Patient Registration Yuma Foot Care Jessica Duggan, DMP

Last Name	Legal First Name		Middle
Physical Address	**City**	**State**	**Zip**
Home Phone (___)___-____	**Work Phone** (___)___-____	**Cell Phone** (___)___-____	**Email**
Date of Birth ___/___/____	**Social Security**	**Gender** Male Female	**Marital Status**
Primary Language	**Race**	**Ethnicity**	
Employment Status	**Occupation**		
Emergency Contact	**Relationship**	**Home Phone** (___)____ - ____	**Cell Phone** (___)____ - ____

Primary Care Physician & Office Phone

_____

Phone (___)____-____

Date Last Seen_____

Referred By

□ Newspaper □ Referring Dr □ Friend □ Insurance □ Internet □ Phone Book □ Health Fair □ Other _____

Primary Insurance	Secondary Insurance	Tertiary Insurance
Company	**Company**	**Company**
ID#	**ID#**	**ID#**
Insured Name	**Insured Name**	**Insured Name**
Relationship	**Relationship**	**Relationship**
Insured Date of Birth	**Insured Date of Birth**	**Insured Date of Birth**

Privacy Information

Please list the name(s) and phone number(s) of persons whom you authorize to have access to your Private Health Information and or medical records.

Print Name	Phone Number	Relationship to Patient

Attest

I do herby attest that this information is true, accurate, and complete to the best of my knowledge. I understand that any falsification, omission, or concealment of any material may subject me to fees for services and/or liability. I also understand that I am to notify Yuma Foot Care. Immediately of any changes to the above information and annually upon request.

Print Name of Patient	Signature	Relationship to Patient	Date

REASON FOR VISIT

Last/First Name **Weight**

Reason for visit: **Date Occurred:**

Are you Diabetic **YES/NO**

Name of treating Physician for Diabetes: _____

Date last seen for Diabetes: _____ Do you wear Diabetic shoes YES/NO

Last time shoes dispensed: _____ Shoe size: _____

ALLERGIES

□ **NONE** □ Adhesive/Tape □ Aspirin □ Codeine □ Demerol □ Nickel
□ Anesthetics Local/General □ Shellfish □ IV Contrast Dye □ Iodine □ Latex
□ Penicillin □ Sulfa □ Other:_____

PREVIOUS FOOT PROCEDURES & SURGERIES

Ingrown Nail : Date Of Surgery _____ Hammer Toe: Date Of Surgery _____

Neuroma: Date Of Surgery _____ Bunion: Date Of Surgery _____

Amputation : Date Of Surgery _____

Previous Foot Surgeries: _____

PAST MEDICAL HISTORY (check all that apply)

□**NONE**

□ Cancer □ Back problems □ Circulation problems □ Diabetes □ Fibromyalgia
□ Foot pain □ Foot problems □ Foot surgery □ Foot ulcer □ Heart conditions
□ Kidney disease □ Lung disease □ Nail disorders □ Neuropathy □ MRSA History
□ Osteoporosis □ Seizure disorder □ Sleep Apnea □ Sports related injury □ Stomach ulcer
□ Stroke □ Hepatitis-Type:_____

BIOLOGICAL FAMILY MEDICAL HISTORY (circle all that apply)

Mother:

□ Alive □ **NONE** □ Cancer □ Diabetes □ Heart Conditions □Hypertension
□ Deceased □ Respiratory Problems □Gout □ Other:_____

Father:

□ Alive □ **NONE** □ Cancer □ Diabetes □ Heart Conditions □Hypertension
□ Deceased □ Respiratory Problems □Gout □ Other:_____

Siblings:

□ Alive □ **NONE**
□ Deceased □ Cancer □ Diabetes □ Heart Conditions □Hypertension
□ Respiratory Problems □Gout □ Other:_____

Grandparents:

□ Alive □ **NONE**
□ Deceased □ Cancer □ Diabetes □ Heart Conditions □Hypertension
□ Respiratory Problems □Gout □ Other:_____

PHARMACY AND CURRENT MEDICATIONS

Name of Local Pharmacy: Pharmacy Location:

