PATIENT INFORMATION

DATE

NAME ADDRESS

SOCIAL SECURITY # CITY STATE ZIP

HOME # / CELL#	DATE OF BIRTH	AGE	SEX	MARITAL STATUS (please circle)
			M___ F___	Mar. Sin. Wid. Div. Sep.

WORK # EMAIL ADDRESS:

EMPLOYER NAME, ADDRESS

NAME, ADDRESS, AND TELEPHONE # OF SPOUSE OR PARENT D.O.B. SOCIAL SECURITY #

EMPLOYER OF SPOUSE (name, address, & telephone number)

NAME & TELEPHONE # OF NEAREST RELATIVE NOT LIVING AT YOUR ADDRESS

Name and Address of Phamarcy:

HOW DID YOU HEAR ABOUT US?

Diabetes Doctor's Name: A1C:

PRIMARY CARE DOCTOR'S NAME: Date last seen by Primary Care:

HEALTH INFORMATION

Describe your foot problem or complaint:

How long have you had this condition? What previous treatment have you had?

Are you in good health? YES____ NO_____

Are you under a doctor's care? YES____ NO_____ For What?

Are you taking any medications? YES____ NO_____ What Kinds?

Are you allergic to? Novocain Penicillin Sulfa Aspirin Codeine Adhesive Tape Latex

(Please circle those that apply) Others

CIRCLE ANY ILLNESSES/CONDITIONS YOU HAVE HAD:

Diabetes	Glaucoma	High blood pressure			
Heart trouble	Vein trouble	Cancer	Asthma	Bleeding tendencies	Tuberculosis
Pneumonia	Kidney trouble	Stroke	Arthritis	Rheumatic fever	Epilepsy
Nervous disorder	HIV	High Cholesterol	Other (please list)_____		

IS THERE A FAMILY HISTORY FOR ANY OF THE ABOVE ILLNESSES OR DISEASES? YES ___ NO ___

WHICH FAMILY MEMBER AND WHAT DISEASE:

HAVE YOU HAD ANY OPERATIONS? YES ___ NO ___ (Please list types and dates)

HAVE YOU EVER HAD - Foot surgery X-rays Other

DO YOU USE TOBACCO NOW? YES ___ NO ___ DO YOU USE ALCOHOLIC BEVERAGES? YES ___ NO ___

IN THE PAST? YES ___ NO ___ AMOUNT TYPE AMOUNT

HEIGHT WEIGHT SHOE SIZE HAVE YOU HAD ANY SERIOUS INJURIES, BROKEN BONES, ETC.?

PERMISSION FOR TREATMENT: I hereby give permission to the physicians of Preuss Podiatry, and whomever Preuss Podiatry may designate as assisstants, to administer treatment and to perform such treatment procedures as may be deemed necessary in the diagnosis and treatment of my foot and or ankle condition.

SIGNATURE _____ DATE _____

AUTHORIZATION FOR ASSIGNMENT OF INSURANCE PAYMENT AND RELEASE OF MEDICAL INFORMATION

I hereby authorize the release of medical information such as may be necessary to expedite this claim. I hereby authorize my insurance company to pay directly to Dr. H. Fred Preuss, Jr. the insurance benefits and/or major medical benefits that are due and payable under this insurance policy. I understand that I am responsible for charges not included or not covered by the insurance payment. I authorize the release of any medical or incidental information necessary to provide continuity of my medical care and to process my medical insurance. I understand that Dr. Preuss has a minority ownership in the hospital Physicians Medical Center. He is proud of the quality of care that this facility provides.

SIGNATURE _____

PLEASE GIVE YOUR INSURANCE CARD AND PHOTO ID CARD TO RECEPTIONIST AND THEY WILL COPY IT FOR OUR RECORDS

PREUSS
PODIATRY
Podiatric Physicians and Surgeons of the Foot and Ankle

Insurance:
We participate in most insurance plans. We will file your primary insurance. If you have a secondary insurance, your medical claim will be forwarded to your secondary insurance after payment and/or explanation of benefits (EOB) is received from the primary insurance.
If you are not insured by an insurance plan we participate with, payment in full is expected at each visit.
If you are insured by an insurance plan that we do participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage.
Knowing your insurance is your responsibility. Please contact your insurance company with any question you may have regarding your coverage.

Copayment and Deductibles:
Co-pays, co-insurance, deductibles, etc., MUST be paid at the time of service. Co-pays, co-insurance, deductibles, etc. are determined by your insurance company contract.
If you are unable to pay at the time of your visit, we will need to reschedule your appointment.

Self-pay:
If you are self-pay, all patient charges incurred must be paid in full at the time of service.

Outstanding Balances:
It is your responsibility to keep your account with us current. This includes all outstanding balances. If your account becomes 90 days past due, your balance will need to be paid before you are able to schedule another appointment. You will be sent up to three notices for your financial responsibility. After the third and final notice, your account may be forwarded to collections. All cost incurred including but not limited to collection fees, attorney fees, and court fees shall be your responsibility in addition to the balance due to this office.

Referrals:
If your insurance requires a referral, it is your responsibility to make sure you have the referral at the time of service; otherwise this may lead to excessive delays or rescheduling of your appointment. If you fail to obtain the necessary referral, you will be responsible for your bill, in full.

Elective Surgical Procedures:
There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.

Non-covered Services:
Please be aware that some of the services your receive may not be covered or not considered medically necessary by Medicare or other insurers. You are responsible for payment of the services.

Claim Submission:
We will submit your claims and assist you in any way we can to help get your claims paid. Your insurance plan may request information directly from you. Your failure to timely comply with your insurance plan's request may result in your claim being denied, and if so, will result in our seeking full reimbursement from you for services rendered. Your insurance benefit is a contract between you and your insurance plan.
Fraud laws prohibit us from changing your procedure and/or diagnostic codes "just to get your claim paid."

No Show Policy:
If you are unable to keep your appointment, please let us know as soon as possible so we can offer that appointment time to another patient. We reserve the right to charge a fee for appointments not cancelled at least 24 hours in advance.

Receipt of Notice of Privacy Practices Written Acknowledgement: (Please Initial)

_____I was provided a Notice of Privacy Practices by Preuss Podiatry to read.

Signature: _____ Date:_____