BAY CITY

Associates in Podiatry, Inc.

Dear Patient,

We would like to take this time to welcome you to this office. We will do all we can to make your visit a pleasant one.

We have enclosed several forms, which we ask you to complete in full. Once you have filled out all the information, please bring them with you to your scheduled appointment.

HISTORY FORMS: We do not treat a toe, a nail or a foot. We treat people. Please fill out all medical information. DO NOT WRITE IN YES OR NO under medical history, check only those which apply. Family history, social history, past Surgeries are required information. PLEASE BRING IN A WRITTEN LIST OF ALL MEDICATIONS- PRESCRIPTION AND OVER THE COUNTER. Include the dosage, amount per day, and the reason you take it.

INSURANCE: Please bring in your insurance cards, copies will be made and kept in your chart which allows for prompt and accurate processing of your claim. As a courtesy, we will be happy to submit *all* claims to your insurer. Should your carrier refuse payment, you will be required to pay for all unpaid claims. All deductibles and balances are also the sole responsibility of the patient. Payment in full must be made within 30 days of the billing or a surcharge of $29.00 may be implemented unless other satisfactory arrangements are made. We do offer payment plans.

COPAYS: *All* copays are required prior to seeing the doctor. This is dictated by your insurance company per your contractual agreement with your insurance carrier.

MANAGED FORMS: If your insurance requires a referral from your Primary Care Physician, that is your responsibility. We do NOT obtain referrals for you.

XRAYS: If applicable, please bring in any x-rays and written reports you may have at the time of your visit that pertain to your problems.

This letter has been created to alleviate any potential misunderstandings or miscommunications. Our office is always open to you for any questions or concerns you may have. We hope that your visit with us is a pleasant one. On behalf of the Doctors and the staff, we sincerely thank you.

105 Mead Avenue, Suite C- Meadville, PA 16335 Phone: 814-337-3668 / Fax: 814-337-3368

UNDERSTANDING DEDUCTIBLES, COINSURANCE AND COPAYS

When both you and your insurance company pay for your health care expenses, it's called cost sharing. Deductibles, coinsurance, and copays are examples of cost sharing. Understanding how they work will help you know how much you'll pay.

DEDUCTIBLE

A deductible is the amount you pay for healthcare services before your health insurance begins to pay.

How it works: If your plan's deductible is $1,500 you'll pay 100 percent of eligible healthcare expenses until the bill's total $1,500. After that, you share the cost with your plan by paying coinsurance.

COINSURANCE

Coinsurance is your share of the costs of healthcare service after your deductible has been met.

How it works: You've paid $1,500 in healthcare expenses and met your deductible. When you go to the doctor, instead of paying all costs, you and your plan share cost. For examples, your plan pays 70 percent. The 30 percent you pay is your coinsurance.

COPAY

A copay is a fixed amount you pay for healthcare service, usually when you receive the service.

How it works: You plan determines what your copay is for different types of services, and when you have one. You may have copay before you've finished paying toward your deductible. You may *also* have a copay after you pay your deductible, and when you owe coinsurance.

Your insurance card may list copays for some visits.

BAYCITY ASSOCIATES IN PODIATRY, INC.

PATIENT INFORMATION FORM

PLEASE PRINT AND COMPLETE ALL ENTRIES

APPT DATE_____

PATIENT NAME (LAST, FIRST, MI) _____ DATE OF BIRTH ____/____/____ SSN# ___-___-____

ADDRESS (STREET, CITY, STATE, ZIP) _____ PRIMARY PHONE# _____ ALT PHONE # _____

NAME & ADDRESS OF EMPLOYER _____ PHONE # _____

M S D W SEP (CIRCLE ONE)

MARITAL STATUS _____ SPOUSE'S NAME (LAST, FIRST, MI) _____ PHONE # _____

PHARMACY NAME _____ ADDRESS _____ PHONE# _____

EMERGENCY CONTACT _____ RELATIONSHIP _____ PHONE# _____

EMERGENCY CONTACT #2 _____ RELATIONSHIP _____ PHONE# _____

FAMILY PHYSICIAN (PCP) _____ PHONE# _____ ENDOCRINOLOGIST _____ PHONE# _____

INSURANCE _____ MEMBER ID# _____ POLICY HOLDER _____ POLICY HOLDER DOB _____

SECONDARY INSURANCE _____ MEMBER ID# _____

BayCity Associates in Podiatry, Inc.

AUTHORIZATION FOR TREATMENT AND RELEASE OF MEDICAL INSURANCE INFORMATION.

AUTHORIZATION OF TREATMENT

I the undersigned hereby authorize **BayCity** Physicians to render treatment / therapy to myself deemed medically necessary in order to treat the condition/ conditions I have requested from himself and his staff.

