

For office use only:

Patient ID # \_\_\_\_\_

### Harford Lower Extremity Specialists

437 South Main Street, Bel Air, Maryland 21014

Phone: 410-836-0131 Fax: 410-836-8594

www.hlsfootcare.com

### Welcome to our office

The following information is needed for proper billing and correspondence.

Should this information change, please notify the office.

If you have any questions, or difficulty completing this form, please feel free to ask for help.

**Please print legibly and use black or navy blue ink.**

Name		Social Security #	
Address		Cell Phone #	
City	State	Zip	
Home Phone #	Preferred contact ( <i>circle</i> ) Home Cell Work Email *Text		
Date of Birth	Sex	M	F
Marital Status ( <i>circle one</i> ) S M W D Separated			
E-mail			
Patient's Employer		Work Phone #	
Spouse's Name		Work Phone #	
Referred By			
<b>PERSON RESPONSIBLE FOR BILL</b> (IF OTHER THAN ABOVE)			
Name		Relationship	
Address			
Home Phone		Work Phone	
<b>NEAREST RELATIVE TO NOTIFY IN AN EMERGENCY</b>			
Name		Relationship	
Address			
Home Phone		Work Phone	
<b>AUTHORIZATIONS</b>			
<b>Benefits to the Physician's office:</b>			
<input type="checkbox"/> YES <input type="checkbox"/> NO, I hereby authorize payments directly to the physician of the medical/surgical benefits.			
<input type="checkbox"/> YES <input type="checkbox"/> NO, I also understand I am responsible for any portion of my bill not covered by my insurance Patient balances are due in 30 days. Interest will accrue at 1.5% on accounts over 60 days with no payment arrangements. Delinquent accounts are sent to collections and have adverse affects on credit history. <b>THERE ARE NO REFUNDS ON CUSTOM or OVER THE COUNTER PRODUCTS.</b>			
<input type="checkbox"/> YES <input type="checkbox"/> NO, I hereby authorize release of information for insurance claim purposes.			
MISSED APPOINTMENTS HURT YOU, THE DOCTOR AND SOMEONE IN NEED OF CARE. MISSED APPOINTMENTS WITHOUT 24 HOUR NOTIFICATION WILL BE ASSESSED: <b>NEW PATIENTS \$75.00, CURRENT PATIENTS \$50.00.</b>			
* <b>you must understand that text authorization may incur a landline fee to your phone*</b>			
I understand all of the above and hereby state that the information is correct to the best of my knowledge.			
Signature		Date	

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Race:

- Caucasian
- African American
- American Indian
- Asian
- Latin American
- No Response
- Other: \_\_\_\_\_

Ethnicity:

- |                                   |                                   |   |                                       |
|-----------------------------------|-----------------------------------|---|---------------------------------------|
| <input type="checkbox"/> American | <input type="checkbox"/> German   | <input type="checkbox"/> Japanese       | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> African  | <input type="checkbox"/> Italian  | <input type="checkbox"/> Mexican        | <input type="checkbox"/> No Response  |
| <input type="checkbox"/> Chinese  | <input type="checkbox"/> Jamaican | <input type="checkbox"/> South American |                                       |

Preferred Language:

- |                                  |                                       |
|----------------------------------|---------------------------------------|
| <input type="checkbox"/> English | <input type="checkbox"/> Spanish      |
| <input type="checkbox"/> French  | <input type="checkbox"/> No Response  |
| <input type="checkbox"/> German  | <input type="checkbox"/> Other: _____ |

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**This is required information effective 1/1/2011 per the Health Care Reform Act for meaningful use of electronic health records enacted by President Obama.**

**MEDICAL HISTORY**

Primary Care Physician	Office phone #
Address	Has he/she referred you to us?
Former Podiatrist	Why did you see your podiatrist?
1. What problems bring you to our office?	
2. List all medications you now use, include over-the-counter, vitamins etc	
Height _____ Weight _____	
3. Pharmacy name & location	Phone #
4. Women: are you pregnant?	If so, how many months?

5. Indicate **immediate RELATIVES** that have/had any of the following diseases such as:  
Mother, Father, Paternal Grandparents, Maternal Grandparents, Brother, Sister, Aunt and Uncle.

