Blue Ridge Footcare and Surgery, PLC

Legal Name:_____ **Date:**____/____/____

Date of Birth (_____**)** **Race (**_____**)** **Gender (**_____**)** **Marital Status (**_____**)**

Mailing Address:_____

Physical Address:_____

Home Phone:_____ **Cell:**_____ **Work:**_____

Email:_____ **Employer:**_____

Social Security #_____ **If Patient is a Minor, Parent Name(s):**_____

Preferred Pharmacy (List Name and Location)_____

Emergency Contact:_____ **Phone:**_____

Primary Insurance Plan:_____ **Secondary Insurance:**_____

Have you seen a podiatrist before? Please list their name, if possible_____

Primary Care Doctor:_____ **Referring Physician:**_____

Is this a work related injury/ Workman's Comp Case?_____ **Date of Injury:** _____

Patient's Medical History *(Please fill out the following information as thoroughly as possible)*

Previous Surgeries:

_____

_____

_____

_____

_____

_____

Current Medications: (____ See List)*

Tobacco Usage: ____ **Currently** ___ **Former Smoker** ____ **Never A Smoker**

Alcohol Consumption: ___ **Never** ____ **Occasional** ____ **Frequently**

Family History Of: (____) Diabetes (____) Hypertension (____) Heart Disease

Time Spent On Your Feet Daily (circle): Minimal 25% 50% 75% 100%

Drug Allergies: (___) Penicillin (___)Amoxicillin (___)Bactrim (___)Keflex (___)Cipro (___) Sulfa (___) Erythromycin (___) Aleve (___) Advil (___) Aspirin (___)Iodine (___) NSAIDs (___)Codeine (___) Tape (___) Latex (___) Contrast Dye (___)Shellfish ( ) Other_____

Name:_____ **Dose:**_____ **Frequency Per Day:**_____

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Blue Ridge Footcare and Surgery, PLC

Patient Name:_____

PATIENT REPORTS A POSITIVE HISTORY OF THE FOLLOWING CONDITIONS: *Please mark in column to the left of the condition*

___AIDS/HIV	___Diabetes	___Hypotension	___Night Cramps
___Amputation(s)	___Dizziness	___Jaundice	___Numbness
___Anemia	___Epilepsy	___Joint Implants	___Organ Transplant
___Asthma	___Foot/Ankle Swelling	___Joint Pain	___Osteoarthritis
___Atrial Fibrillation	___GERD	___Joint Stiffness	___Osteoporosis
___Blood Clot(s)	___Gout	___Kidney Problem	___Pneumonia
___Bursitis	___Heart Attack	___Leg Cramps	___Rheumatoid Arthritis
___Cancer	___Heart Problems	___Liver Problems	___Shortness of Breath
___Charcot Foot	___Hepatitis	___Mitral Valve Prolapse	___Stroke
___Chest Pain	___Herpes	___Muscle Spasms	___Tendonitis
___COPD	___Hypertension	___Nerve Disorder	___Walking Leg Pain

Reason(s) for your visit: _____

Previous Treatment:_____

Onset	Course	Duration	Disability	Pain		Quality of Pain	
(__) Sudden	(__) Acute	(__) Days	(__)Limping	Mild	R or L	Dull	R or L
(__) Gradual	(__) Chronic	(__) Weeks	(__)Working	Moderate	R or L	Burning	R or L
(__)Unknown	(__) Increasing	(__) Months	(__) Recreational	Severe	R or L	Sharp	R or L
	(__)Remission	(__) Years	(__) Walking Aides	Numbness	R or L	Ache	R or L
		(__) Unknown	(__) Interference with Shoe Wear			Throbbing	R or L
						Shooting	R or L

Patient Vaccinations: Flu Shot ( ) Pneumonia Vaccine ( ) Date of Vaccination: _____

Height:_____ Weight:_____ Shoe Size:_____ BP:_____/_____ Pulse:_____

Information Below Is For Office Use Only:

History of Present Podiatric Issue/History and Physical Exam

Class Findings:

Class A- Amputation[s] ( )

Class B- Absent DP Pulse( ) PT Pulse( ) Decreased Hair Growth( )Trophic Changes( ) Thick Nails( ) Pigmentary Changes ( )

Class C- Claudication ( ) Edema ( ) Burning ( ) Cold Feet ( ) Paresthesias ( )