SIGNATURE OF PATIENT (OR POA / GUARDIAN):_____

RELATIONSHIP OF POA OR GUARDIAN TO PATIENT:_____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance or employee healthcare benefits coverage with the enclosed captioned, and hereby assign and convey directly to **BayCity Associates,** Inc. all medical benefits, insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor. I also admit full disclosure of my deductible, what has been met, if any, and what is currently owed. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments, and understand that these balances are due within 90 days from the date or Insurance payment, and or denial, and if outside collections attempts are necessary. I will also remain responsible for all collection and legal fees. I hereby authorize the doctor to release all medical information necessary to process this claim. I authorize any plan any administrator or fiduciary, insurer, and my attorney to release to such doctor, any end all plan documents, insurance policy/ settlement, information upon written request from such doctor, in order to claim such medical benefits, reimbursements or any applicable remedies. I authorized the use of this signature on all my insurance / employee health benefit claim submissions.

I hereby convey to the above named doctor to the full extent permissible under the law and under any applicable insurance policies / employee healthcare plan to and claim, chase In action, or other right I may have to such insurance/ employee healthcare coverage under my applicable insurance policies and or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and to the extent permissible under the law to claim such medical benefits. Insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor in any attempts by such doctor to pursue such claim, chose in action or right against my Insurers/ employee health care plan, including, If necessary, bring suit with such doctor against such insurers; employee healthcare plan In *my* name but at such doctor's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____

SIGNATURE OF PATIENT (OR POA/GUARDIAN) DATE

IF POA OR GUARDIAN, RELATIONSHIP TO PATIENT _____

I ACKNOWLEDGE THAT I HAVE RECEIVED **A NOTICE OF PRIVACY.**

PATIENT HIPAA ACKNOWLEDGMENT DESIGNATION DISCLOSURE FORM

I. Acknowledgment of Practice's *Notice of Privacy Practices*

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP) and that I have read (or had the opportunity to read if I so chose) and understand the Notice or Privacy Practices (NPP) and agree to its terms

Name or Patient	Date of Birth	Signature or Patient/Parent/Guardian

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain pieces of my health Information to a Personal Representative of my choosing, since such person is involved with my healthcare or payment relating to my healthcare. In that case, the Physician Practice will disclose only information that Is directly relevant to the person's involvement with my healthcare or payment relating to my healthcare.

Print Name:_____ Phone or other identifier:_____

Print Name:_____ Phone or other identifier:_____

III. Request to receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.52.2(b). I hereby request that the Practice make all communications to me as I have listed below.

Home telephone number.

_ ok to leave a message with detailed information -OR- _ Leave message with call back number only

Work telephone number:

_ ok to leave a message with detailed Information -OR- _ Leave message with call back number only

Cell telephone number:

_ok to leave a message with detailed Information -OR- _ Leave message with call back number only

Fax telephone number:

_ok to fax to number listed here:_____

Email:

ok to email address Practice has on file

1. The above authorizations are voluntary and I may refuse their terms without affecting any of my rights to receive healthcare *at* the Practice.
2. These authorizations may be revoked at any time by notifying the Practice in writing at the Practice's mailing address marked to the attention of "HIPAA Compliance Officer".
3. The revocation of this authorization will not have *any* effect on disclosures occurring prior to the execution of any revocation
4. If you request it, a copy of the Information described in this form can be obtained at the front desk.
5. This form was completely filled In before I signed it and I acknowledge that all of my questions were answered to my satisfaction and that I fully understand this authorization form.
6. This authorization is valid as of the date I have signed below and shall remain valid until changed or revoked.

Name of Patient (PRINTED)	Signature of Patient	Date

PATIENT NAME_____DOB _____ Chart #_____

WE ARE PLEASED TO HAVE YOU AS A PATIENT. PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY. WE TREAT PEOPLE, NOT FEET.

SHOE SIZE_____ HEIGHT: ____Ft_____In WEIGHT _____

I. CHIEF COMPLAINT: Please be specific: I am here today for _____

_____

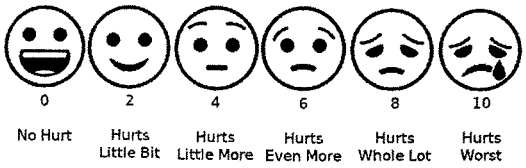
I have no pain_____ My area of pain Is:

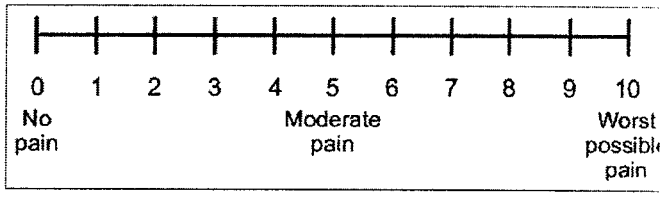
Right or Left: Foot___ Ankle___ Arch___ Heel____ Achilles Tendon (Heel Cord)___

