Dr. Scott T. Grodman, D.P.M., P.C. & Associates

Patient History Questionnaire

NAME_____TODAYS DATE_____

ADDRESS_____APT#_____CITY_____ZIP_____

BIRTHDATE_____ AGE_____ ARE YOU MARRIED? YES NO

PHONE:
HOME_____CELL_____

E-MAIL_____

PREFERRED METHOD OF CONTACT FOR APPOINTMENTS: PHONE CALL CELL TEXT

HOW WERE YOU REFERRED TO OUR OFFICE? _____

PRIMARY
DOCTOR_____PHONE#_____

ADDRESS_____

LAST DATE YOU WERE SEEN BY YOUR PRIMARY DOCTOR_____

DIABETICSLAST SUGAR CHECK DATE_____RESULT_____LAST A1C-_____

HEIGHT_____ **WEIGHT**_____ **SHOE SIZE**_____

WHAT FOOT PROBLEM BROUGHT YOU IN TO SEE THE DOCTOR TODAY?_____

TYPE OF PROBLEM (YOUR MOST COMMON COMPLAINT)

□ NAILS	□ DIABETIC FOOT CARE	□ FRACTURE/SPRAIN
□ CORNS/CALLOUS	□ INGROWN NAIL	□ ANKLE PAIN
□ WARTS	□ BUNIONS	□ NEUROMA/NERVE PAIN
□ CYSTS/TUMORS	□ HAMMERTOES	□ GOUT

□ OTHER_____

MEDICATIONS PLEASE LIST **ALL** MEDICATIONS YOU CURRENTLY TAKE. INSULIN, INHALER, AND PATCHES SHOULD ALL BE INCLUDED HERE:

_____
_____
_____
_____
_____
_____
_____

NAME OF PHARMACY YOU USE _____

PHONE #_____ADDRESS_____CITY_____

PAST SURGICAL HISTORY HAVE YOU EVER HAD **ANY** SURGERY BEFORE? □ YES □ NO

IF YES PLEASE LIST ALL PROCEDURES AND YEAR PERFORMED:

_____
_____
_____

ALLERGIES DO YOU HAVE ANY **ALLERGIES** TO **MEDICATIONS**? □ YES □ NO

□ PENICILLIN
□ ASPIRIN
□ CODEINE
□ SULFA DRUGS
□ TETRACYCLINE
□ ANTIHISTIMINES
□ IODINE
□ DEMEROL
□ TETNUS
□ DARVON
□ ANESTHETICS
□ NYLON/PLASTIC
□ ADHESIVES
□ LATEX PRODUCTS
□ LIDOCAINE/NOVOCAIN
□OTHER_____

SOCIAL HISTORY

ARE YOU A □ SMOKER- CIGARETTES PER DAY _____ □ VAPE/E-CIGARETTE USER

□ NON-SMOKER □ PREVIOUS SMOKER – QUIT DATE_____

DO YOU DRINK ALCOHOL? □ YES □ NO DRINKS PER WEEK_____

DO YOU TAKE/USE ANY ILLICIT DRUGS? □ YES □ NO
(marijuana (medical or otherwise), cocaine, etc.)

PLEASE CHECK ALL SYMPTOMS OR CONDITIONS THAT YOU HAVE

ENDOCRINE SYSTEM

DO YOU HAVE DIABETES? □ YES □ NO
DO YOU HAVE A THYROID DISORDER? □ YES □ NO

CARDIOVASCULAR SYSTEM

DO YOU HAVE HYPERTENSION (HIGH BLOOD PRESSURE)? □ YES □ NO
DO YOU EXPERIENCE SHORTNESS OF BREATH? □ YES □ NO
DO YOU EXPERIENCE CHEST PAIN (ANGINA)? □ YES □ NO
DO YOU HAVE PALPITATIONS (IRREGULAR HEARTBEAT)? □ YES □ NO
HAVE YOU EVER HAD A HEART ATTACK? □ YES □ NO
HAVE YOU EVER HAD A STROKE? □ YES □ NO
DO YOU EXPERIENCE COLD EXTREMITIES? (hands & feet) □ YES □ NO

