ADVANCED PODIATRY

Patient Appointment & Payment Policy

Patients are asked to arrive on time for their appointments and are seen by Dr. Gagnon *based on their appointment time, not by the time they arrive*. If you arrive early, we will try to see you as soon as possible but patients that have appointments before you will be given priority. If you are unable to keep your appointment, please contact the office before 9:00 a.m. on the day of your appointment.

All Copays are due and payable at the time of your visit and balances are due upon receipt of your statement unless you have a payment plan in place with our office or a credit card on file.

It will be at the discretion of Advanced Podiatry to charge a $50 fee for patients not showing up for appointments.

By signing below, I confirm that I have read and understand the Policy above.

_____ _____

Patient Signature **Date**

Patient Credit Card Policy

We prefer a credit card or HSA (Health Savings Account) card on file for any balances other than copays. We text or call if a balance exists and no payments are processed without patient permission. When a payment is processed, you will get notification from your financial institution or see the payment on your account. If your HSA needs detailed receipts, check the box and we will provide one.

Credit Card # _____ Exp: _____ Security Code: _____

[ ] HSA (Health Savings Account) – Please provide a detailed receipt

Authorization for Credit Card: _____ _____

Patient Signature **Date**

ADVANCED PODIATRY

WELCOME TO OUR OFFICE

Patient's Name: _____
First Name Middle Initial Last Name

Address: _____
Street City State Zip Code

Home Phone: _____ **Cell Phone:** _____ **Preferred Contact: [ ] Home [ ] Cell**

Would you like a texted appointment reminder? **[ ] Yes [ ] No (*Crestwood Patients Only)***

Social Sec #: _____-_____-_____ **Date of Birth:** _____ **Email:** _____
Month / Day / Year

Sex: Male Female **Marital Status:** Married Never Married Widowed Divorced Separated Other
(**If Married, Spouse's Name / Date of Birth**: _____/_____)

Preferred Language: English Spanish German Polish Other: _____

Race: Caucasian African-American Hispanic Asian Other: _____

Retired [ ] Employer: _____ **Phone:** _____

Employer's Address: _____
Street City State Zip Code

Pharmacy Name & Location: _____

Primary Insurance (if more than one): _____ **2ndary Insurance:** _____

Referred by: Friend _____ Primary Dr. Family Internet Saw Sign Ins Bk/WebSite Orland Twnshp _____

Subscriber (Are you the Insured?) [ ] Yes [ ] No If no, please fill out below information

Insured's Name: _____ **Relationship to Patient:** _____

Address (if different than above): _____
Street City / State / Zip

Date of Birth: _____ **Home Phone:** _____ **Cell Phone:** _____
Month / Day / Year

Employer/Address: _____ **Work Phone:** _____

Emergency Contact & Person designated to receive your Protected Health Information

Name: _____ **Phone:** _____ **Relationship:** _____

Address: _____ **City:** _____ **Zip:** _____

Patient Signature: _____ **Date:** _____

Patient or Guardian Signatures

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read) and understood the Notice.

I also hereby authorize payment for services rendered directly to *ADVANCED PODIATRY*. I agree that I am responsible for any portion not contractually covered by insurance as well as Service Fees ($15/month) on unpaid balances. If my account is turned over to Collection, I agree to pay an additional 25% over the unpaid balance including but not limited to filing fees, court costs, collection agency fees, and attorney fees. I certify that the information provided is true and correct and my insurance information is up to date.

Signature: _____ **Date:** _____

ADVANCED PODIATRY

Present Illness/Injury (Is today's visit the result of an accident/work injury? [ ] Yes [ ] No)

Foot/Ankle Problems you currently have or have had in the past:

Ankle Pain Athlete's Foot Bunions Corns/Calluses Cramps in Feet/Legs Flat Feet Heel Pain
Ingrown Nails Tired Feet Plantar Warts Numbness in feet, legs, toes Swelling in feet, legs, toes

Describe current foot/ankle problem: _____

How long have you had this problem? _____ **Were you previously treated for this problem?** [ ] Yes [ ] No