Toe(s) 1 2 3 4 5 Toenail(s) 1 2 3 4 5 Lower Leg____

II. My problem has been present for:_____

III. I would rate my pain as: Use either scale.





IV I would describe my pain as: No Pain___Dull____Sharp____Throb____Burn____
Numb____Tingling_____ Shooting_____Deep_____ Achey____ Other_____

V Do you remember any trauma or incident which may have caused this? Unsure_ No_Yes,
_____

VI Did the pain come on: Slowly Suddenly

VII My pain is present in AM PM Both Varies

VIII My Pain is: Constant Intermittent Transient Worsening Improving Unchanged

IX I mostly notice my pain: When I bear weight When I am off of my feet Both on and off my feet With activity

X With my shoes on, My pain: Improves Worsens Remains unchanged

XI Does anything else make it feel better? No Yes Explain_____
_____

XII Does anything else make it feel worse? No_Yes Explain
_____

XIII Treatment(s): None / I have tried:_____
The treatment. Succeeded Partially Succeeded Unsuccessful

XIV Have any doctors treated this condition? No Yes Treatment:_____
Succeeded Partially Succeeded Unsuccessful

Name: _____

FAMILY PHYSICIAN Name_____
-Date of your last checkup by your doctor: ___/___/_____
-Do you feel that you are in good, general health? No ____ Yes _____

MEDICAL HISTORY

Please CHECK ANY illnesses you have had IN THE PAST or NOW CURRENTLY HAVE:

- ☐ AIDS
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Clots
- ☐ Cancer (Type? When?)_____
- ☐ Chemotherapy: Current____ History of_____
- ☐ Congestive Heart Failure
- ☐ Diabetes Type I_____Type 2 _____
- ☐ Dialysis
- ☐ Edema (swelling)
- ☐ Emphysema
- ☐ Epilepsy / seizures
- ☐ Glaucoma I Cataracts
- ☐ Gout
- ☐ Heart problems (type)
- ☐ Heart valve problems
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ High Lipids
- ☐ HIV
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Lymphedema
- ☐ Lung Problems
- ☐ MRSA
- ☐ Phlebitis: Which leg?_____
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Stomach Ulcer/ Hiatal Hernia
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Vein/Artery Disease
- ☐ Venereal Disease
- ☐ _____
- ☐ _____
- ☐ _____

BLEEDING/ SCARRING PROBLEMS

Transfusions ☐No ☐Yes Year_____ Reason_____
Bruise Easily ☐No ☐Yes Clotting Problems ☐No ☐Yes
Scar Poorly ☐No ☐Yes Sickle Cell disease/trait ☐No ☐Yes

CHILDHOOD ILLNESSES

☐Chicken Pox ☐Measles ☐TB
☐Rheumatic Fever ☐Rubella (German Measles)
☐Scarlet Fever ☐Mumps

All of my immunizations are up to date
☐ No ☐ Yes

ALLERGIES/ REACTIONS: I have no drug allergies. _____

Please List and indicate reaction. _____
_____
_____

PRIOR SURGERY(S) (Check only the Items that apply)

- ☐ Angioplasty
- ☐ Appendectomy
- ☐ Breast Biopsy
- ☐ Breast Surgery
- ☐ Carotid Artery
- ☐ Cataract
- ☐ Colonoscopy
- ☐ Cesarean
- ☐ D and C
- ☐ Endoscopy
- ☐ **Foot or Ankle**
- ☐ Gallbladder
- ☐ Heart Cath
- ☐ Heart Valve Replacement
- ☐ Heart Stent
- ☐ Hernia Repair
- ☐ **Hip Replacement**
- ☐ Hysterectomy
- ☐ Kidney Removal
- ☐ Kidney Stones
- ☐ **Knee Replacement**
- ☐ Mastectomy
- ☐ Neck
- ☐ Organ Transplant _____
- ☐ Prostate
- ☐ Shoulder Replacement
- ☐ Venous Ligation

Other surgery(s) please list: _____
Did you have any adverse reactions to Anesthesia or Medications before, during or after your surgery? No___ Yes___
Did you have ANY COMPLICATIONS with healing? No_____Yes _____

NAME:_____

CURRENT PRESCRIPTION MEDICATIONS

□ No prescription medications at this time ** You MAY attach a medication list to this form.

NAME OF MEDICATION & DOSAGE (Include all OTC and Herbal medications as well)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

FAMILY HISTORY

Not applicable, I am Adopted

If any of your relatives in the column below currently HAS or has PASSED AWAY from the following illnesses, please WRITE IN the correct cause of death.

