Please Print Clearly

Riverside Podiatry Patient Demographic Form

Patient Information

Name (Last,first, Mi)			Todays Date
Street Address	City	State	Zip
Home Phone ( ) Preferred ☐		Cell Phone ( ) Preferred ☐	
SSN	Date of Birth	Gender: ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Race	Pharmacy	Pharmacy Loc:	Email Address:

Financially Responsible Party

Is patient responsible party/gaurantor? ☐ Yes ☐ No (If you are over the age of 18and not in the care of the institutionyou are the gaurantor as you are the person financially responsible for any charges you may incur during this visit)

Name	Address	
City/State/Zip	Relationship to Patient	Date Of Birth
Occupation	Employer	Email Address
Home Phone ( ) Preferred ☐		Cell Phone ( ) Preferred ☐

Emergency Contact

Name		Relationship To Patient
Home Phone ( ) Preferred ☐	Work Phone ( ) Preferred ☐	Cell Phone ( ) Preferred ☐

PCP Info

Primary Care Physician Name	Physician Phone/Fax (if known)
Physician Address	

By signing below, I acknowledge that the information I provided is correct to the best of my ability.

Patient Signature: _____ Date: ___/_____/_____

Gurantor Signature (if other than patient): _____ Date: ___/_____/_____

Please print clearly

Name:_____ **Date of Birth (MM/DD/YYYY):** _____

Why are you seeing the doctor today? _____

_____

Height:_____ **Weight:** _____ **Shoe Size:**_____

Are you currently having or have you had problems with: (CIRCLE YES)

Anemia	Yes	Foot/Leg Cramps	Yes	Rheumatic Fever	Yes
Arthritis	Yes	Gout	Yes	Scarring Tendency	Yes
Artificial Valve or Joint	Yes	Headaches	Yes	Shortness of Breath	Yes
Asthma	Yes	Heart Disease	Yes	Skin Problems	Yes
Back Problems	Yes	Hemophilia	Yes	Stomach Problems	Yes
Bleeding Disorders	Yes	Hepatitis	Yes	Stroke	Yes
Cancer	Yes	High Blood Pressure	Yes	Swelling in Ankle/Feet	Yes
Chest Pain	Yes	High Cholesterol	Yes	Thyroid Problem	Yes
Chills	Yes	Joint Pain or Sitiffness	Yes	Tired Feet	Yes
Circulatory Problems	Yes	KIdney Problems	Yes	Tubercilosis	Yes
Diabetes: T1 . T2	Yes	Liver Disease	Yes	Ulcers in foot or legs	Yes
Ear Problems	Yes	Mental Disorder	Yes	Varicose Veins	Yes
Epilepsy	Yes	Muscle Aches	Yes	Weight loss, unexplained	Yes
Fever	Yes	Radiation Treatment	Yes	Other	Yes

Social History

Do you use tobacco? ☐ No ☐ Yes Do you smoke cigarettes? ☐ No ☐ Yes: how much _____ how long _____

Previous smoker? ☐No ☐Yes: quit for _____years

Allergies:

- ☐ No Known Drug Alleriges
- ☐ Codeine
- ☐ Penicillin
- ☐ Latax
- ☐ Adesive/Tape
- ☐ Iodine
- ☐ Sulfa
- ☐ Local Anesthetic
- ☐ Other_____

Past Medical History

Surgeries/Hosptalization	**Year**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PLEASE PRINT CLEARLY

Name:_____ **Date of Birth (MM/DD/YYYY):** _____

MEDICATION SHEET

PLEASE LIST ALL OF YOUR CURRENT MEDICATIONS, THE DOSE, AND HOW MANY TIMES A DAY YOU TAKE THEM

Name of Medication	Dosage	Per Day

AUTHORIZATION FOR TREATMENT

I hereby authorize the physician(s) in charge of the care of the patient of Riverside Podaitry to administer treatment as may be deemed necessary in the diagnosis and treatment of this patient.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the physician(s) of Riverside Podiatry to disclose any or all of the information in my medical records to any person, corporation, or agency which is or may be liable for all or part of Riverside Podiatry charge or who may be responsible for determining the necessity, appropriateness, amount or other matter to the physician's treatment or charge including, but not limited to, insurance companies, health maintenance organizations, preferred provider organizations, or its intermediaries or carriers.
With this knowledge, I give my consent to the release of all information in my medical records, including my information concerning identity, **and release Riverside Podiatry,** it's agents and its employees from liability in connection with the release of the information contained therein.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment directly to my physician(s) of the medical insurance benefits otherwise payable to me for services rendered during my visit at Riverside Podiatry. I understand I am financially responsible for charges not covered by this assignment.

You agree that, to the fullest extent permitted by law, we may remit all or a portion of any credit balances or other amounts due to you from us to any of our affiliates to whom you have any balance owing for fees, items, or services. We will advise you of any payments we make on your behalf to our affiliates.

I understand a photocopy of this document is as valid as the original.

SIGNED _____ **DATE** _____

(PATIENT)

OR _____

(NEAREST RELATIVE OR RESPONSIBLE PARTY)

_____ _____

(RELATIONSHIP TO PATIENT) **(POLICYHOLDER'S SIGNATURE)**

RIVERSIDE PODIATRY

Financial Policy

Thank you for choosing Riverside Podiatry. At Riverside Podiatry we are dedicated to providing the highest quality, most cost effective care specializing in Podiatric Medicine.

In addition to accepting traditional insurance plans and Medicare we are contracted with numerous, Preferred Provider Organizations (PPO) and Health Maintenance Organizations (HMO). Because each plan is different and constantly updating providers participation status, please check with your particular plan to make sure we are currently participating in your network. It is the your responsibility to know whether your insurance requires a referral or pre-authorization for visit and treatment prior to all appointments.

Please be aware that all insurance carriers do not consider some services rendered a covered benefit.
It is important that you are aware of your insurance policy provisions of coverage.

Please note, we are not a Medicaid provider, if you have Medicaid as a primary or secondary insurance you will be responsible for any charges incurred that are not covered by another primary or secondary insurance carrier you may have.

Accurate, up to date information is the patient's responsibility; please notify our office of any changes in your insurance or personal billing information.

Please bring to each appointment your insurance card, or any other information that is required by your insurance carrier. By maintaining updated information this ensures that your medical claims are filed correctly and prevents any unnecessary delays in processing your claims.

Payment for all co-insurance, deductible, and non-covered services are due at the time of service unless special payment arrangements have been made. Payments can be made by cash, check, money order, Visa, Discover Card, American Express, or Master Card. We do have a payment plan for patients who have financial concerns. Please notify our office at 205-633-3606 to make payment arrangements.

Please be aware that charges for physical therapy, durable medical equipment, laboratory testing, anesthesia, hospital, ambulatory surgery facilities and some radiology services may be billed separately.

Again, thank you for allowing Riverside Podiatry to participate in your care.

Sincerely,

Riverside Podiatry Physician & Staff

My signature below acknowledges receipt of this Financial Policy:

Signed: _____ Date _____

(Signature of person financially responsible for payment)

Relationship, if other than patient: _____

RIVERSIDE PODIATRY
Dr.Robert Hope D.P.M.

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____