WALKER
FOOT & ANKLE

New Patient Information Form

Patient Information

Name (Last): _____ (First): _____ (MI): _____

Date of Birth: _____ Social Security #: _____ Marital Status: _____

Mailing Address: _____ City/State/Zip: _____

Age: _____ Sex: _____ Race: _____ May we leave a message/text?

Home Phone #: (_____) _____ Yes No

Cell Phone #: (_____) _____ Yes No

Work Phone #: (_____) _____ Yes No

Employer: _____ Occupation: _____

Email Address: _____

How did you hear about us? _____

Contacts

Emergency Contact: _____ Relationship: _____

Phone #: (_____) _____

Do you have a Legal Guardian or Healthcare Power of Attorney? Yes No

If yes, Name: _____ Relationship: _____ Phone #: (____) _____

Primary Care Doctor: _____ Phone #: (_____) _____

Pharmacy: _____ Location/Phone #: _____

Insurance

Primary Insurance Company Name: _____

Policy/ID #: _____ Policy Holder Name/Date of Birth: _____

Secondary Insurance Company Name: _____

Policy/ID #: _____ Policy Holder Name/Date of Birth: _____

Please list all medications you are currently taking:

Name Dose How often do you take?

_____

_____

_____

_____

_____

_____

_____

_____

Please list all prior surgeries:

_____

_____

_____

Social History

Use of Alcohol: Never No Longer Use Rare Occasional Daily

Use of Tobacco: Never Quit ___ Years Ago Smoke ___ Packs a Day for ___ Years

Recreational Drugs: Never Quit ___ Years Ago Current Use – Type _____

Family History

Circle all that apply (List which family member): Diabetes Type 1 or 2 _____

Cancer _____ Heart Disease _____ High Blood Pressure _____

Stroke _____ Thyroid Disorder _____ Rheumatoid Arthritis _____

Personal Medical History

Allergies (Include Medications, Anesthesia, Latex, Tapes, Shellfish, Iodine, Foods, Etc.):

_____

_____

What specific problem brought you to our office today?

_____

_____

_____

Have you had any of the following? Circle all that apply:

ACID REFLUX	Y	N	HEART DISEASE	Y	N	SEIZURE/EPILEPSY	Y	N
AIDS/HIV	Y	N	HEPATITIS	Y	N	SICKLE CELL DISEASE	Y	N
ANEMIA	Y	N	HERNIA	Y	N	SKIN DISORDER	Y	N
ARTHRITIS	Y	N	HIGH BLOOD PRESSURE	Y	N	SLEEP APNEA	Y	N
ARTIFICIAL JOINTS	Y	N	HIGH CHOLESTEROL	Y	N	STOMACH ULCERS	Y	N
ASTHMA	Y	N	KIDNEY DISEASE	Y	N	STROKE	Y	N
BACK PAIN	Y	N	LEG/FOOT ULCER	Y	N	SUBSTANCE ABUSE	Y	N
BLEEDING DISORDER	Y	N	LIVER DISEASE	Y	N	THYROID DISORDER	Y	N
BLOOD TRANSFUSION	Y	N	LOW BLOOD PRESSURE	Y	N	TUBERCULOSIS	Y	N
CANCER	Y	N	LUNG DISEASE	Y	N	VARICOSE VEINS	Y	N
CORONARY ARTERY DISEASE	Y	N	MIGRAINES	Y	N			
DEEP VEIN THROMBOSIS	Y	N	MITRAL VALVE PROLAPSE	Y	N			
DIABETES TYPE 1 OR 2	Y	N	NEUROPATHY	Y	N			
DIALYSIS	Y	N	ORGAN TRANSPLANT	Y	N			
EDEMA	Y	N	OSTEOPEROSIS	Y	N			
FIBROMYALGIA	Y	N	PACE MAKER	Y	N			
FOOT DEFORMITY	Y	N	PVD	Y	N			
FROST BITE	Y	N	PULMONARY EMBOLISM	Y	N			
GOUT	Y	N	RAYNAUD'S DISEASE	Y	N			
HEART ATTACK	Y	N	RHEUMATOID ARTHRITIS	Y	N			

Shoe Size: _____ Height: _____ Weight: _____

How long ago did this problem start? _____ Days/Weeks/Months/Years

Did your pain or problem occur suddenly or gradually over time? _____

How would you describe your pain? (Circle): No Pain Sharp Dull Aching
Burning Radiating Itching Stabbing Other _____

How would you rate you pain on a scale of 1 to 10?

