

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 _____

****DIABETICS**** LAST 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 | ☐ IODINE | ☐ NYLON/PLASTIC |
| ☐ ASPIRIN | ☐ DEMEROL | ☐ ADHESIVES |
| ☐ CODEINE | ☐ TETNUS | ☐ LATEX PRODUCTS |
| ☐ SULFA DRUGS | ☐ DARVON | ☐ LIDOCAINE/NOVOCAIN |
| ☐ TETRACYCLINE | ☐ ANESTHETICS | ☐ OTHER _____ |
| ☐ ANTIHISTIMINES | | |

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

HAVE YOU BEEN **DIAGNOSED** WITH DIABETES?..... ☐ YES ☐ NO
OR HAVE YOU BEEN TOLD YOU HAVE PRE-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/BONE 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 HAVE HIV/AIDS?..... ☐ YES ☐ NO
DO YOU HAVE ANEMIA OR BRUISE EASILY?.....☐ 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 MPHCC) 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 _____

PAYMENT AUTHORIZATION & BILLING AGREEMENT

Many insurance plans require patients to pay deductibles, coinsurance, copayments, or other charges that are not known at the time of service. To simplify billing, please choose only one of the options below.

OPTION 1: CREDIT/DEBIT/HSA CARD ON FILE

I authorize Scott T. Grodman, D.P.M., P.C. to keep my credit, debit, or HSA card on file and charge only the amount identified by my insurance company as Patient Responsibility after my claim has been processed.

- Insurance will be billed first.
- If needed, a receipt will be provided for all charges.
- Office visit copays remain due at the time of service.
- Laboratory, pathology, biopsy, and other outside provider charges are billed separately.
- This authorization remains in effect until canceled in writing and my account is in good standing.

Card Type: ☐ Visa ☐ Mastercard ☐ Discover ☐ American Express

Cardholder Name: _____

Card Number: _____/_____/_____/_____

Expiration Date: _____ CVV Code: _____

OPTION 2: OPT OUT OF CARD-ON-FILE

☐ I decline to keep a card on file.

I understand that:

- Any balance owed after insurance processing will be billed to me
- Payment is due within 30 days of the statement date.
- A \$15 monthly billing fee will be added for each statement, including the 1st statement, that must be mailed for an unpaid balance.

OPTION 3: PAY IN FULL AT TIME OF SERVICE

☐ I will pay the full charge for services at the end of each visit. This includes current remaining deductibles.

I understand that:

- Any overpayment will be refunded after my insurance claim is processed.
- If my insurance determines I owe additional patient responsibility, a statement will be generated at no charge and payment is due within 30 days of the statement date.
- A \$15 monthly billing fee will be added to the next statement and each subsequent monthly statements if the balance remains unpaid after 30 days.

IMPORTANT INFORMATION

- Office visit copays are due at the time of service.
- Patients with Medicaid or Medicaid HMOs (Molina, Meridian, BC Complete, etc.) may opt out of the card-on-file program but still must choose an option.
- If a card on file is declined and billing becomes necessary, the \$15 monthly billing fee will apply.
- Patients with previous collection issues will be required to keep a card on file.
- If this form is not completed and signed, you will be considered opted out of the card-on-file and will be subject to the \$15 monthly billing fee when statements are mailed.
- This agreement does not affect your right to question or dispute your insurance company's determination of benefits.

Patient Name: _____

Signature: _____ Date: _____