Hoover Podiatry

PATIENT DEMOGRAPHIC INFORMATION

Date:_____/_____/_____

Patient Name: _____ O Male O Female
(LAST) (FIRST) (MI)

Date of Birth: _____/_____/_____ Age: _____ Social Security: _____/_____/_____

Address: _____
(STREET) (CITY) (STATE) (ZIP)

Primary Phone: (_____)_____ Secondary Phone: (_____)_____
O HOME O CELL O WORK O HOME O CELL O WORK

May we leave a message: O Yes O No Consent to text: O Yes O No

Patient portal account: O Yes O No Email: _____

Preferred method of contact: O Primary Phone O Secondary Phone O Email O Mail

Emergency Contact Name: _____ Phone: (_____)_____

Relationship: _____

Employer: _____ Occupation: _____

Referring Doctor: _____ Primary Care Doctor: _____

Preferred Pharmacy: _____

Pharmacy Location: _____

Marital Status: _____ Race: _____ Ethnicity: _____
(Optional) (Optional)

Language(s): _____

Guarantor: _____ Relationship to Patient: _____

Address: _____
(STREET) (CITY) (STATE) (ZIP)

Primary Insurance: _____ ID#: _____

Subscriber Name: _____ Group: _____

Subscriber SSN: _____ Subscriber DOB: _____

Relationship to Patient: _____ Employer: _____

Secondary Insurance: _____ ID#: _____

Subscriber Name: _____ Group: _____

Subscriber SSN: _____ Subscriber DOB: _____

Relationship to Patient: _____ Employer: _____

(COMPLETE THIS SECTION IF YOUR VISIT IS INJURY RELATED)

Injury Related: O Yes O No Injury Date: _____/_____/_____ Claim #: _____

Claim Manager: _____ Phone: (_____)_____

Employer at time of injury: _____ Phone: (_____)_____

Injury details: _____

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PATIENT MEDICAL INFORMATION

Patient Name: _____ DOB: _____/_____/_____
(LAST) (FIRST) (MI)

Height: _____ Weight: _____ Shoe Size: _____

Previous Podiatrist: _____ Location: _____ Last Visit: _____

Describe the foot and/or ankle problem(s) that brings you into our office:

_____

_____

Medications

Include prescriptions, over the counter meds and vitamins:

❑ ADDITIONAL INFORMATION ON BACK OF PAGE

1. _____ Dose: _____
2. _____ Dose: _____
3. _____ Dose: _____
4. _____ Dose: _____
5. _____ Dose: _____
6. _____ Dose: _____
7. _____ Dose: _____
8. _____ Dose: _____

Allergies

- ❑ Antibiotics: _____
- ❑ Pain Medication: _____
- ❑ Iodine
- ❑ Sulfa
- ❑ Local Anesthetic
- ❑ Adhesives
- ❑ Latex
- ❑ Other: _____

_____

❑ ***NO KNOWN ALLERGIES***

Family History

	Mother	Father
• Deceased	❑	❑
• Cancer	❑	❑
• Stroke	❑	❑
• Blood Pressure	❑	❑
• Diabetes	❑	❑
• Heart Problems	❑	❑
• Foot Problems	❑	❑
• Other: _____	❑	❑

Surgical History

Please include same day surgery

Reason:_____Date_____

Reason:_____Date_____

Reason:_____Date_____

Reason:_____Date_____

Reason:_____Date_____

Recreational Habits

- ❑ Prior or Current Alcohol/Drug Problem_____
- ❑ Caffeine _____drinks/day
- ❑ Alcohol _____drinks/day
- ❑ Tobacco: ☐ Cigarettes ☐ Chew _____pack(s)/day
  ☐ Electronic Cigarettes

Tobacco Year Began: _____ Year Quit: _____

Marijuana Use: _____

Other Drug Use: _____

Medical Conditions

❑ Arthritis	❑ Stomach Problems	❑ Blood Disease
❑ Asthma	❑ Shortness of Breath	❑ Liver Trouble
❑ Diabetes	❑ Blood Clots/Embolism	❑ Slow Healing
❑ Cancer	❑ High Blood Pressure	❑ Stroke
❑ Thyroid	❑ Tuberculosis	❑ AIDS/HIV
❑ Anemia	❑ Kidney Trouble	
❑ Gout	❑ Heart Trouble	