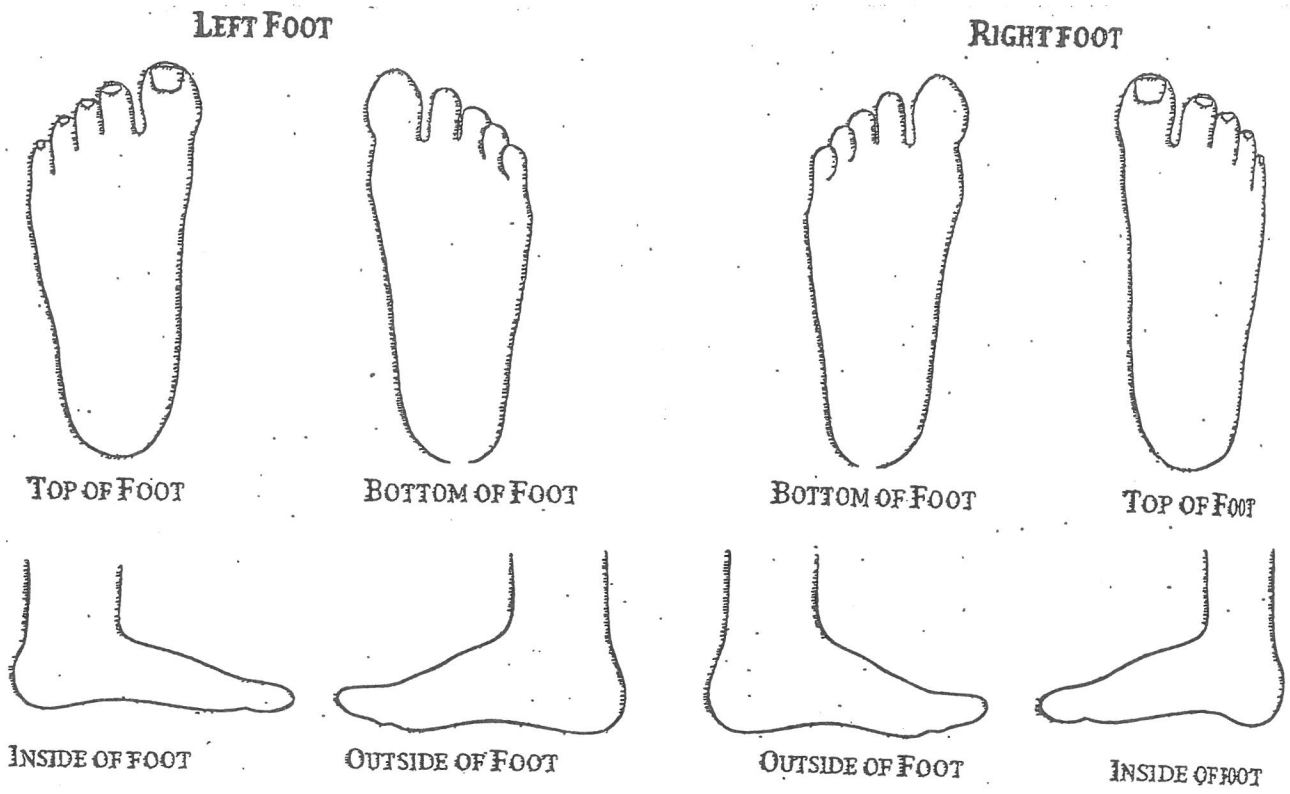
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain)

Since the time your pain or problem began, has it: Stayed the same Become Worse Improved

What makes your pain feel worse (example; walking, resting, flat shoes, etc.) _____

What makes your pain or problem feel better? _____

Where is the pain/problem located? Please mark on the picture below:



What treatments have you had for this problem?

