# WELCOME TO THE OFFICE OF KENNETH FOLLOWWILL, D.P.M.

Date_____

## PATIENT INFORMATION

Name_____ Date of birth____/____/____
first middle last

Age_____ Male____Female____ Single____Married_____ Referred by_____

Address_____
Street City St. Zip

Preferred Phone:_____ Email _____

Family Physician_____Phone_____

Employer_____phone_____Occupation_____

**Employment** requirements Sitting_____Standing_____walking_____lifting_____pushing_____
hours hours hours

Athletic Activities _____Frequency _____

## EMERGENCY CONTACT INFORMATION

Name_____ Phone_____ Relationship_____

## EXPLANATION OF PAYMENT POLICY AND INSURANCE FILING PROCEDURES

I hereby authorize Affiliated Foot Center, PC, to release medical information and necessary data pertinent to filing of insurance claims in the interest of the patient named above. I authorize my insurance carriers to pay benefits directly to Affiliated Foot Center, PC on any unpaid services filed on my behalf by Affiliated Foot Center, PC. I understand that I am responsible for payment to Affiliated Foot Center, PC for charges for the above patient, regardless of my insurance coverage.

## ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the notice of Privacy which is located on our **web site** and posted in our office, and that I have had the opportunity to read it if I so choose.

## CONSENT AND AUTHORIZATION FOR TREATMENT

I hereby give Dr. Kenneth Followwill, D.P.M. permission to diagnose and administer treatment for my foot condition and authorize any release of information obtained in the course of my treatment.

**SIGNATURE**_____**DATE**_____

**OFFICE OF KENNETH FOLLOWWILL, D.P.M.**

**PATIENT HISTORY** Patient Name_____

Current foot problem_____

height_____weight_____shoe size_____usual shoe gear_____

Tobacco user currently No _____ Past No____ Yes _____years of Tobacco_____year of cesation_____

Tobacco user currently Yes_____ Type_____ _____Amount per day _____

Alcohol consumption No_____Yes_____daily _____social_____

Current immunization Influinza_____ Pneumonia (over 50)_____ _____

**Medical History**

| | | | | | |
|---|---|---|---|---|---|
| **DIABETES** | yes | no | | | |
| AIDS/HIV | yes | no | Gout | yes | no |
| Anemia | yes | no | Heart Trouble | yes | no |
| Arthritis | yes | no | Hepatitis | yes | no |
| Artificial Heart Valve | yes | no | Hypertension | yes | no |
| Asthma | yes | no | Kidney Disease | yes | no |
| Cancer | yes | no | Respiratory Disease | yes | no |
| Circulatory Problems | yes | no | Stroke | yes | no |
| Epilepsy | yes | no | Thyroid Proble | | |
| Currently Pregnant? | yes | no | | | |

**MEDICATIONS** pleasc include dosage and frequency

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

**ALLERGIES** **NO KNOWN DRUG ALLERGIES**_____

1._____2._____3._____

**Other information you think we should be aware of:**_____

_____

**Signature:**_____Date_____

## INSURANCE INFORMATION

Primary insurance _____ _____ _____phone_____ _____ _____

Member ID#_____ _____ _____Group#_____ _____SS#_____ _____ _____

Policy holder_____ _____ _____ realtionship____ _____ _____DOB____ _____

Secondary insurance_____ _____ _____phone_____ _____

Memeber ID#_____ _____Group#_____ _____

Policy holder_____ _____ _____relationship_____ _____DOB_____ _____

# 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: _____ _____

# Consent and Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

*(Revised March 2013)*

I, _____ (Patient's Name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my healthcare;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I have been provided with a copy of the *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this facility's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

I understand that:

- I have the right to review this facility's Notice of Information practices prior to signing this consent;
- This facility, reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this facility is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that this facility, has already taken action in reliance thereon.
- It is this facility's procedure to share Protected Health Information with labs, x-rays, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.
- *I have the right to restrict disclosure of PHI to a health plan with respect to treatment for which the individual has paid fully out-of-pocket.*

_____

Signature of Patient or Legal Representative Witness

_____ _____

Printed Name of Patient or Legal Representative Witness Date

Insurance accepted

Aetna
Blue Cross Blue Shield
Cigna
GEHA
Humana
Medicare
    Traditional, AARP Medicare, UHC Medicare, Care N Care, Care Improvement Plus
Medicaid
    Traditional, Amerigroup, Cigna HealthSpring
Tricare
    Tricare for Life, TriWest
United HeathCare

**[redacted] Website Disclaimer**

The information on this site is provided for your assistance only; this site does not provide podiatric advice. You should never diagnose or treat yourself for a podiatric condition based on the information provided herein, and the information is not provided for that purpose. Likewise, you should never determine that treatment is unnecessary based on this information. The information contained herein is not a substitute for podiatric care provided by a licensed podiatric professional. The information provided herein is not podiatric, medical or professional advice. This site does not create a doctor-patient relationship.