Arthritis		High blood pressure	
Bleeding disorder		Kidney disease	
Cancer		Mental/emotional disease	
Diabetes		Neurological disorder	
Foot problems		Poor circulation	
Heart disease		Stroke	

6. Do you have any artificial joints, implants, or stents? ( ) no ( ) yes If yes, please explain \_\_\_\_\_

7. Have you previously had physical therapy? ( ) no ( ) yes If yes, when and for what condition?

8. Is this injury a result of an automobile accident or a worker's compensation claim? ( ) no ( ) yes

If yes, please provide the following information: Claim # \_\_\_\_\_

Contact \_\_\_\_\_ Phone # \_\_\_\_\_

**MEDICAL CONDITIONS**

10. Please check “Yes” or “No” and **CIRCLE** options and provide details in comment space for any yes response

YES	NO	NATURE OF PROBLEM	COMMENTS AND GIVE APPROX. DATE
		Allergic reaction to medication	
		Allergic reaction to latex	
		Allergic reaction to nickel	
		Anemia	
		Arthritis	
		Asthma	
		Back pain	
		Bladder problems	
		Bleeding tendency	
		Cancer	
		Chest pain/heart attack	
		Circulation problems	
		Cramps in feet or legs	
		Depression	
		Diabetes	
		Fainting or convulsions	
		Fibromyalgia	
		Frequent infections	
		Glaucoma	
		Gout	
		Headaches	
		Heart (CHF, bypass, etc.)	
		Healing problems	
		Hearing impaired	
		High blood pressure	
		HIV positive or carrier	
		Hormonal imbalance	
		Joint pain or stiffness	
		Kidney disease or stones	
		Leg ulcers	
		Liver/Gall bladder (jaundice)	
		Lung (pneumonia, TB, etc.)	
		Mitral valve, prolapsed/murmur	
		Multiple Sclerosis	
		Neurological disorder	
		Numbness in feet or legs	

**MEDICAL CONDITIONS**

	Osteoporosis	
	Other illness or problems	
	Pain in other areas	
	Parkinson's	
	Problem taking aspirin/Motrin	
	Psychiatric care	
	Reynaud's' disease	
	Scarring tendency	
	Shortness of breath (wheezing)	
	Skin disorders	
	Stomach ulcers/GERD	
	Strokes	
	Swelling in feet or ankles	
	Thyroid	
	Varicose veins	
	Vision impairment	
	Weight loss or gain	
	Do you smoke? How much?	
	Drink alcohol? How much?	
	Do you take drugs? How much?	
	Do you exercise? How much?	
	Do you stand or sit at work?	

**11. Please give detail of any:**

Surgeries/serious injuries	Approx. date	Physician	Hospital

12. I understand that honest and complete answers to each question asked in this medical history Questionnaire is important to the provision of my medical care. I have answered them to the best of my ability. I assume all risks which occur as a result of my failure or refusal to disclose all medical information. I understand that if I am uncertain about any questions. I should ask the doctor or a member of the office staff for assistance.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Witness Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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**Acknowledgment of Notice of Privacy Practices**

I understand I have certain rights to privacy regarding my protected health information under the Health Insurance Portability & Accountability Act of 1996 (HIPAA).

I understand that this information can and will be used, without additional consent, for the following purposes:

- Treatment, including sharing the protected health information with providers and others involved in your treatment and follow-up, either directly or indirectly
- Payment
- Healthcare operations of this facility

I have been provided a copy of the Notice of Privacy Practices for this office. I understand the Notice of Privacy Practices contains a complete description of the uses and disclosures of my health information. I understand this office has the right to change its Notice of Privacy Practices at any time, and I may contact this office at the number listed above at any time and obtain a current copy of the Notice of Privacy Practices.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Relationship to patient (if minor): \_\_\_\_\_

Please identify anyone to whom you grant personal data and information about your care to be released to: \_\_\_\_\_  
(If you have a POA, please list here)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_



We would like to thank you for choosing our office for your Medical & Surgical foot care needs. The Doctors and staff take pride in offering the highest quality service in a warm, friendly atmosphere. Our philosophy is that communication and patient education are the cornerstones of successful treatment. The goal of the practice is to alleviate foot pain without surgery. In the event that surgery is necessary, our in-office, Medicare-approved, State licensed, Ambulatory Surgical Center is prepared for your comfort and convenience.