_____

_____

How has this problem affected your lifestyle or ability to work?

_____

_____

Was this problem caused by an injury? If yes, please include date of injury.

_____

_____

Was this a work related injury? If yes, please include date.

_____

_____

Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with certain insurers and other health plans 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/co-insurance/deductible.
- 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 an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- 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.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.
- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party _____ Date: _____

_____ Patient initials to indicate copy received.

Revised June 2015

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

Consent for routine treatment: I hereby consent to the performance of such diagnostic procedures and/or medical treatment as deemed necessary or advisable by my physician, Kelly M. Walker, DPM. I hereby consent to the performance of all nursing and technical procedures and tests as directed by my physician. I understand that my medical care may require the collection of samples, including fluids or tissues, from my body. This may include having blood drawn or tissues removed during tests, treatments, or surgery. I also consent to communication between Dr. Kelly Walker and my primary care provider regarding any information about my health. Further, I understand that should any hospital or emergency medical personnel, physician, or other persons be exposed or report an exposure to my blood or body fluids, my blood will be tested for blood borne infections including Hepatitis B and C as well as HIV/AIDS. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examination by Kelly M. Walker, DPM. I have the right to refuse tests or treatments (as far as the law allows) and to be told what might happen if I do. I have the right not to have any photos or videos taken of me unless I agree to this, except as needed to treat me.

Patient (Guardian) Signature	Kelly M. Walker, DPM
Date	Date

HIPAA Acknowledgement of receipt of Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. The Notice contains a patient rights section describing your rights under law. You have the right to review our Notice before signing this acknowledgement. The terms of our Notice may change; if we change our notice, you may request a revised copy by contacting our office or you will receive a new notice the next time you are treated at our office.

The practice provides this form to comply with the Health Information Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice reserves the right to change the notice of privacy practices.

Please list names of individuals that we may talk to about your treatment. Please note this does not allow these individuals to obtain copies without a complete and valid authorization from the patient.

_____ _____

I acknowledge receipt of the Notice of Privacy Practices.

_____ _____

Printed name of patient or representative **Signature of patient or representative**

_____

Date

Relationship to patient (if other than patient): _____

□ Check if patient refused to take a copy of the Notice of Privacy Practices

State reason for refusal, if known: _____

_____ _____

Witness (Staff) Signature Witness (Staff) Printed Name

_____

Date

No-Show/Cancellation Policy

Quality care for our patients is our priority. Please review our No Show/Cancellation Policy and sign at the bottom of the form. If you have any questions, please let us know.

Walker Foot and Ankle defines a "No-Show" appointment as any scheduled appointment in which the patient either:

1. Does not arrive to the appointment
2. Arrives more than 15 minutes late and is consequently unable to be seen

"No-Show" appointments have a significant negative impact on our practice and the care we provide to our patients. When a patient "No-Shows" a scheduled appointment, it may potentially jeopardize the health of the "No-Show" patient, and other patients. We strive to keep our schedules on time, so please help us do so by adhering to the recommendations below:

1. **CONFIRM** your appointment
    - Walker Foot and Ankle will attempt to contact you 2 days prior, via an automated phone call, to confirm your appointment. You may press 1 to confirm your appointment or call our office during business hours to cancel or reschedule.
2. **ARRIVE** at least 10 minutes early
    - Please arrive at least 10 minutes early for your scheduled appointment time. This allows our staff time to address any insurance, billing, or health history questions.
3. **GIVE 24 HOURS NOTICE** to cancel appointment
    - We are aware that instances come up that make it impossible to keep your scheduled appointment. We ask that you give a 24-hour notice for cancellations and reschedules, when possible. We can be reached at (731) 325-5360 Monday – Thursday 8:30a/4:30p. Friday 8:30a/12:00p. Lunch closing 12:00p-1:30p.

No-Show patients will be subject to a $25.00 Fee. This fee is not covered by insurance.

We appreciate your compliance regarding this matter and look forward to providing you with excellent care at each visit at Walker Foot and Ankle.

_____ _____

Patient/Guardian Signature Date