankle injury? Yes ___ No ___
If you answered Yes to any of the previous questions, a Notice of Injury form must be filled out before seeing the physician.

Circle all that apply: Left Foot Left Ankle Right Foot Right Ankle
Have you seen anyone else for this problem? _____

Primary Care Physician: _____
Date of last visit: _____ Pharmacy: _____

Can you take aspirin? Yes ___ No ___
Do you smoke? Yes ___ No ___ If so how much? _____
Have you ever smoked? Yes ___ No ___ If so, how long and how much? _____
Do you drink alcohol? Yes ___ No ___ If so, how much? _____
Do you use recreational drugs? Yes ___ No ___ If so what, and how often? _____

Any problems with local anesthetic? Yes ___ No ___
If Yes, check all that apply: Nausea ___ Vomiting ___ Weakness ___ Other _____
Women: Are you to your knowledge, pregnant? Yes ___ No ___
Post-menopausal? Yes ___ No ___
On oral contraceptives? Yes ___ No ___

Medications you are CURRENTLY taking (include dose and frequency) _____
_____

Past surgery? _____
_____
_____

Allergies:
Are you allergic or sensitive to: Penicillin ___ Novocaine ___ Aspirin ___ Sulfa drugs ___
Anesthetic ___ Adhesive tape ___ Iodine ___ Metal ___ Latex ___
Drugs: _____ Other: _____
____ I have no allergies that I know of

General Health: (If you have or have had, check all that apply)

| | | | | | |
|---|---|---|---|---|---|
| | Measles | | Hip Problems | | Burning or numbness in Feet |
| | Mumps | | Ankle Problems | | Burning or numbness in Legs |
| | Chicken Pox | | Skin Problems | | Scarlet Fever |
| | Bone Fracture | | Headaches | | Pneumonia |
| | Lower Back Pain | | Bruise Easily | | Neck Pain |
| | HIV | | Hepatitis | | Shortness of breath on exertion after being on feet |

Family Health:
Have you or your family members ever had any of the following (check all that apply)

| You | Family | | You | Family | |
|---|---|---|---|---|---|
| | | High Cholesterol | | | Heart Disease |
| | | Diabetes, Insulin Dependent<br>Last A1C? _____ | | | Lung Disease/COPD/ Asthma<br>(Circle all that apply) |
| | | Diabetes, Non-Insulin Dependent<br>Last A1C? _____ | | | Depression/Anxiety/ Mood Disorder<br>(Circle all that apply) |
| | | Circulatory Problems | | | Liver Problems |
| | | High Blood pressure | | | Hepatitis |
| | | Bleeding Problems | | | Anemia |
| | | Renal/Kidney Disease | | | Blood Disease |
| | | Thyroid disease | | | Lymph disease |
| | | Epilepsy | | | Rheumatic Fever |
| | | Muscle Disease: _____ | | | Gout |
| | | Bone Disease:_____ | | | Skin Problems |
| | | Varicose Veins | | | Cancer:_____ |
| | | Osteoarthritis/ Rheumatoid<br>Arthritis/ Psoriatic Arthritis | | | Other: _____ |

I agree that the above information is accurate and true to the best of my knowledge.

Signature: _____ Date: _____

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## Insurance Agreement

Insurance is a contract between you and your insurance company.

We will inform you if we are a party to your insurance contract and will handle claims according to our agreement with the Insurance Company. For the insurance plans with which we participate, we will file your claims for you.

Healthy Steps Podiatry Center, PLLC must be able to establish eligibility with your insurance company for you within 60 days of the first date of service. If eligibility cannot be verified by 60 days, the visit charges will become your personal responsibility.

You are responsible for responding to any claim request sent to you by your insurance company. Failure to respond to these inquiries will result in the fees charged by our office becoming your personal responsibility.

We will not become involved in disputes between you and your insurance company regarding deductibles, Co-payments and covered charges, secondary insurance, "usual and customary" charges etc., other than to supply information as necessary.

You are responsible for the timely payment of your account. All patients will pay co-pays, deductibles, coinsurance, or amounts not covered by insurance at the time of visit. Any outstanding balances after insurance has been paid on a bill are due with the first billing to you. Failure to do so will result in the unpaid bill being sent to our collection agency.

By signing below, I acknowledge my understanding and will abide by the Financial Policy of Healthy Steps Podiatry Center, PLLC.

