SPRINGFIELD PODIATRY
648 CHILDS AVE.
DREXEL HILL, PA 19026

ACCURATE FOOT AND DIABETIC CARE
839 LINCOLN AVE. STE. A
WEST CHESTER, PA 19380

PATIENT INFORMATION

NAME:_____ TODAYS DATE:_____

Social Security#_____ Birth Date:_____ Age_____ Sex: M / F

Address:_____ Apt#:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____ Email:_____

Marital Status:Single____ Married___ Widowed___ Divorced____ Spouse/Partner's Name:_____

Primary Language:_____ How did you hear about us?_____

*Ethnicity: Hispanic or Latino_____ Not Hispanic or Latino____ Decline to specify_____

*Race:Asian_____ American Indian or Alaska Native____ African American_____ Caucasian_____

Native Hawaiian or other Pacific Islander____ Decline to specity____ (***Goverment Mandated Information.**)

Emergency Contact:_____ Phone#_____

Employment Status:Full Time ( ) Part Time ( ) Retired ( ) Non Employed ( ) Student ( )

Primary Physician:_____ Date Last Seen:_____ Phone#_____

Pharmacy:_____ Location:_____

Employer Name:_____ Employer Phone#_____

Employer Address:_____

INSURANCE INFORMATION

Insurance:_____ Are you the Insured? Yes ( ) No ( )

Name of Insured:_____ Relation to Insured: Self( ) Spouse( ) Child( ) Other( )

Insured Birth date:_____

Medical Information

What is reason for your visit today?_____

Is it the result of a work injury or accident?_____ How long has it bothered you?_____

On a scale of 1 – 10 (1 being no pain and 10 being the worst) what is your pain level?_____

The pain quality is? Constant( ) Throbbing( ) Sharp( ) Dull( ) Shooting( ) Burning( ) Tingling( ) Numbness( )

FAMILY HISTORY

Is there any family history of these conditions?: If so, please indicate family member:

{ } Alzheimer's/Dementia _____ { } Heart Disease _____

{ } Cancer _____ { } High Blood Pressure _____

{ } Diabetes _____ { } Rheumatoid Arthritis _____

{ } Gout _____ { } Stroke _____

{ } Other (specify) _____

{ } **Please check if NO significant family history.**

ALLERGIES

{ } Please check if no known allergies

Allergy	Type of Reaction	Allergy	Type of Reaction
1. _____	_____	5. _____	_____
2. _____	_____	6. _____	_____
3. _____	_____	7. _____	_____
4. _____	_____	8. _____	_____

MEDICATIONS

Please list all medications you are currently taking including prescriptions, over the counter meds, vitamins and herbal supplements: Please attache a list if needed. { } Please check if you are taking NONE presently.

1. _____	6. _____	11. _____
2. _____	7. _____	12. _____
3. _____	8. _____	13. _____
4. _____	9. _____	14. _____
5. _____	10. _____	15. _____

HEIGHT: _____LBS

WEIGHT:_____ FT/INCHES

MEDICAL HISTORY

Please check any of the following conditions that you have now and/or have had in the past:

{ } Acid Reflux
{ } Anemia
{ } Anxiety Disorder
{ } Arrhythmia
{ } Arthritis
{ } Asthma
{ } Atrial Fibrillation
{ } Back Pain/Problems
{ } Bleeding Disorders
{ } Blood Clots/DVT
{ } Cancer: Type
{ } Cerebral Palsy
{ } COPD
{ } Congestive Heart Failure/CHF
{ } Diabetes
{ } Dementia
{ } Depression
{ } Emphysema
{ } Epilepsy/Seizures
{ } Fibromyalgia
{ } Gout
{ } Heart Attack
{ } Heart Disease
{ } Heart Murmur
{ } Heart Valve Disease
{ } Hepatitis
{ } High Blood Pressure
{ } High Cholesterol
{ } HIV
{ } Kidney Disease
{ } Liver Disease
{ } Neuropathy
{ } Pacemaker
{ } PVD/Circulation Problems
{ } Psoriasis
{ } Psychiatric Disorder/Care
{ } Pulmonary Embolism/PE
{ } Rheumatoid Arthritis
{ } Sleep Apnea
{ } Stomach Ulcers
{ } Stroke
{ } Thyroid Disease: { } Hypo { } Hyper

{ } Other not listed: _____

Are you pregnant?: { } Yes { } No

Are you nursing?: { } Yes { } No

Last Flu Shot Date: _____

Did you get the Pneumococcal Vaccination?: { } Yes { } No

Have you fallen in the last 12 months?: { } Yes { } No Is so, were you injured from the fall?: { } Yes { } No

Surgical History

Please list all prior surgical procedures:

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____
10._____

Social History

Do you smoke?: { } Never { } Former Smoker { } Current Smoker

If yes, how many packs per day _____
How long have you smoked?: _____

Do you drink alcohol?: { }No { }Yes If yes, please check: { }Social/occasional { }Weekly { }Daily

