NEW PATIENT MEDICAL INTAKE FORM

PATIENT INFORMATION:

Name:_____ Birthdate: ___/___/_____ Male [ ] Female [ ]
Social Security Number _____ Marital Status: Single [ ] Married [ ] Other [ ]
Home Address:_____
Street **City** **State** **Zip**
PRIMARY Phone (_____) _____-_____ EMAIL: _____

Are you employed? No [ ] Yes; Full Time [ ] Part Time [ ] Name of Employer:_____
Address:_____
Street **City** **State** **Zip**
Emergency Contact _____Relationship _____
Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____ Other (_____) _____-_____

PRIMARY CARE DOCTOR: _____CITY:_____
OTHER PHYSICIANS: _____CITY:_____
OTHER PHYSICIANS:_____ CITY:_____
Primary Insurance Company Name
_____
Please provide cards to the receptionist so we may copy them to your patient chart.
Secondary Insurance Company Name
_____
RESPONSIBLE PARTY: Name _____DOB ____/____/_____
Social Security Number _____The person who supplies the patient's insurance or who is responsible for payment if uninsured Relation to Patient _____
Phone (_____) _____-_____ Other (_____) _____-_____

PHARMACY INFORMATION:
_____
NAME OF PHARMACY CITY/ZIP CODE

I certify that the above insurance information is current and accurate; I authorize assignment of insurance to Peninsula Podiatry and Sarah Neitzel DPM PLLC. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Peninsula Podiatry and its representatives may use my health care information and may disclose such information to the above-named insurance company for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services received. This consent will end when my current treatment plan is completed or one year from the date signed below.

Patient Name (Print):_____

Patient Signature: _____Date: _____

How did you hear about us? Google (or other search engine)_____, Facebook_____,
Hospital referral_____, Referral from a physician (Name)_____,
Referral from another patient (Name)_____, Other_____.

Peninsula Podiatry
Sarah A. Neitzel, DPM

NEW PATIENT MEDICAL INTAKE FORM

Medical History *Weight:_____ Height:_____*

Have you ever been treated for (select all that apply):

☐ Corns/Calluses ☐ Fungal Toenails ☐ Ingrown Nails
☐ Warts/Rash ☐ Foot/Leg Ulcers ☐ Athletes Foot
☐ Arch Pain ☐ Heel Pain ☐ Leg Pain
☐ Ankle Pain ☐ High Arch Feet ☐ Flat Feet
☐ Bunions ☐ Hammer Toes ☐ Neuromas
☐ Foot Numbness ☐ Foot/Leg Cramping
☐ Toe Walking ☐ In-toeing

Do you get cramping in your calves after walking? _____
If so, how long can you walk before you have to rest? _____

Do you have pain in your foot/feet? _____
How long/ during what activities?_____
What relieves your pain?_____
What exacerbates the pain?_____
What treatments have you tried?_____
_____
Do you have shoe inserts/orthotics? _____
What sports/activities are you involved in?
_____
_____

Patient Medical History:

☐ Heart Attack ☐ Stroke ☐ High Blood Pressure
☐ Vascular Disease ☐ Heart Disease ☐ Emphysema
☐ Asthma ☐ Lung Disease ☐ Thyroid Problem
☐ Liver Disease ☐ Kidney Disease ☐ Dialysis
☐ Hepatitis ☐ Tuberculosis ☐ Glaucoma
☐ Osteoporosis ☐ Arthritis ☐ Gout
☐ Epilepsy ☐ Nerve Disorder ☐ Alzheimer's
☐ Depression ☐ Anxiety ☐ Stomach Ulcers
☐ Congestive Heart Failure ☐ Heart Murmur/Afib
☐ Diabetes Are you on Insulin? Yes[ ] No[ ]
☐ Chronic Obstructive Pulmonary Disease (COPD)
☐ Cancer: _____
☐ Other: _____

Surgical History: Procedures and complications:

_____
_____
_____
_____

Past Family and Social History

Family History: Please check and list family relation:

☐ Diabetes: _____
☐ Cancer:_____
☐ Heart Attack:_____
☐ Stroke: _____
☐ High Blood Pressure: _____
Any abnormal bleeding/slow healing? _____
Do you smoke tobacco? Yes [ ] No [ ]
If so, how much (per day/week/etc)?_____
If you quit, what year?_____
Do you drink Alcohol?_____
If so, what and how often?_____
Do you use recreational drugs? _____

Allergies: ☐ No known drug allergies OR
Please list any and all allergies below:
_____
_____
_____
_____
_____

Are you currently taking any medications?
Please list below with dosage and frequency:
_____
_____
_____
_____
_____
_____
_____
_____

Review of Systems:

General: ☐ Fatigue ☐ Weight changes ☐ Weakness
Head: ☐ Headaches ☐ Vertigo ☐ Dizziness
Eyes: ☐ Vision Changes ☐ Eye discharge
Ears: ☐ Hearing changes ☐ Tinnitus ☐ Infection
Nose: ☐ Bleeds ☐ Inflammation
Neck: ☐ Stiffness ☐ Pain ☐ Masses
Chest: ☐ Cough ☐ Short of Breath ☐ Wheezing
Heart: ☐ Chest pain ☐ Palpitations ☐ Weakness
Abdo: ☐ Vomiting ☐ Appetite change
Neuro: ☐ Seizures ☐ Tremors
Psych: ☐ Depression ☐ Anxiety

Peninsula Podiatry
Sarah A. Neitzel, DPM

PATIENT PRIVACY POLICY

Please read the following carefully and sign at the bottom of the page. You have the right to review our privacy practices at any time. Please refer to our HIPAA notice located in our reception area. I have read and understand the HIPAA notice, or I decline reading the HIPAA notice but, am fully aware that it is always available to me.
Please CHECK where we may leave a message if necessary:

☐HOME ☐WORK ☐CELL PHONE or indicate the phone number here: _____

May we discuss your medical condition with anyone besides you? YES_____ NO_____
If YES, please list the name of that person and their relationship to the patient.
NAME: _____
RELATIONSHIP TO PATIENT: _____
PHONE NUMBER: _____

Please list ANY information from your medical record you would NOT like this office to disclose:
_____
_____
_____
I give permission to Peninsula Podiatry to release information, either verbal or written regarding my medical condition only, for the purpose of medical management.