NEUROLOGICAL SYSTEM

DO YOU EXPERIENCE HEADACHES? □ YES □ NO
HAVE YOU EVER FAINTED OR EXPERIENCED SYNCOPE? □ YES □ NO
DO YOU HAVE NUMBNESS? □ YES □ NO
DO YOU EXPERIENCE DIZZINESS? □ YES □ NO
DO YOU HAVE MEMORY IMPAIRMENT? □ YES □ NO
HAVE YOU BEEN DIAGNOSED WITH AUTISM? □ YES □ NO

MUSCULOSKELETAL SYSTEM

DO YOU HAVE ARTHRITIS? □ YES □ NO
DO YOU EXPERIENCE MUSCULOSKELETAL PAIN? □ YES □ NO
DO YOU HAVE LIMITED RANGE OF MOTION? □ YES □ NO
DO YOU HAVE DECREASED STRENGTH? □ YES □ NO

INTEGUMENTARY (SKIN) SYSTEM

DO YOU HAVE A RASH? □ YES □ NO
DO YOU EXPERIENCE PRURITUS (ITCHING)? □ YES □ NO
DO YOU HAVE XEROSIS (DRY SKIN)? □ YES □ NO

HEMATOLOGIC/LYMPHATIC SYSTEM

DO YOU BRUISE EASILY? □ YES □ NO
DO YOU HAVE ANEMIA? □ YES □ NO
DO YOU HAVE BLOOD ABNORMALITIES? □ YES □ NO
ARE YOU CURRENTLY TAKING BLOOD THINNING MEDICATIONS? □ YES □ NO
DO YOU HAVE LYMPHADENOPATHY (ENLARGED LYMPH NODES)? □ YES □ NO

ACCEPTANCE OF FINANCIAL RESPONSIBILITY, ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION

Due to the many changes in insurance policies, it is no longer an easy task to interpret each policy. Although we try to stay aware of these changes, it is not always possible. It is your responsibility to know your individual coverage. We urge you to please check with your insurance company to see what your policy covers for foot care. You will be responsible for ALL co-pays and deductibles not paid by your insurance. **All payments are due within 30 days. All balances carried more than 90 days will be charged a late fee of $35 and will be subject to small claims court.** If this occurs, you may be subject to additional fees. All co-pays are due at the time of service. Any remaining deductible on your insurance policy may be due at time of service. **Any account past due more than 60 days is subject to collection. Failure to call to cancel or reschedule your appointment 24 hours in advance may result in a $60 No Call No Show fee.** Any check returned for Non-Sufficient funds will be charged a $45.00 fee in addition to the amount of the check.

WE DO NOT TREAT PATIENTS WITH ANY TYPE OF INJURY CLAIM SUCH AS AUTO ACCIDENT or WORKMANS COMP., ETC…

I request that payment of authorized Medicare/Other insurance company benefits be made on my behalf to Scott T. Grodman, D.P.M., P.C. & Associates for any services provided to me by that physician or his associates. I authorize any holder of medical information to release it to the Health Care Financing Administration/Other insurance company and its agents any information needed to determine these benefits payable to related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare/Other insurance company assigned cases, the physician agrees to accept the charge determined as full payment and the patient is responsible only for the deductible, co-insurance, co-pays and non-covered services. Co-insurance, deductibles and co-pays are based upon the charge determination of Medicare/Other insurance company.

I give permission for Scott T Grodman DPM to access my pharmacy benefits data electronically through RxHub. This consent will enable Scott T Grodman DPM to**:** determine the pharmacy benefits and drug co pays for a patient's health plan, check whether a prescribed medication is covered (in formulary) under a patient's plan, display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications, determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies, download a historic list of all medications prescribed for a patient by any provider.

I authorize any holder of information concerning my treatment to release that information to the Social Security Administration and its intermediaries, insurance carriers, all HIPPA covered entities and other governmental offices if needed for this or related claim for payment. I also authorize release of information concerning care and treatment including copies of my medical records and information related claims for payment. I also authorize release of information concerning care and treatment including copies of my medical records and information relating to treatment for serious communicable diseases (as defined by the MPHC) to my health plan administrator, its agents and representatives, insurance carrier or its authorized agent for the purpose of conduction, concurrent, retrospective or medical review of treatment and services provided by Dr. Scott T. Grodman, D.P.M., P.C. & Associates. I understand that a duplicate copy of this authorization may be used and is acceptable as the original and may not be revoked unless this request is submitted in writing. I understand that if my health information needs to be released to any non-HIPPA covered entity, I will be required to sign a separate release. I understand that I have the right to my PHI and to request that any part of my medical record be amended. This request must be made in writing. I further understand that Dr. Scott T. Grodman is not obligated to make requested changes, and I may have my request reviewed by another member of his compliance team and their decision will be final. I have the right to refuse to disclose my PHI, and I must make this refusal in writing. I am aware that if I refuse consent to disclose, then Dr. Scott T. Grodman has the right to refuse treatment. I have the right to request that we restrict when and where we call you. This request must be made in writing. I understand that Dr. Scott T. Grodman is not obligated to comply with this request, but if he can't, we must give you a reason why. I understand that Dr. Scott T. Grodman will not be held responsible for what a 3rd party does with my PHI after we disclose it to them.