Have you seen any other physician regarding your foot/ankle problem: [ ] Yes [ ] No

If yes, by whom and when: _____

Are you currently under a physician's care? [ ] Yes [ ] No **Reason?** _____

Primary Care Physician: _____**City:** _____ **Phone:** _____

Height: _____ **Weight:** _____ **Shoe Size:** _____ (Circle one) Narrow Med Wide Extra-Wide)

Smoking status? (Circle one) Never smoked Former smoker Current every day smoker Current some day smoker

Do you drink alcohol/beer? [ ] Yes [ ] No **If yes, how often:** 1-2/day 3+/day 1-2/wk 3+/week

At work, do you: Sit Stand Walk

Allergies (Prescription & Over-the-Counter Drugs)

Circle and/or list any allergies: No Known Allergies

Latex Penicillin Sulfa Codeine Iodine/Betadine Adhesive/Tape Vicodin Cortisone Aspirin/NSAIDS Local Anesthetics

Other: _____

Medications

Current prescription and over-the-counter drugs (with dosages): None Coumadin/Warfarin _____mg Aspirin _____mg

Others (Please list below or provide a list we can copy)

_____ _____ _____

_____ _____ _____

_____ _____ _____

Family History (Circle all that apply)

Patient's family history (parents and brothers/sisters):

Anxiety/Depression	Emphysema	Liver Disease	Psoriasis/Skin Prob
Arthritis	Epilepsy	Neurologic Disorder	Respiratory Disease
Asthma	Gastrointestinal/Reflux/Ulcers	Neuropathy	Stroke
Cancer	Heart Disease	Osteoporosis	Varicose Veins
Cholesterol Problems	High Blood Pressure	Poor Circulation	
Diabetes	Kidney Disease/Dialysis	Prostate Problems	

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Medical History (Circle all that apply)

Do you have a pacemaker? [ ] Yes [ ] No **Any Implants?** [ ] Yes [ ] No **Any Artificial Joints?** [ ] Yes [ ] No

If Yes, Describe: _____

Please *circle all* that apply to you in *each* row or circle "None":

General:	Chills Fatigue Fever Weakness Weight Gain/Loss	**None**
Respiratory:	Asthma COPD Cough Emphysema Shortness of Breath	**None**
Cardiac:	Cramps Heart Disease Murmur High BP Heart Attack Heart Valve Rheumatic Fever Varicose Veins	**None**
GI:	Constipation Diarrhea Hepatitis Jaundice Liver Disease Nausea/Vomiting Stomach Ulcers	**None**
M/S:	Arthritis Gout Joint Stiffness Low Back Pain Paralysis Toe Walking Weakness	**None**
Psychiatric:	Depression Disorientation Memory Loss	**None**
Skin:	Athletes Foot Dryness Eczema Fungal Nails Ingrown Nails Itching Lumps Rash Warts	**None**
Neurologic:	Burning Charcot Neuroma Numbness Strokes Tingling Tremors Unsteady Gait	**None**
Endocrine:	Diabetes (Age of Onset: _____) Last A1C: _____ Thirst Thyroid	**None**
Hemotology:	Anemia Bleed Easily Blood Clots Chemotherapy	**None**
Urinary:	Burning/Pain on Urination Dialysis Frequent Kidney Problems	**None**

Surgery / Injury History

Any problems with anesthesia? [ ] Yes [ ] No **Describe:** _____

Surgeries/Injuries: _____

_____

_____

_____

_____

Treatment Consent / Assignment of Benefits

I hereby request and give permission for treatment of my foot/ankle condition(s) by Dr. Mark J. Gagnon, DPM (and whomever he may designate as his assistants) as he deems necessary. I understand that information relating to my medical condition may be released to my insurance company for claims purposes and I understand that this information may include my insurance identification number/social security number, as well as other personal information. I hold harmless Mark J. Gagnon, DPM, for any action taken by present or future insurers as a result of this information.

I understand the above and hereby state that the information I have provided is correct to the best of my knowledge.

_____/_____ _____/_____

Signature **Date** **Reviewed by** **Date**