Patient Name (print) _____ Date _____

Signature of Patient/Legal Guardian Date _____

This release may be rescinded at any time in writing from the patient/legal guardian.

Peninsula Podiatry
Sarah A. Neitzel, DPM

FINANCIAL POLICY

FINANCIAL INFORMATION

Traditional Medicare Insurance: Our office participates with Medicare. This means that we will send your claim to Medicare and we will adhere to Medicare's allowable fee schedule, which Medicare sets for each service that they cover. Once you have met your annual deductible Medicare will pay us 80% of the allowable fee and you will be responsible for the remaining 20%. If you have a secondary insurance this amount will then be sent on to them and you will be billed for any remaining balance after their payment.

Medicare and Routine Foot Care

Medicare has strict guidelines concerning their coverage of routine foot care such as trimming nails, or paring corns and calluses. The doctor will be able to determine if your routine foot care is or is NOT covered by Medicare. Should these services not be covered, but you still agree to have these services performed, you will be asked to pay for the service yourself. The amount we charge for these services is consistent with Healthcare Blue Book. We will also ask you to sign Medicare's Advanced Beneficiary Notice (ABN) indicating you were informed that Medicare will not be paying for that particular service. The ABN will be provided at the time of visit. If you have any other service such as a new patient office visit or a visit for a new problem performed on the same day as routine nail care or another non-covered service, Medicare will be billed for the covered service.

All Other Insurances including Medicare Replacement Plans: We will submit your claims to all other insurance companies providing we have a copy of all current insurance identification cards and our patient financial policy has been signed. If we have not heard from your secondary insurance within 60 days, you will be billed directly. In that event you must contact the insurance company directly to find out why your claim has not been paid. It is the patient's responsibility to give us their current insurance information. If we do not have a copy of your current insurance card, or have received incorrect or old insurance information, the charges will likely come back from insurance as non-covered and will become the patient's responsibility. All uncollected co-pays and co-insurances from prior visits will be due at the time of your next appointment, as specified in your insurance contract and mandated by your carrier in our participating provider agreement.

No Insurance: If you do not have health insurance, charges for all services/treatments are due at the time of service unless other arrangements have been made with the office in advance. In many cases a cash payment discount may be given to patients without health insurance.

Referrals/Authorizations: It is the patient's responsibility to obtain all referrals if your insurance requires one. We will do all we can to assist you, but it is ultimately your responsibility. If a required referral is NOT in place PRIOR to your appointment, we may reschedule the appointment until it is received.

Billing: We use an outside billing service called Stat Medical Billing. They are a locally owned business and are available to handle all your billing and account questions. You will receive a billing statement for all personal balances due. If we have not received a response from you by phone or received a payment or letter regarding your unpaid balance within 90 days, your account will be reviewed to be sent to our collections department. There is a $25.00 fee assessed for returned checks. Peninsula Podiatry understands that unexpected financial problems do arise. We encourage you to contact the office at (360) 286-0404 immediately for assistance in managing your account.

Initial: _____

Peninsula Podiatry
Sarah A. Neitzel, DPM

FINANCIAL POLICY

Missed Appointment Policy: Peninsula Podiatry reserves the right to charge a patient for a missed appointment. If you cannot make your scheduled appointment, please provide 24 hours notice. A charge for a missed appointment is NOT a charge for the service itself. One missed appointment, or severe weather problems will NOT result in a patient being charged. Consecutive missed appointments or repeated missed appointments will be assessed at a fee of $30.00 for each missed appointment. Habitually missed appointments could lead to a patient being discharged from the practice.

Collections: Peninsula Podiatry will attempt to make payment terms that meet your needs. If we do not hear from you by phone, mail or partial payment within 90 days of a statement being sent, you may be referred to a collection agency. In the event your account is assigned to collection, the patient agrees to be responsible for a 25% collection fee, as well as all court costs and attorney fees.

Custom Products: I understand that if a custom DME product is ordered for me, such as orthotics or special shoes, or I receive an air cast, night splint, surgical shoe, and ankle brace, CAM Walkers, Spenco or Powersteps, that they are non-refundable and non-returnable. If my insurance denies them for any reason, I understand it is ultimately my responsibility and I will pay for the product(s) I have received.

I understand that Peninsula Podiatry's financial policy is in effect for the entire time I am a patient not just for the date that I sign the policy. If Peninsula Podiatry has any changes, our office will advise you of this and have you fill out a new form/addendum at that time. I authorize Peninsula Podiatry and/or Dr. Sarah Neitzel to release information regarding my medical history and treatments to my insurance company in order for them to be paid. I also authorize payments for services to be paid directly to Peninsula Podiatry/Dr. Sarah Neitzel from my insurance company. I acknowledge by signing my name below, as the patient or guardian of the patient, that I have read all of the above financial disclosures and understand and will comply. I have asked questions, if necessary, and I have had those questions answered and I understand.

Patient Name (Print): _____ Date: _____

Patient/Guardian Signature: _____