I hereby give permission to Dr. Scott T. Grodman, D.P.M., P.C. & Associates, to administer treatment and to perform such minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of my foot condition.

By signing I agree that I have read and understand the financial policy of this office as stated above as well as the assignment of benefits and release of information policy.

PLEASE BE ADVISED… IF YOU FAIL TO SHOW FOR 2 OR MORE SCHEDULED APPOINTMENTS, YOU MAY BE ASKED TO SEEK A NEW PODIATRIST OFFICE.

NAME PRINTED_____

SIGNATURE_____DATE_____
PATIENT

SIGNATURE_____DATE_____
GUARDIAN/GUARANTOR

By signing below, you also agree to allow the sharing of your personal/medical information/findings with ONLY the family members/spouse listed below. There is a 2-person maximum with which we will agree to share information/findings with.

AUTHORIZED PERSON (1)_____(2)_____

AUTHORIZING PATIENT SIGNATURE_____DATE_____

As you may be aware, the current healthcare market has resulted in insurance policies increasingly transferring costs to **you**, the insured. Some insurance plans require deductibles, co-insurance and copayments **in amounts not known to you or us** at the time of your visit.

Similar to hotels and car rental agencies, our corporate office requires we keep your credit or debit card on file as a convenient method of payment for the portion of services that your insurance company identifies as "Patient Responsibility". We will first bill your insurance for the services provided. Upon receipt of the explanation of benefits (EOB) statement from your insurance company, we will charge your credit card for the amount identified by the insurance company as "Patient Responsibility" .We will provide a receipt with the details of this transaction. These charges are for our services. Charges for Laboratory work (i.e. blood work or biopsy) are billed separately by the provider of those services.

This will be an advantage to you since you will no longer have to write out and mail us checks. It will be an advantage to us as well since it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everybody in helping to keep the cost of health care down. Without this authorization, if you choose to opt out of the program, a monthly billing fee of $15.00 will be added to your account for any balances that we must attempt to collect through mailing a monthly statement. Alternatively, you may pay the full amount for your visit at check out and you will be refunded any excess monies paid on your behalf by your insurance carrier.
This in no way will compromise your ability to dispute or question your insurance company's determination of payment. Office visit copays will still be collected at time of service
You MAY BE REQUIRED to put a credit card on file if we have had previous issues collecting monies from you

Sincerely,
Scott T. Grodman, D.P.M., P.C.

I authorize Scott T. Grodman, D.P.M. to charge outstanding balances on my account to my credit, debit, or HSA card identified below:

❑ Visa ❑ Mastercard ❑ Discover ❑ American Express

Cardholders Name_____

Card #_____/_____/_____/_____

Expiration Date _____CCV(3 digit code/4 if Amex) _____

Physical Address associated with this card_____ Zip_____

This authorization will remain in effect until/unless I cancel this authorization. To cancel I must give a written notification to Scott T. Grodman, D.P.M. and the patient account must be in good standing.

If you have Medicaid or a Medicaid HMO (Molina, Meridian, BC Complete, etc…) you may choose to opt out as you would only receive a bill if you came in for treatment & your insurance deems you inactive on that date.

❑ I opt out of providing credit card information and would like a statement mailed to me
($15 monthly billing fee will be applied each month we have to send you a bill)

❑ I will pay the full charge for Medical Services provided at the end of each visit.
(This includes any deductible and/or coinsurance)

Signature_____Date_____

If you do not complete/sign this form, you will be opted out & assessed the $15 monthly fee

If the credit card on file gets declined you will be assessed the $15 billing fee for each month a bill is sent