Current Medications: □**NONE**

Is patient on any blood thinner? YES / NO

If YES, Name of Blood Thinner_____ Prescribing Physician _____

Name Of Medication _____ Dose/Strength _____

Name Of Medication _____ Dose/Strength _____

Name Of Medication _____ Dose/Strength _____

Name Of Medication _____ Dose/Strength _____

Name Of Medication _____ Dose/Strength _____

Name Of Medication _____ Dose/Strength _____

Name Of Medication _____ Dose/Strength _____

CHIEF COMPLAINT

Area of Discomfort: □Right foot □ Left foot □Bottom of foot □Top of foot □In between toes
□ Inside of foot □Ankle □Arch □Ball of foot □Calf
□ Foot □Heel □Leg □Toe

Discomfort Started: # of _____ □ Days □Weeks □Months □Years

How often: □In the AM □At night □Constant □ Off and on □Rare □ Recurrent

Pain scale: (Circle) 0 1 2 3 4 5 6 7 8 9 10 Worst
□Improving □ Resolved □Unbearable □ Unchanged

Caused by: □ Walking barefoot □ Increased activity □ Injury □Running □Unknown

Better with: □Compression □Elevation □Heat □Ice □In shoes □Medication □ Rest □Nothing

Worse with: □Increased activity □In shoes □No shoes □Pressure □Running □Walking □Nothing

REVIEW OF SYSTEMS - CHECK ANY CURRENT PROBLEMS

CONSTITUTIONAL: □Chills □Fatigue □Fever □Sweats □Weakness □Weight gain □Weight loss

HEAD: □Dizziness

PSYCHIATRIC: □Depression □Memory loss

RESPIRATORY: □Asthma □Bronchitis □COPD □Cough □Short of breath □Wheezing □Other:

CARDIOVASCULAR:
□Chest pain □Cramps in legs/feet □Extremity(s) cool □Hair loss on legs
□High blood pressure □History of heart attack □Leg/foot ulcers □Palpitations
□Heart problems □Replace heart valve □Varicose veins □Vascular grafts
□Other:

GASTROINTESTINAL:
□Constipation □Diarrhea □Liver disease □Nausea □Rectal bleeding
□Swallowing problem

ALLERGIC:
□Hives
□ Seasonal Allergies

MUSCULOSKELETAL:
□Ankle Sprain □Arch pain □Arthritis □Back problems □Broken ankle □Broken foot bone □Bunions
□Calluses □Childhood foot problems □Corns □Flat feet □Gait-walking problems
□ Gout □Hammer/Mallet toes □Heel pain □High arch feet □In-toeing □Joint implants
□Joint pain □Joint stiffness □Knee pain □Lower back pain □Muscle cramps
□Muscle stiffness □Nerve pain

SKIN:
□Athlete's foot □Dryness □Eczema □Fungal nails □Hives □Ingrown nails □Itching
□Keloid scar □Lumps □Mole changes □Open sores □Rash □Ulcers □Warts
□Other:

NEUROLOGICAL:
□Balance problems □Burning □Charcot neuroarthropathy □Neuromas □Numbness □Strokes □Tingling
□Tremors □Other:

ENDOCRINE:
□Diabetes □Excessive thirst □Fatigue □Goiter □Increased appetite □Increased urination □Sweats
□Thyroid □Weight gain □Weight loss □Other:

HEMATOLOGIC/LYMPH:
□Anemia □Bleeding easily □Blood clots □Easy bruisability □Recent chemotherapy □Slow heeling cuts
□ Swollen glands □Transfusion reaction □Other:

GENITOURINARY:
□Blood in Urine □Excessive urination □Infections □Painful Urination
□Other:

SOCIAL HISTORY

Tobacco Use: □**None** □Packs per day____ □Number of years as a smoker: _____

Alcohol: □**None** How Often: _____

YUMA FOOT CARE

Jessica Duggan DPM P.C./Johanna M. Richey DPM, P.C.

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

INSURANCE: We participate in most insurance plans. If you are not insured by a plan, we participate with payment in full is expected at each visit. If you are insured by a plan we 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 benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

MEDICARE: We are a participating Medicare provider. We accept Medicare benefit amount. Medicare as well as your secondary insurance (if any) will be billed for you. However, that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any **co-payments,** which are usually **20%** of the allowed amount for an item or service.

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company.

SELF PAY: Payment in full is due at the time of services if you do not have health insurance.

NON-COVERED SERVICES: Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for full payment of these services at the time of service.