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### **Financial Policy**

The responsibility of providing complete and accurate insurance information to our office staff belongs to you, the patient. **Your insurance policy is a contract between you and your insurance company.** Please bring your insurance card with you at each visit. As a courtesy, we will gladly submit a claim to your insurer. You must inform the office of all insurance changes and authorization and referral requirements. In the event the office is not informed, you will be responsible for any charges denied. If your insurance company does not pay the practice within a reasonable period, (30-45 days per federal law) we will have to look to you for payment and/or assistance with your insurance company.

If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.

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 "not covered", or you do not have authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services; however, you remain responsible for charges of any service rendered. Patients are encouraged to contact their insurance companies for clarification of benefits prior to services rendered.

If you are uninsured, payment is expected in full on the day of your visit.

#### **Co-Pays, Deductibles, and Co-Insurance**

Legally, we cannot waive co-pays, deductibles or co-insurance amounts. Contractually, your insurance company requires us to collect the portion for which you are liable at the time services are rendered. Payment made at the time of service allows us to keep administrative costs to a minimum.

#### **Medicare**

Under the Medicare program, there are some services that are not covered. You will be asked to pay for these services at the time they are rendered.

In some cases, we will ask you to make a decision to receive covered services that we expect may be denied by Medicare. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. The physician will explain why (s) he feels you should receive the service. This will be done in writing on a form called an Advance Beneficiary Notice (ABN). The ABN will also provide you the opportunity to agree or refuse the services. It also explains that we will not know if the service is denied until Medicare processes the actual claim.

If you have any questions, either our staff or your Medicare representative will be happy to assist you.

#### **Acceptable Forms of Payment**

We accept the following forms of payment:

- Cash
- Check – (\$25 returned check fee)
- Money Order
- Visa
- MasterCard
- Discover

**\*\*\*PLEASE NOTE REGARDLESS OF METHOD OF PAYMENT, CUSTOM MADE DEVICES FOR OVER THE COUNTER PRODUCTS ARE NOT REIMBURSABLE\*\*\***

**Payment Plans**

Payment plans are available under certain circumstances; however, advance notice and pre-approval is required. Please contact our billing office at 410-836-0131 for more information.

**Past Due Accounts**

Every attempt will be made, including the services of a collection agency, to collect past due accounts. If it is necessary to utilize a collection agency, you will be assessed the fee for such service up to 30% of total amount owed. Past due accounts are transferred to the collection agency after 60-days.

**Missed Appointments**

We understand your time is valuable, so we will make every effort to be on time. Our time is also valuable so we expect you to keep your appointment. If you are unable to keep your appointment, we require a 24-hour notice. **Any cancellation without 24-hours notice and any missed appointment will result in a charge of \$75 for new appointments and \$50 for return appointments.**

**Medical Records**

Authorized written requests for copies of medical records will be honored. Our fees are in accordance with Maryland State Law. Please allow 7-10 business days for processing.

**Forms Completion**

Payment for the completion of forms (disability forms, etc.) must be made at the time of service. The fees are as follows:

Simple/Single page forms: \$10 (each form)  
Complex/Multi-Page Forms \$25 (set fee)  
**Please allow 7-10 business days for completion of forms.**

**Billing Office – Questions and Concerns**

**There is usually a 3-5 business day delay in receipt of your insurance information after you have received your copy.** Therefore an instant response to billing questions is unreasonable. Our preferred method of resolving billing questions is via email at info@hlsfootcare.com. Please attach any supporting documents. We can be reached Monday through Friday, 8:30am – 12:00pm and 2:pm – 5:00pm at 410-836-0131, to assist you with account inquiries and the resolution of billing issues. **We will try to answer all questions promptly, however, please allow 3 to 5 business days for a response to all billing inquiries.**

**Please note: Harford Lower Extremity Specialists has no ownership rights or financial incentives regarding any referrals or consultation requests made. In event that such a relationship is established, full disclosure will be included here. Please note, the ambulatory surgical center for all on site podiatric surgeries is solely owned by Howard L. Schultheiss, Jr., D.P.M.**

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I, \_\_\_\_\_, have both read, and fully understand the Financial Policy described above. I further understand that my signature signifies that I accept the terms as set forth in this agreement.

\_\_\_\_\_  
Signature of Patient or Financially Responsible Person

\_\_\_\_\_  
Date

\_\_\_\_\_  
ID# (for office use only)