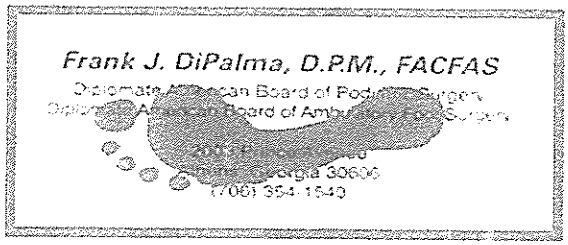

Welcome to Five County Foot Care!

We have you scheduled for an appointment on _____ at _____.

Here is what to prepare and complete **before** arriving for your appointment:

- All co-pays are due at the time of service. Medicare patients that do not have a secondary insurance are responsible for a 20% co-pay. It is your responsibility to verify your co-pay with your insurance company prior to your appointment. *Please note: We are a **specialist office**, therefore *the co-pay will differ from a regular office visit.* If you are unable to pay your co-pay at the time of service, we will need to reschedule your appointment.

- You will find your new patient paperwork attached here. Please fill out each page and email the **completed paperwork** to oldtiredfeet@gmail.com before your 1st appointment. **If unable to sign pages, we will have it printed at your appointment and will have you sign when you come in. Please physically sign each signature line.*

- Please bring **photo ID**, **insurance cards**, a list of all **medications/vitamins**, and a few **pairs of shoes** that you wear on a regular basis to your first appointment.
- Your first appointment will be approximately 1.5 - 2 hours long. Please let us know of any conflicts so that we can reschedule you to a more convenient day/time.
- If you are more than 20 minutes late, we will need to reschedule your appointment.
- If you need to reschedule your appointment, please give our office 24 hours advance notice. Our office number is **706-354-1540**.
- If you are a "no show", we will **not be able to reschedule** another new patient appointment for you. Thank you for your understanding.
- There is a $50 charge for any missed appointments.

* If any questions don't pertain, please write "N/A" *

We look forward to helping you feel better! Please let our office staff know if we can be of any assistance prior to your appointment.

Sincerely,

Dr. DiPalma & the Five County Foot Care Team

PATIENT INFORMATION

Five County Foot Care Dr. Frank J. DiPalma

Full Name: _____ Sex: Male / Female
Address: _____
City/State/Zip: _____
Social Security Number: _____
Date of Birth (0/0/00) _____ Age: _____

Height: _____
Weight: _____
Shoe Size: _____

Contact Phone: _____ Alternate Phone: _____
Email Address: _____

Each line below should have one word circled that best describes you:

Marital Status:	Married	Divorced	Widowed	Single	Separated	Minor
Race/Ethnicity:	White	Black	Hispanic	Asian	Other	
Primary Language:	English	Spanish	Other			

Your Occupation: _____
Patient Employer/School: _____
Employer/School Address: _____
Employer/School Phone: _____

Spouse's Name _____ Birth Date: _____
Spouse's Social Security #: _____

Emergency Contact Name: _____ Relationship: _____
Emergency Contact Phone: _____

Family Physician: _____ City/State: _____
Last appointment: _____

What is the chief complaint for which you came to be treated today?

_____

Have you ever been to a Podiatrist before? If yes, list Doctor name & date of last visit:

_____

Athletic Activities (list and indicate frequency):

_____

Please list any/all allergies: _____
Surgeries you have had: _____
How did you hear about us? Internet Advertisement/Sign Friend* Physician*
*If you were referred, we'd love to know who sent you! _____

Please indicate which foot problems you have now or have had in the past:

Ankle Pain	YES	NO
Athletes Foot	YES	NO
Bunions	YES	NO
Corns and Calluses	YES	NO
Cramps or Numbness in Feet or Legs	YES	NO
Flat Feet	YES	NO
Heel Pain	YES	NO
Ingrown Toenails	YES	NO
Plantar Warts	YES	NO
Swelling in Ankles or Feet	YES	NO
Tired Feet	YES	NO
Do you Smoke?	YES	NO
Do you drink alcohol?	YES	NO
Do you use illegal drugs?	YES	NO

Please ✓ to indicate if you or any of your family members have had any of the following:

