

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

TELEPHONE: HOME _____ CELL _____

E-MAIL _____ (Must disclose email to gain ability to pay bill online)

EMERGENCY CONTACT: NAME _____

PHONE _____ RELATIONSHIP _____

HOW WERE YOU REFERRED TO OUR OFFICE? (Circle how you were referred & list name where applicable)

DOCTOR (list name) PATIENT (list name) INTERNET SIGN INSURANCE I'VE BEEN HERE BEFORE

REFERRING DOCTOR (if marked above) _____

REFERRING PATIENT (if marked above) _____

PRIMARY DOCTOR _____ PHONE# _____

ADDRESS _____

LAST DATE YOU WERE SEEN BY YOUR PRIMARY DOCTOR _____

WHAT CONDITION WOULD YOU CONSIDER YOUR GENERAL OVERALL HEALTH TO BE IN?

GOOD FAIR POOR

HEIGHT _____ WEIGHT _____ SHOE SIZE _____

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

TYPE OF PROBLEM (YOUR MOST COMMON COMPLAINT)

- | | | |
|--|---|---|
| <input type="checkbox"/> NAILS | <input type="checkbox"/> DIABETIC FOOT CARE | <input type="checkbox"/> FRACTURE/SPRAIN |
| <input type="checkbox"/> CORNS/CALLOUS | <input type="checkbox"/> INGROWN NAIL | <input type="checkbox"/> ANKLE PAIN |
| <input type="checkbox"/> WARTS | <input type="checkbox"/> BUNIONS | <input type="checkbox"/> NEUROMA/NERVE PAIN |
| <input type="checkbox"/> CYSTS/TUMORS | <input type="checkbox"/> HAMMERTOES | <input type="checkbox"/> OTHER _____ |

DATE IT BEGAN _____ HOME TREATMENT/RESPONSE _____

PAST MEDICAL HISTORY DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING?

- DIABETES
- HYPERTENSION
- HEART/CIRCULATION TROUBLE
- HYPOGLYCEMIA
- BLEEDING TENDENCIES
- TUBERCULOSIS
- MITRAL VALVE PROLAPSE
- KIDNEY DISEASE
- LIVER DISEASE
- HIV/AIDS
- GLAUCOMA
- EMPHYSEMA
- ASTHMA
- ULCERS
- STROKE
- EPILEPSY
- CANCER
- TUMORS
- ANEMIA
- ARTHRITIS
- NERVOUSNESS
- THYROID DISORDER
- HEPATITIS
- VARICOSE VEINS
- LEG CRAMPS
- GOUT
- DRUG ABUSE

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

IF YES PLEASE LIST ALL PROCEDURES AND DATES: _____

ALLERGIES DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? YES NO

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

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

NAME OF **PHARMACY** YOU USE MOST OFTEN _____

PHONE # _____ ADDRESS _____ CITY _____

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 ANY ILLICIT DRUGS? (marijuana (medical or otherwise), cocaine, etc.) YES NO

DO YOU HAVE AN ADVANCED DIRECTIVE (living will) ? YES NO

YOUR RACE- *Mark all that apply* WHITE BLACK OR AFRICAN AMERICAN HISPANIC
 ASIAN ARAB ITALIAN OTHER _____ DO NOT WANT TO REPORT

REVIEW OF SYSTEMS PLEASE CHECK IF YOU CURRENTLY HAVE ANY OF THE FOLLOWING

CONSTITUTIONAL

- FEVER
- WEIGHT LOSS
- LETHARGY

EAR, NOSE, & THROAT

- TINNITIS
- NOSE BLEEDS
- SINUS CONGESTION
- SORE THROAT
- DIFFICULTY SWALLOWING

GENITOURINARY

- URINARY FREQUENCY
- BLOOD IN URINE
- ABNORMAL URINE COLOR
- PAINFUL URINATION
- AWAKEN TO URINATE
- UNABLE TO EMPTY BLADDER
- INCONTINENCE

HEMATOLOGIC/LYMPHATIC

- BRUISE EASILY
- ANEMIA
- BLOOD ABNORMALITIES
- BLOOD THINNERS
- LYMPH NODE ENLARGEMENT

EYES

- BLURRED VISION
- CATARACTS
- GLASSES

RESPIRATORY

- COUGH, CHRONIC
- COUGH, PRODUCTIVE
- COPD
- WHEEZING
- EMPHYSEMA
- ASTHMA

NEUROLOGICAL

- HEADACHE
- FAINTING
- NUMBNESS
- DIZZINESS
- MEMORY LOSS

INTEGUMENTARY

- RASH
- ITCHING
- DRY SKIN

GASTROINTESTINAL

- PAIN
- DIARRHEA
- CONSTIPATION
- CHANGE IN STOOL
- BLOOD IN STOOL
- IBS
- HEARTBURN/GERD
- LOSS OF APPETITE
- FOOD INTOLERANCE
- NAUSEA
- VOMITING

ENDOCRINE

- DIABETES
- THYROID DISORDER
- NIGHT SWEATS

CARDIOVASCULAR

- HYPERTENSION
- SHORTNESS OF BREATH
- CHEST PAIN (ANGINA)
- HEART PALPITATIONS
- HEART ATTACK
- STROKE
- COLD EXTREMITIES

MUSCULOSKELETAL

- ARTHRITIS
- PAIN
- LIMITED RANGE OF MOTION
- LIMITED STRENGTH

**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 furnished 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 MPHIC) 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 _____
P A T I E N T

SIGNATURE _____ DATE _____
G U A R D I A N / G U A R A N T O R

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 chose 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

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

****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) _____

Billing Address _____ Zip _____

This authorization will remain in effect until I cancel this authorization. To cancel I must give a 60-day written notification to Scott T. Grodman, D.P.M. and the patient account must be in good standing.

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

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 of Medical Services provided at the end of each visit.
(This includes any deductible and/or coinsurance)

Signature _____ Date _____