X-RAYS ARE NOT ALWAYS COVERED Patient Initials _____

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan which mandates us that when you visit a specialist such as ours, you must have a referral from your primary care physician prior to seeking specialty care. Therefore, you are financially responsible for the services received, unless your referral is presented at the time of this visit. If you do not have a referral from your primary care physician at the time of a visit, you will be financially responsible for all services due in full upon completion of the visit. Full credit will be given if a referral is presented to our office with 48 hours of this visit. You will also be given the option to reschedule your appointment.

CLAIM SUBMISSION: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays your claim or not. Your insurance benefit is a contract between you and your insurance company.

PATIENT BILLING: ***ALL CO-PAYMENTS, CO-INSURANCE, OR DEDUCTIBEL AMOUNTS MUST BE PAID AT THE TIME OF SERVICE.*** This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your portion of insurance benefits at each visit. As a courtesy, our office does verify benefits with your insurance carrier; however, the insurance agreement is a contract between you and your insurance carrier. It is recommended that you verify your benefits with your carrier as well.

PHYSICIAN PHONE CALLS: Phone calls with our physician(s) are a billable service, may be billed to your insurance company, and are subject to your insurance benefits. You are responsible for your portion of insurance benefits for physician phone calls.

NON-CUSTOM DURABLE MEDICAL EQUIPMENT RETURNS: If a patient is unsatisfied with any non-custom Durable Medical Equipment item, it must be returned within 30 days per Medicare guidelines. Returns after 30 days will not be permitted. The item will only be accepted as a return if it is in returnable condition. Any custom durable medical equipment item including custom orthotics **MAY NOT BE RETURNED** for any reason.

COPY FEE: We will provide copies of patient records at the patient's request. Copies of records may be subject to a $0.20 per single page copy fee. You will bear complete financial responsibility for any fee(s) incurred.

CANCELLED/MISSED APPOINTMENT FEE: If you cannot keep your appointment time, please call our office at least 24 hours prior to your scheduled appointment time. There may be a **$25 fee** for any appointment cancelled, missed or rescheduled. If you arrive late for an appointment, we may need to reschedule your appointment. You will bear complete financial responsibility for any fee(s) incurred. Repeated missed or late appointments may result in dismissal from our practice.

COLLECTIONS FEE: You will be sent up to three notices for your financial responsibility (co-insurance, deductible) after payment and/or explanation of benefits(EOB) is received from your insurance company/companies. After the third and last notice, your account will be forwarded to our collection agency. If your account is sent to a collections agency, a **35% fee** will be added to your account. You bear complete financial responsibility for any fee(s) incurred.

Payment arrangements can be made on a case by case basis. We accept the following payment methods: Cash, check or Visa/MasterCard/Discover/AMEX. An additional **$25.00** will be added to your statement if the check is returned from your bank. We do not accept starter checks. If your insurance company sends payment to you, the patient, it should be forwarded to our office to be applied to your balance.

I have read the above policy regarding my financial responsibility to **Jessica Duggan DPM, P.C./Johanna M. Richey DPM, P.C.** for medical services provided. I agree to pay **Jessica Duggan DPM, P.C./Johanna M. Richey DPM, P.C.** any balance unpaid by my insurance carrier for myself or the below named person.

PRIVACY STATEMENT: Any information disclosed in your records will remain confidential and will not be used for any other reason except in providing quality care and treatment as well as to submit your claim to your insurance company and contact you as needed.

PATIENT ACKNOWLEDGE OF NOTICE OF PRIVACY PRACTICES: By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have (or had the opportunity to read if I so chose) and understand the Notice and agree to its terms.

ASSIGNMENT OF BENEFITS: I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to **Jessica Duggan DPM, P.C./Johanna M. Richey DPM, P.C.** all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, co-insurance, non-covered services and other fees **AT THE TIME OF SERVICE.** I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize Release of Medical Information to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR'S OFFICE IF THERE IS A CHANGE IN MY HEALTH INSURANCE INFORMATION AND ACKNOWLEDGE I WAS PROVIDED WITH A COPY OF THE NOTICE OF PRIVACY PRACTICES AND UNDERSTAND AND ACCEPT ITS TERMS:

PRINT Patient Name: _____ **Signature:** _____

If patient is under 18, please complete the following for the *FINANCIALLY RESPONSIBLE PARTY:*

PRINT Name: _____ **Signature:** _____

Relationship to Patient: _____ **Date:** _____