	You	Mother	Father		You	Mother	Father
High Blood Pressure	( )	( )	( )	Anemia	( )	( )	( )
Kidney Problems	( )	( )	( )	Artificial Heart Valves/Joints	( )	( )	( )
Asthma	( )	( )	( )	Back Problems	( )	( )	( )
Bleeding Disorders	( )	( )	( )	Cancer	( )	( )	( )
Rheumatic Fever	( )	( )	( )	Circulatory Problems	( )	( )	( )
Diabetes	( )	( )	( )	Stroke	( )	( )	( )
Foot or Leg Cramps	( )	( )	( )	Tuberculosis	( )	( )	( )
Gout	( )	( )	( )	Ulcers	( )	( )	( )
Heart Disease	( )	( )	( )	Unexplained Weight Loss	( )	( )	( )
Bladder	( )	( )	( )	Bunions	( )	( )	( )
Flat Feet	( )	( )	( )	Frequent Infections	( )	( )	( )
Hammertoes	( )	( )	( )	Hormones	( )	( )	( )
Lung Condition	( )	( )	( )	Stomach Ulcers	( )	( )	( )

Family History:

Mother Living	YES	NO	Age _____	Cause of Death_____
Father Living	YES	NO	Age _____	Cause of Death_____
Brother Living	YES	NO	Age _____	Cause of Death_____
Sister Living	YES	NO	Age _____	Cause of Death_____

I authorize the release of any medical information necessary to Frank J. DiPalma, DPM. I authorize the release of my medical records to any other physician participating in my care. We reserve the right to charge for missed appointments that were not canceled 24 hours prior.

Signed: _____ **Date:** _____

Please ✓ next to any problems that you are currently experiencing or have experienced in the past.

Constitutional:

( ) abuse/neglect ( ) chills ( ) fainting ( ) lack of sleep ( ) night sweats
( ) appetite (decreased) ( ) convulsions ( ) fever ( ) loss of appetite ( ) sleep problems
( ) appetite (increased) ( ) dehydration ( ) headache ( ) major trauma ( ) weight gain
( ) addiction ( ) dizziness ( ) hot flashes ( ) migraine ( ) weight loss

Eyes:

( ) blurred vision ( ) double vision ( ) itchy eyes ( ) painful/sore eyes
( ) cloudy vision ( ) dry eyes ( ) vision loss ( ) redness of eyes

Ears, Nose, Mouth, Throat:

( ) congestion ( ) ear infection ( ) cough ( ) nose bleed
( ) problems hearing ( ) ears ringing ( ) nose stuffy ( ) difficulty smelling
( ) issues swallowing ( ) dry mouth ( ) lockjaw ( ) ear drainage
( ) mouth ulcers ( ) teeth painful ( ) ear pain ( ) nose running
( ) post-nasal drip ( ) white patches in mouth

Cardiovascular:

( ) ankle swelling ( ) chest pain ( ) cold feet ( ) chest tightness ( ) cold hands
( ) cramping ( ) palpitations ( ) murmur ( ) pacemaker ( ) varicose veins
( ) shortness of breath ( ) color change in extremity ( ) excessive sweating ( ) high blood pressure ( ) low blood pressure ( ) rapid heartbeat

Respiratory:

( ) asthma ( ) asthma attack ( ) sleep apnea ( ) snoring ( ) wheezing
( ) blood in sputum ( ) chest pain when inhaling ( ) chest tightness
( ) cold-like symptoms ( ) shortness of breath( ) difficulty breathing
( ) coughing up excess sputum
( ) flu-like symptoms

GI:

( ) abdominal cramps ( ) abdominal pain ( ) black, tarry feces
( ) blood in stool ( ) change in bowel habits ( ) constipation ( ) diarrhea
( ) excessive gas ( ) heartburn ( ) hemorrhoids ( ) vomiting ( ) watery stool

GU:

( ) blood in urine ( ) burning with urination ( ) decreased urination
( ) excessive urination ( ) frequent urination ( ) impotence
( ) inability to urinate ( ) kidney (flank) pain ( ) kidney dialysis
( ) kidney failure ( ) urinary incontinence ( ) vaginal discharge

Musculoskeletal:

( ) abdominal pain ( ) back pain ( ) decreased flexibility ( ) difficulty walking
( ) episodic weakness ( ) foot pain ( ) heel pain ( ) hip pain ( ) joint pain
( ) joint redness ( ) joint swelling ( ) leg cramps ( ) morning stiffness
( ) neck pain ( ) stiffness ( ) weakness

Integumentary:
( ) athlete's foot ( ) blistering ( ) burning sensation of skin ( ) dermatitis
( ) contact dermatitis ( ) dry, scaly skin ( ) eczema ( ) itchy skin ( ) rash
( ) non-healing wound ( ) excessive scar tissue ( ) tingling sensation of the skin
( ) ulcers

