FRANKLIN Foot Care

James A. Anderson, Jr. & Associates Podiatric Physicians

Personal Information

Name: _____ Birthdate: _____ Age: _____

Address: _____ Marital Status: _____

City: _____ State: ____ Zip: _____ Spouse's Name: _____

Race: _____ Ethnicity:_____ Preferred language:_____

Patient SS#: _____ Email: _____

Home Phone: _____ Work Phone: _____ Cell: _____

In case of emergency contact: Name: _____Relationship: _____

Home: _____ Work: _____ Cell: _____

****Person financially responsible for this account. (Skip if self)**

Name of responsible party: _____Relationship to patient_____

Billing Address: _____Phone number: _____

Who may we thank for referring you to our office: _____

Insurance Information:

Primary Insurance Company: _____ Do you need a referral: _____

Subscriber: _____ Relationship to patient: _____ Subscriber Date of Birth: _____

PRIMARY CARE PHYSICIAN_____ Phone: _____

Secondary Insurance Company: _____ Do you need a referral: _____

Subscriber: _____ Relationship to patient: _____ Subscriber Date of Birth: _____

PHARMACY _____ Location**:** _____

MEDICAL HISTORY:

Reason for Visit: *(Describe foot problems and concerns)*_____

_____

When Did Problem Start? _____ How long have you had your current symptoms? _____

Have your symptoms increased, decreased or remained the same since they began? _____

Is this injury accident or work related?_____

If yes, do you currently have a claim open with the insurance company?_____

Please provide information to our office for billing.

Medical History: *(check if you had or have any of the following)*

____Diabetes ____Type I _____Type II _____Controlled _____Uncontrolled

____Hypertension *(High blood pressure)* ____Tuberculosis ____Asthma ____Kidney Disease
____Bleeding/Clotting Disorders ____Rheumatic Fever _____Anemia ____Gout
____PVD *(Circulation Disease)* ____Arthritis ____Cancer ____Epilepsy
____Hepatitis *(Liver Disease)* ____Stomach Ulcers ____Thyroid
____Heart Disease
____High Cholesterol
____Cramps or numbness in feet or legs
____Other(s) _____

Past Surgical History**:** *(Please include date of surgery)* _____

_____

Social History**:** Smoking (packs/day x years) _____ Alcohol _____
Recreational Drugs _____ Other(s) _____

Family History**:** Diabetes _____ Heart Disease _____ Cancer _____ Hypertension ____
Anemia _____ Stroke _____ Other _____

MEDICATIONS / ALLERGIES

Medications: *(Including Non-Prescription and Herbal Medications **you are currently taking)***

_____

_____

Allergies: *Please list any known allergies and reactions:*

_____ No Known Allergies

_____ Penicillin: _____ _____ Local Anesthetic:_____

_____ Iodine: _____ _____ Sulfa: _____

_____ Asprin: _____ _____ IV Dye: _____

_____ Latex _____ _____ Tape: _____

_____ Other: _____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. If my insurance requires authorization or referral I am responsible for obtaining that information for all services rendered.
I have read all the information on both sides of this sheet and have completed the above answers. I certify this information is true and correct to best of my knowledge. I will notify you on any changes in my status or the above information.

Signature: _____ Date: _____

Relationship to patient: _____

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NOTICE OF PRIVACY PRACTICES

This note describes how medical information about you can be used and how you can get access to this information. Please read carefully.

Your medical record is protected under HIPAA federal law. There are limitations upon to whom and under what circumstances your medical information can be disclosed. **We do not share your private medical information with anyone including your spouse, parent or employer unless you request it or unless required by law.**

The law allows us to share your medical information with your insurance company in order to verify eligibility and that payment is appropriated for the visit. They may also review your record to ensure that we meet quality standards. We share information with other providers who are treating you or who referred you to us for consultation or treatment. We also provide information about your care and diagnosis when we request tests at the hospital or labs, such as x-ray or laboratory testing. These other providers are also required to protect the confidentiality of your health information under HIPAA.

We may consult you by mail or leave a general message by phone, but we will not give your test results or other private information to a family member without your permission.

We are not affiliated with any drug companies or other marketing services and will not release your health information to anyone for the purpose of marketing services to you. We may, however, give you a reminder by phone of an upcoming appointment. We may disclose information to the FDA in the event of an adverse drug reaction, as required by law, to the Dept. of Public Health in the event of certain communicable diseases.

You may review your medical records or obtain a copy of them upon request. There is a charge for copying depending on the number of pages involved. HIPAA also allows you to make additions or corrections to your medical records. If you have questions about our policy of protecting your private medical record, you may discuss them with our office manager.

CANCELLATION POLICY

I understand the office requires 24 hours notice for appointment cancellations. If 24 hours notice is not provided, I understand I may be charged a $25 No-Show/Cancellation Fee.

PERMISSION TO TREAT

I hereby give permission to Franklin Foot Care to examine and/or administer treatment as necessary in the diagnosis & treatment of my foot problem(s), **including but not limited to in person visits as well as telehealth visits**. I certify that I and/or my dependents have insurance coverage or will pay privately & assign directly to Franklin Foot Care all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance.

COVID-19 DISCLAIMER: To minimize the possibility of cross contamination for our patients and our staff, we are instituting verbal consent procedures. Please notify the staff of your acceptance or declination of the above 3 policies. They will check off, sign and witness as instructed by you. Thank you for your understanding in these unusual times.

☐ I Accept ☐ I Decline the NOTICE OF PRIVACY PRACTICES
☐ I Accept ☐ I Decline the CANCELLATION POLICY
☐ I Accept ☐ I Decline the PERMISSION TO TREAT

Verbal Consent received from: (Name): _____ Date: _____
Verbal Consent given by: (Name): _____ Witness: _____

**Signature:_____ Date: _____
(Hard signature will be obtained when CDC guidelines are lifted for COVID-19)