Arthritis…...Cancer (Type?)…...Diabetes…...Gout…...Heart Disease….
High Blood Pressure…...Kidney Disease……Stroke…...Thyroid Problems

	Alive or Deceased?	Cause of Death? Age?
Your Mother	A / D	
Your Father	A / D	
Grandmother (Mom's)	A / D	
Grandfather (Mom's)	A / D	
Grandmother (Dad's)	A / D	
Grandfather (Dad's)	A / D	
Siblings	A / D	

SOCIAL HISTORY

Smoking □No □Yes Packs per day_____ How long?_____ Have you Quit? □No □Yes When?_____
Pipe___ Cigar___ Chew/Snuff___Vape___ Is there smoking in the house? □No □Yes

Alcohol □No □Yes # of beers / wk____ Wine # of glasses / wk _____ # of drinks / wk____
Social___ Quit___ Number of months?_____ Years____

Caffeine □No □Yes Coffee___ Tea___Energy___Pop___Other___ #Cups/day _____

Exercise □No □Yes Infrequently ___ Regularly____ Type_____

Recreational Drugs □ Never □Current Usage Type_____
Quit Date:_____ Rehab □No □Yes # of times_____

OCCUPATIONAL HISTORY

Job Title (Be specific)_____ Full-Time___ Part-Time___ Retired_____

Typical shoes worn: Steel Toe Boots? Non slip shoes? High Heels? Sneakers?

Percentage of your day that you stand / walk? 0___20___40___50___60___80___100

INJURIES/ TRAUMA

(Automobile accidents, Fracture(s) Dislocation(s) Laceration(s) Burn(s) Blunt trauma.

_____

Name _____ DOB _____

REVIEW OF SYSTEMS (You MUST circle a Y OR N)

I. General	Now	Past
Weight Change	Y / N	Y / N
Chills	Y / N	Y / N
Sleep Disorder	Y / N	Y / N
Other _____		

II. Eyes	Now	Past
Double Vision	Y / N	Y / N
Cataracts	Y / N	Y / N
Glaucoma	Y / N	Y / N
Glasses/Contacts	Y / N	Y / N
Other _____		

III. Ears/Nose/Throat	Now	Past
Hearing problems	Y / N	Y / N
Balance Problems	Y / N	Y / N
Smell Disorder	Y / N	Y / N
Sore Throat	Y / N	Y / N
Other _____		

IV. Cardiovascular	Now	Past
High Blood Pressure	Y / N	Y / N
Heart Valve Problems	Y / N	Y / N
Chest Pain	Y / N	Y / N
Irregular Beat	Y / N	Y / N
Other _____		

V. Endocrine	Now	Past
Diabetes	Y / N	Y / N
Thyroid (High or Low)	Y / N	Y / N
Too Hot/ Too Cold	Y / N	Y / N
Other _____		

VI. Blood/Lymph	Now	Past
Clotting problems	Y / N	Y / N
Bruise Easily	Y / N	Y / N
Swollen Glands	Y / N	Y / N
Transfusion	Y / N	Y / N
Other _____		

VII. Musculoskeletal	Now	Past
Bone Pain	Y / N	Y / N
Joint Pain	Y / N	Y / N
Sprain/Strain	Y / N	Y / N
Other _____		

VIII. Skin	Now	Past
Rash / Hives	Y / N	Y / N
Mole Changes	Y / N	Y / N
Skin Cancers	Y / N	Y / N
Thick Nails	Y / N	Y / N
Other _____		

IX. Kidneys	Now	Past
Prostate Problem	Y / N	Y / N
Pain with Urination	Y / N	Y / N
Night Time Urination	Y / N	Y / N
Other _____		

X. Lungs	Now	Past
Pain with breathing	Y / N	Y / N
Shortness of Breath	Y / N	Y / N
Asthma/Emphysema	Y / N	Y / N
Persistent Cough	Y / N	Y / N
Other _____		

XI. Stomach	Now	Past
Ulcer/ GERD	Y / N	Y / N
Abdominal Pain	Y / N	Y / N
Nausea/ Vomiting	Y / N	Y / N
Heartburn	Y / N	Y / N
Other _____		

XII. Circulation	Now	Past
Leg Cramps	Y / N	Y / N
Blood Clots	Y / N	Y / N
Vein Problems	Y / N	Y / N
Other _____		

XIII. Nerves	Now	Past
Seizures/ Strokes	Y / N	Y / N
Mini Strokes	Y / N	Y / N
Numbness/Tingling	Y / N	Y / N
Dizzy Spells	Y / N	Y / N
Other _____		

**** Positive ROS responses not related to the podiatric problems have been discussed with the patient. The patient has been advised to see their PCP.

I, the undersigned, understand that the above information is necessary to provide me with the best medical care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient's signature: _____ Date __/__/__

(POA, Parent, or Guardian, if applicable)