Updated: _____ _____ _____ _____

Consents and Releases

Name of Patient:_____

1. **Consent for Treatment**: This is to certify that I, the patient or the patient's legal representative, hereby consent to and authorize the administration and performance of all treatments and/or diagnostic services which, in judgement of _____DPM, the podiatrist, may be considered necessary or advisable including the administration of blood products or derivatives. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a results of examination, treatment, surgery, and/or diagnostic services to be performed.
2. **Permission for Release of Medical Information**: I hereby authorize Blue Ridge Footcare and Surgery, PLC to release any and all information obtained in the patient's medical record which may be requested by my insurance company or other third party payer in order to compete the processing of the patient's claim for benefits.
3. **Assignment of Benefits**: I hereby assign to Blue Ridge Footcare and Surgery, PLC to the extent necessary to satisfy the patient's outstanding indebtedness, if any, all sums payable by the patient pursuant to any health benefits policy, policy of insurance including, but not limited to: health, liability, uninsured, or underinsured motorist, workers compensation, or medical payment insurance and/or pursuants to any settlement or judgement arising out of or related to any incident which caused the patient's need for medical or surgical treatment. I understand and agree that neither Blue Ridge Footcare and Surgery, PLC, nor its physicians have any obligations to collect benefits covered by this assignment other than benefits payable by a health maintenance organization or patient responsibility amounts. **For Medicare Patients:** "I request that payment of authorized Medicare benefits be made on my behalf to Blue Ridge Footcare and Surgery, PLC for any services furnished to me by my podiatric physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services."
4. **Notice of Deemed Consent for HIV, Hepatitis B/C and Blood Testing**: I understand and acknowledge that Virginia Code 32.1-45.1 authorizes health care providers to test patients for HIV antibodies as well as Hepatitis B and C when the health care provider or any person employed by or under the direction of the health care provider is exposed to the bodily fluids of patients in a manner which may transmit blood borne pathogens. Pursuant to this law, the patient will be deemed to have consented to such testing and to have consented to the release of test results to the health care provider who may have been exposed. Positive test results will be disclosed as medically necessary for the patient's treatment or as required or permitted by law. I understand that the patient will be given an opportunity to have appropriate counseling in connection with such test results. The patient will make the provider aware per state law is they are positive for HIV, Hepatitis B or C.
5. **Use of Specimens and Tissues**: I hereby authorize Blue Ridge Footcare and Surgery, PLC to retain, photograph, preserve for scientific or teaching purposes, or dispose of at its convenience, any specimens taken from the patient's body during operation or procedure.
6. **Financial Policy**: Payment is requested at time of service, unless prior arrangements have been made. In the event that my account is turned over for collections, I agree to pay all costs related to collection, including court costs and 25% attorney fees that may ensue from collection proceedings. Any amounts that are patient responsibility will be collected at the time of service per our Office Financial Policy, which will be reviewed and signed by the patient.

Purpose of Content: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices (NPP) before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities and health care operations, of the uses and disclosures we may make of your protected health information (PHI), and of other important matters about your PHI. A copy of our notices is posted and a copy will be provided to the patient upon request. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our NPP. If we change our privacy practices, we will issue a revised NPP, which will contain the changes. Those changes may apply to any of your PHI we maintain. *You may obtain a copy of our NPP, including any revisions, by contacting: Dr. Theodore B. McKee, 111 Fairway Lane, Staunton, VA 24401 Phone# 540-885-8891 or Fax# 540-885-0016.*

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the office. Please understand that revocation of the consent will not affect any action we took in reliance on the consent before we received your revocation, and that we may decline to treat your or to continue treating you if you revoke this consent. I have had full opportunity to read and consider the contents of this consent form and the Notices of Privacy Practices. I understand that by signing this form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations. I acknowledge receipt of having received a copy of the Notice of Privacy Practices.

Patient Signature:_____ Date:_____

Witness_____ Date:_____

I grant permission to receive and discuss my protected health and financial information with this office to the following person(s)

Name:_____ Relationship:_____ POA: yes / no

☐ **By checking this box, I grant Blue Ridge Footcare and Surgery, PLC permission to leave voicemails at the telephone number provided.**

Reviewed: _____ Date:_____/_____/_____

Reviewed: _____ Date:_____/_____/_____

Reviewed: _____ Date:_____/_____/_____

Blue Ridge Footcare and Surgery, PLC

Office Policy for Doctors Appointments, Surgery, & Patient Accounts

1. Deductibles and Co-Payment

We are committed to providing exceptional podiatric care for our patients. In order to do so, we must run the financial aspects of our practice as efficiently as possible; therefore, **deductible and co-payment amounts will be collected at the time of service.** Co-payments, coinsurance, and payment for non-covered services are due the day of the appointment unless prior arrangement have been made with the billing department. For your convenience we accept cash, credit card, or check.

2. Scheduled Appointments

Our office understands that delays can happen and life is hectic; however, we must try to keep other patient's appointments with our doctors on a timely schedule. **If a patient is 20 minutes or more past their scheduled appointment time, we reserve the right to reschedule your appointment.**

3. Cancellation/ No Show Policy for Doctor's Appointment

We understand there are times when you must miss an appointment due to emergencies or obligations for work or family; however, when you do not call to cancel an appointment, you may be preventing another patient from receiving much needed treatment. **If an appointment is not cancelled with at least four hours advance notice OR you do not show for your appointment, you will be charged a $50.00 fee per visit; this *will not* be covered by your insurance company. Cancellation/ No Show Policy for Surgery:** Due to the large block of time needed for surgery, last minute cancellations can cause problems with our appointment schedule and prevent another patient from receiving treatment**. If surgery is cancelled the same day or you do not show for a surgical appointment, you will be charged a $200.00 fee**; this *will not* be covered by your insurance company.

4. Account Balances

Our office requires that patients with self-pay accounts pay for their visit in full at the time of service. Patients with a balance over **$100.00** must make payment arrangement prior to future appointments being scheduled. Please contact the billing department with any questions.

5. FMLA/ Short Term Disability Paperwork

Effective June 1, 2013 there will be a **$25.00 fee** for FMLA or Short Term Disability paperwork to be filled out. This fee is to be paid *before* paperwork is filled out.

I have had the opportunity to read and consider the contents of this office policy and guidelines. I understand, that by signing this form, I am consenting to the policies carried out by Blue Ridge Footcare and Surgery, PLC.

_____	_____	____/____/____
Print Patient Name	**Signature Patient/Guardian**	**Date**