Neurological:
( ) burning ( ) increased sensitivity to touch ( ) numbness ( ) paralysis
( ) seizure (recent) ( ) tingling or pricking sensation ( ) uncontrolled movements

Psychiatric:
( ) addiction to alcohol ( ) addictive personality ( ) anger management issues
( ) anxiousness ( ) depression ( ) disorientation ( ) emotional or mental abuse
( ) extreme highs and lows ( ) forgetfulness ( ) irritability ( ) memory loss
( ) obsessive-compulsive personality ( ) panic attacks ( ) paranoia

Endocrine:
( ) blood sugar (high) ( ) blood sugar (low) ( ) delayed wound healing
( ) dry skin ( ) excessive thirst ( ) fatigue ( ) intolerance to cold
( ) intolerance to heat ( ) loss of skin color

Hematologic/Lymphatic:
( ) anemia ( ) bleed easily ( ) blood transfusion (recent) ( ) bruise easily
( ) calf pain ( ) difficulty to stop bleeding ( ) fatigue ( ) night sweats
( ) frequent nose bleeds ( ) sickle cell ( ) swollen ankles
( ) swollen face ( ) swollen hands ( ) swollen legs ( ) swollen lymph nodes

Allergic/Immunologic:
( ) arthritic flare-up ( ) asthma attack (recent) ( ) coughing ( ) environmental allergies ( ) gout attack ( ) hay fever symptoms
( ) Hepatitis B Carrier ( ) seasonal allergies ( ) sneezing

Patient Name: _____

Patient Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Five County Foot Care Dr. Frank J. DiPalma

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it's *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgement, but was unable to do as documented below:

Date	Initials	Reason

Financial Policy

Five County Foot Care Dr. Frank J. DiPalma

Please verify your mailing address, phone and insurance information at <u>each visit</u>.
It is the patient /guarantor's responsibility to verify the information that we have on file is correct.

Copays: Five County Foot Care accepts most insurance fee schedules including Medicare. Medicaid is accepted only as secondary insurance. It's our policy to verify each patient's insurance before he/she is rendered service. If your insurance plan has a co-pay, we are required by the insurance providers to collect it on the day of your visit. If you ask that we bill you for your co-pay, a $10 billing fee will be added unless otherwise agreed. **The billing fee is not covered by insurance.**

Check Out: When you check out, the receptionist will collect money for any co-pays, over-the-counter products, and any outstanding balance. The receptionist will not know the amount of your charges for your visit that same day. You may request that information through your insurance company.

Methods of Payment: We accept cash, major credit cards, care credit and checks, Apple Pay and Google Pay. There is a $35 fee for returned checks.

No Insurance: Five County Foot Care accepts self pay patients. 100% of any service provided is due on the day that it's rendered. Over-the-counter products must be paid in full on the day they are dispensed. Payment arrangements for any balance remaining must be made with the billing manager **prior** to services being provided.

Billing: We bill your insurance company first. Any remaining balance will be billed to you. You will be responsible for any charges billed to the wrong insurance carrier as a result of not providing us with the correct insurance information. We will not refile your claim to the correct insurance after 30 days of service date. If you receive a bill from us, it is because we believe the bill to be your responsibility. **If you feel there is an error, please contact your insurance company first. If there are still issues, please contact our billing manager in a timely manner to discuss.** We will assist you in getting it resolved. We expect bills to be paid in full within 30 days. We offer payment plans for patients who demonstrate the need. If you cannot pay your entire balance, please contact the billing manager immediately to make payment arrangements.

Other Services: There may be an additional charge for medical records. **We also charge a missed appointment fee of $50 for appointments not canceled 24 hours prior to the scheduled time.** These fees are not covered by insurance. Please contact the billing manager if you have any questions regarding these fees.

Collections: Accounts that are not paid within 30 days begin our in house collections process. A 3% interest fee will accrue monthly to any balance more than 30 days past due. If your balance becomes 90 days past due, Dr. DiPalma will be notified and you will not be seen as a

patient until the balance is paid in full. We do refer overdue accounts to a collections agency or magistrate court.

Dismissal: If you have multiple missed appointments, you are subject to being dismissed from our practice. Unfortunately, we are unable to continue care to patients who choose not to pay their bills. Being dismissed means you can not schedule appointments or get prescriptions from our practice. Please do not let this happen. Please contact the billing manager before your account becomes a problem.

Office Manager, Miranda Sheridan (706)354-1540

Patient Name: _____

Patient/Guardian Signature: _____ **Date:** _____