Patient Signature: _____ Date: _____
Parent/Guardian Signature: _____ Date: _____

## No Show Policy

In the event you are unable to keep your appointment with this office, it is imperative that you call to cancel and/or reschedule your appointment. Any patient that does not keep an appointment and has not called to cancel, will be charged a $25 fee. You will not be permitted to schedule an appointment until this fee is paid. This policy is necessary to ensure that patients needing appointments can get them in a timely manner. Healthy steps Podiatry center, PLC reserves the right to waive the fee on a case-by-case basis. We thank you for your cooperation.

Patient Signature: _____ Date: _____

## Consent for treatment, authorization to release information, and allow payments of insurance benefits

Patient Name: _____ Date: _____

I acknowledge and authorize Healthy Steps Podiatry Center, PLLC to deliver, teach, administer, or perform as necessary, the product and treatment prescribed by my physician. I authorize Healthy Steps Podiatry Center, PLLC to submit a claim for services to my insurer on my behalf and I authorize my physician and Healthy Steps Podiatry Center, PLLC to release any of my medical information required by my insurance to process the claim. I understand that I am responsible for, and I agree to pay, any portion of the amount due for such services not paid by my insurance carrier when resulting from deductibles, co-pays, coinsurance or amount due as patient responsibility.

Patient or Guarantor Signature: _____
Relationship to Patient: _____

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## Acknowledgement of receipt of notice of privacy and practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I choose) and understand the notice.

I also give permission to the following:

| | Leave appointment message on | | Leave other medical information on | |
|---|---|---|---|---|
| Home Answering machine | Y | N | Y | N |
| Office Voice mail | Y | N | Y | N |
| With another person | Y | N | Y | N |
| Send through mail | Y | N | Y | N |
| Send via email | Y | N | Y | N |
| Cell phone #___-___-____ | Y | N | Y | N |
| Text message | Y | N | Y | N |
| Patient Portal | Y | N | Y | N |

Please list person(s), and the relationship to you, we are authorized to communicate with. We will communicate with any and all doctors, hospitals, and facilities unless you specify otherwise:

_____

_____

Patient Signature: _____

Date: _____

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## Medicare Extended Authorization
## Signature on File

Beneficiary Name _____ Medicare HIC# _____

I request that payment of authorized Medicare Benefits be made either to me or on my behalf to Healthy Steps Podiatry Center, PLLC for any services furnished to me by the physician. I authorize any holder of medical information about me to release to the CMS and its agents, any information needed to determine these benefits or benefits payable for related services.

Patient Signature: _____
Date: _____

## Medigap Assignment of Benefits
## Signature on File

I request that payment of authorized Medigap benefits be made either to me or on my behalf to Healthy Steps Podiatry Center, PLLC for any services furnished to me by the listed physician/supplier. I authorized any holder of medical information about me to release my Medigap insurer any information needed to determine these benefits for related services. This assignment shall remain in effect until revoked by me in writing. A copy of this assignment is considered as valid as the original.

Patient Name (Printed): _____ Healthy Steps Podiatry Center, PLLC
1529 E Chocolate Ave
Patient Signature: _____ Hershey, PA 17033

Medicare Number: _____ Medigap Insurer _____

Medigap Number: _____

## Patient Responsibility

I understand and agree that I am financially responsible for all charges for all services rendered. This includes any medical service or visit including but not limited to routine examination, X-rays, in office surgical procedures, and orthotics. I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance. I understand and agree that it is my responsibility to know if my insurance has any deductible, copayment, coinsurance, out of network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full. I understand and agree that it is my responsibility to know if my insurance requires A referral from my primary care physician and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered. I agree to inform the office of any changes in my insurance coverage. If my insurance is changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full. If I am a Medicare patient, I understand that I need to provide the office with both my Medicare ID card and my secondary ID card. If the office does not have the proper information for secondary insurance, the secondary will not be billed. It will be my responsibility to pay the balance and then file a claim with the secondary for reimbursement. By signing this form, I consent to the use and disclosure of protected health information about me for treatment, payment, and healthcare operations, and or as required by law. I have the right to revoke this consent, in writing, signed by me. However, such revocation shall not affect any disclosures already made in compliance with my prior consent.
Our office does not make these rules. They are determined by your specific medical insurance or plan.

Printed Name:_____ Date: _____

Signature: _____