Grants Pass Podiatry

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Grants Pass Podiatry
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www.gppodiatry.com

WELCOME!

Welcome to Grants Pass Podiatry. We are pleased to have you as a new patient. Please feel free at any time to notify us of any way we can assist you with the medical care of your feet and ankles. When making an appointment, please try to call our office at least two weeks before you need to be seen. However, if you have an emergency, we will try to accommodate you or make sure you have an alternative for your emergency care.

If for any reason you have to cancel your appointment, please give us at least 24 hours notice. **For all appointments, please arrive 10 minutes early. If you are more than 5 minutes late past your appointment time, we will have to reschedule your appointment.** You will receive an appointment reminder by text message or phone call at least 24 hours before your appointment, and we ask that you confirm your appointment with us by phone or through our automated text message system .

BILLING PROCEDURES

MEDICARE We are participating providers with Medicare. If you have supplemental insurance, we will bill that insurer for any services Medicare does not cover. If you don't have supplemental insurance, you will be responsible for anything that is not covered.

UNINSURED PATIENTS Payment for all charges is due at the time of service. We offer a 10% discount to all uninsured patients.

INSURED PATIENTS If you have insurance, be prepared to pay at the time of service for over the counter supplies and copays that are not covered by your insurance. Insurance may pay all, some, or none of your bill. After we bill your insurance and receive their payment, you will owe the balance. We will not know what that balance will be until we receive the insurance payment. You are responsible for payment in full, regardless of your coverage.

PAPERWORK FEE Disability forms, medical records, and requested letters will incur an $18 fee which is due when you pick up the paperwork, unless the doctor waives the fee.

STATEMENTS This office utilizes electronic statement delivery via text message and email by default. **If you would prefer a paper statement and opt-out of electronic statement delivery, you must check the box below.**

☐ I want a paper statement mailed to me ☐ I want my statements sent electronically

AUTHORIZATION

I authorize my insurance benefits to be paid directly to Grants Pass Podiatry. I understand that I am financially responsible for any balance unpaid by my insurance. I understand the above information and agree to abide by these rules.

Signature _____ Date _____

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CONSENT TO USE OR DISCLOSE MEDICAL INFORMATION

Name _____ Date of Birth _____

I authorize Grants Pass Podiatry to use and disclose the health and medical information of the patient named above for the purposes of treatment, payment, and health care operations as defined below:

Treatment (includes services performed by a physician, nurse, office staff and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers our practice by telephone as the on-call physician.)

Payment (includes activities involved in determining your eligibility or health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, recertification and preauthorization.)

Healthcare Operation (includes the necessary administrative and business functions of our office.)

NOTICE OF PRIVACY PRACTICES

Please review the Notice for additional information about the uses and disclosures of information described in this consent. Copies of our complete Notice of Privacy Practices is available upon request and can also be found on our website.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Privacy Notice may change also.

As more fully explained in the Privacy Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment and health care operation purposes. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment.

RELEASE OF INFORMATION TO FAMILY AND FRIENDS

Your medical information can only be released to friends and family if you list their names and the type of information they may receive below. Please list here:

Name	Medical and/or Financial information to be released

I understand that I have the right to revoke this consent provided that I do so in writing, except to the extent that Grants Pass Podiatry has already used or disclosed the information in reliance on this consent.

ACKNOWLEDGMENT

I understand the above information and the Notice of Privacy Practices and agree to abide by it.

Patient Signature _____ Date _____

OR Signature of Legal Guardian _____ Date _____

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PATIENT REGISTRATION

Patient's Name _____ Date _____

Date of Birth _____ Gender ☐ M ☐ F Age _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

SS# _____ Email _____

Marital Status ☐ Single ☐ Married

Education ☐ High School ☐ Undergraduate ☐ Masters ☐ Doctorate Field of Study _____

Employment ☐ Employed ☐ Not employed ☐ Full-time student ☐ Part-time student ☐ Retired

Employer Name _____ Occupation _____

Employer Address _____ City _____ Work Phone _____

EMERGENCY CONTACT

Name _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

INSURANCE

Primary Insurance Company _____ Phone _____

Policy Holder _____ Patient's Relationship to Policy Holder _____

Group # _____ ID # _____ Co-pay? _____

Employer of Policy Holder _____ Employer Phone _____

Secondary Insurance Company _____ Phone _____

Policy Holder _____ Patient's Relationship to Policy Holder _____

Group # _____ ID # _____ Co-pay? _____

Employer of Policy Holder _____ Employer Phone _____

SIGNATURE

I agree that the above information is correct to the best of my knowledge, and that I have read and understand all of the Grants Pass Podiatry patient privacy and billing procedures.

Patient Signature _____ Date _____

OR Signature of Legal Guardian _____ Date _____

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PATIENT HEALTH INFORMATION

Name _____ Today's Date _____

When was your last physical examination? _____

Did you have an EKG? ☐ Y ☐ N A chest X-Ray? ☐ Y ☐ N What were the results? _____

Who is your Primary Care Physician? _____

HEALTH ISSUES

Please check the box next to any health conditions you have.

- ☐ Diabetes Type 1 or 2? _____
- ☐ High Blood Pressure
- ☐ Breathing difficulty (explain _____)
- ☐ Heart issues (explain _____)
- ☐ Hepatitis (explain _____)
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Retinopathy
- ☐ Thyroid abnormality
- ☐ Blood circulation problems
- ☐ Varicose veins
- ☐ Excessive bleeding
- ☐ Excessive bruising
- ☐ Rheumatic Fever or Scarlet Fever
- ☐ Stomach or intestinal ulcers
- ☐ Blood clots

Other major health issues: _____

SURGICAL HISTORY

List below all surgeries, broken bones, and traumatic injuries you have had.

Surgery/Injury	Approx. Date	Physician/Surgeon	Complications, if any

MEDICATIONS

List anything you are taking, including prescriptions, over-the-counter medications, and herbal/vitamin supplements.
If you have a printed or handwritten medication list, bring it with you and leave this section blank

Name	Prescribed by	For what condition?	Dose	Frequency

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Name _____ Today's Date _____

ALLERGIES

List anything you are allergic to, including medications, environmental agents, food, etc.

☐ No allergies

Allergic to:	Reaction	Allergic to:	Reaction

SOCIAL HISTORY

☐ Y ☐ N Do you live alone?

☐ Y ☐ N Do you drink alcohol? If yes, how much? _____

☐ Y ☐ N Do you drink caffeine? If yes, how much? _____

☐ Y ☐ N Do you currently smoke tobacco products?

→ If **no**, are you a former smoker? ☐ Y ☐ N

→ If **yes**, how much? _____

☐ Y ☐ N Do you use illicit drugs?

☐ Y ☐ N Do you have trouble sleeping?

☐ Y ☐ N Do you exercise regularly?

FAMILY HISTORY

Please indicate any major illnesses or health conditions affecting your immediate family members. Specify which relative has each condition.

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Name:_____ DOB:_____

Please provide your **CELL PHONE NUMBER** in order to receive **automated text reminders** for any future appointments.

Please provide your **E-mail Address** in order to have **access to our Patient Portal**, where you can **access chart notes** from your visits, **pay your bills**, **message your doctor directly**, and **receive appointment reminders**.

Thank you!