CONSENT

I certify that the above information is true and correct to the best of my knowledge. I hereby give permission for Dr. Hoover to examine, photograph, administer treatment and perform minor procedures as may be deemed necessary in the diagnosis and/or treatment of my foot and/or ankle condition(s). I authorize the exchange of my medical records with other treating physicians. I understand as a courtesy Hoover Podiatry will assist with insurance authorizations and work with your referring doctor to authorize your visit with your insurance but it is your responsibility for any and all insurance authorizations prior to being seen in our office. I authorize payments of insurance benefits, including Medicare, directly to my physician. I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees.

Signature: _____ **Date:** _____

Relationship (if minor): _____

MEDICARE AUTHORIZATION (Only if you have Medicare or Medicare Supplement)

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Cody Hoover, DPM for any services furnished by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the determination of the Medicare carrier.

Signature: _____ **Date:** _____

INSURANCE

We have made prior arrangements with most insurers to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay, coinsurance, and/or deductible. All health plans are not the same, and do not cover the same services. In the event your health plan determines a service to be "non-covered", or you do not have an authorization, you will be responsible for the complete charge. We will always attempt to verify benefits for specialized services; however you remain responsible for charges to any services rendered. You must inform the office of all insurance changes and authorizations referral requirements. In the event the office is not informed, you will be responsible for any charges denied. I (the undersigned) certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Cody Hoover, DPM, all insurance benefits, if any otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____ **Date:** _____

Relationship: _____

Hoover Podiatry

FINANCIAL POLICIES

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skillful high quality care. The medical service provided by our office and services you have elected to receive imply some financial responsibility on your part. Due to the complicated nature of health insurance, your understanding of our financial policies is essential to your care and treatment. If you have any questions, please do not hesitate to ask our front office staff.

COPAYMENTS/DEDUCTIBLES

All co-payments and co-insurance and a portion of your deductible must be paid at the time of service. This arrangement is part of your contact with your insurance company. If your health plan has a high deductible we ask for 75% of the fee at the time of service. Please note any other services rendered are subject to deductible.

CANCELLATIONS/NO SHOWS/LATE POLICY

We require 24 hour notice on all cancellations so we may have the opportunity to schedule another patient that may need an appointment. If you cannot call 24 hours prior to your appointment, please call at your earliest convenience to cancel or reschedule. If you no show an appointment there will be a $25.00 fee added to your account. If you are late to your scheduled appointment time and we can't accommodate, you will be rescheduled to a different time.

PAYMENTS

We accept the following payment methods: Cash, Check, and VISA/MasterCard. Please let the office know if you have any difficulties in resolving your bill.

RETURN CHECK FEE

An additional $30.00 will be added to your statement if the check is returned for insufficient funds.

ACKNOWLEDGEMENT FORM

I have read the Notice of Privacy Practice and I have been provided an opportunity to review it.

Name: _____ **Birthdate:** _____

Signature: _____ **Date:** _____

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CONSENT TO SHARE & EXCHANGE INFORMATION

Patient Name: _____ DOB: _____/_____/_____
(LAST) (FIRST) (MI)

I AUTHORIZE HOOVER PODIATRY TO DISCUSS (check all that apply)

O Appointment History
O Medications
O Lab Results
O Billing & Financial Information
O Other:_____

WITH THE FOLLOWING PEOPLE

Name: _____ Phone: (_____)_____ Relationship: _____

Name: _____ Phone: (_____)_____ Relationship: _____

Name: _____ Phone: (_____)_____ Relationship: _____

Name: _____ Phone: (_____)_____ Relationship: _____

I understand that I may inspect or copy the protected health information to be used or disclosed. Also I may revoke this authorization in writing by contacting Hoover Podiatry. This authorization is giving Hoover Podiatry the right to discuss my medical information with the one or more people listed above. Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the HIPAA. Also, I may refuse to sign this authorization and you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment).

Name: _____ **Relationship to Patient:** _____

Signature: _____ **Date:** _____