Do you or have you used drugs?: { }No { }Yes

If yes, please describe: _____

Have you ever had a past substance abuse problem?: { }No { }Yes

If yes, please describe: _____

What is your occupation?:_____

Does it involve mostly { } Standing or { } Sitting

Do you exercise regularly?: { }No { } Yes

If yes, please specify: _____

Springfield Podiatry

Accurate Foot and Diabetic Care

Full Name_____ Date_____

REVIEW OF SYSTEMS

For our new patients, established patients who may be having a new problem, or our patients who we have not seen for a while, we need to update our records as to your general medical health. In each area, **if you are not having any difficulties, please check "no problems."** If you are experiencing any of the symptoms listed, **Please Circle the Ones That Apply**, or explain any that may not be listed. If you have any questions about this, please ask one of the technicians, or your doctor.

Const. (Health in General) ☐ No problems. Lack of energy, unexplained weight gain or loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer.
Other:_____

Ears, Nose, Mouth, Throat ☐ No problems. Difficulty with hearing, sinus problems, runny nose, postnasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness.
Other:_____

C-V (HEART AND BLOOD VESSELS) ☐ No problems. Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs when walking. Other:_____

Resp. (Lungs and Breathing) ☐ No problems. Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray.
Other:_____

G.I. (Stomach and Intestines) ☐ No problems. Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence.
Other:_____

GU (Kidney & Bladder) ☐ No problems. Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence. Other:_____

MS (Muscles, Bones, Joints) ☐ No problems. Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain
Other:_____

Integ. (Skin, Hair, Breast) ☐ No problems. Persistent rash, itching skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other:_____

Neurologic (Brain and Nerves) ☐ No problems. Frequent headaches, double vision, weakness, change in sensation, problems walking or with balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss.
Other:_____

Psychiatric (Mood and Thinking) ☐ No problems. Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other:_____

Endocrinologic (Glands) ☐ No problems. Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive. Other:_____

Hematologic (Blood/Lymph) ☐ No problems. Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other_____

Allergic/Immunologic ☐ No problems. Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV
Other:_____

_____

HIPPA NOTICE OF PRIVACY

SPRINGFIELD PODIATRY, LLC

ACCURATE FOOT AND DIABRETIC CARE

This Notice Describes a Medical Information About You May Be Used and Disclosed How You Can Get Access to This Information. Please Review It Carefully.

This notice of privacy practices describes how we may use and disclose your protected health information (PHI), carry out treatment, payment or health operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present and future physical or mental health or condition and related health care services.

Uses an Disclosure of Protected Health Information: Our office staff and others outside the office that are involved in your care and treatment for the purpose of providing healthcare services to you, to your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclosure protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party. For example, we would disclosure protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: your protected health information will be used, as needed, to obtain payment for your health care service. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support business activity of your physician's practice. These activities include, but are not limited to, quality assessment, active employee review activities, training of medical students, licensing, and conducting a reading for other business activities. For example, we may disclose your protected health information to medical school students that see patients in the office. In addition, we may use a sign in sheet at the registration desk, where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you, we may also use or disclosure protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclosure protected health information in the following situations without yours authorization. Situations include: as Required by Law, Public Health Issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: FDA requirements: Legal Proceedings: Law Enforcement: Corners, Funeral Directors, and Organ Donation: Research: Criminal Activity: military activity And National Security: Workers' Compensation. Under the law, we must make disclosures to you, and required by the secretary of the Department of Health and human services to investigator determine our compliance with the requirements of sections 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization, or opportunity to object unless required by law.

You May Revoke This Authorization at Any Time in Writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Following is a statement of your rights with respect to your protected health information:

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use I, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operation. You may also request that any part of protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by all alternative means or at any alternative location. You have the right to obtain a paper copy of this notice from us, upon request even if you agree to accept this notice alternatively, i.e., Electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You have then the right to object to withdraw as provided in this notice.

Complaints

You may complain to us of the secretary of health and human services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. We required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information.

I authorize **Springfield Podiatry/Accurate Foot and Diabetic Care** to discuss my medical care and treatment with the following individuals:

Name	relationship
Name	relationship
Name	relationship

I Authorize Springfield Podiatry/ Accurate Foot and Diabetic Care to leave confidential messages on my voicemail: Yes ☐ No ☐

Your personal health record may be available to you by your submitted email address, as part of our electronic health record system. You may request this PHR, or, the office may enroll you in the PHR program as a courtesy. This includes your medication list, diagnosis history, allergies and appointment history. Your individual visit notes are not included in the system and can be requested separately subject to our office's records release policies.

This notice was published became effective on/or before **April 14, 2003**

Signed _____

Print Name _____ **Date** _____

Accurate Foot and Diabetic Care

839 Lincoln Ave Suite A

West Chester, PA 19380

610-436-5883

Springfield Podiatry, LLC.

648 Childs Ave

Drexel Hill, PA 19026

484-521-0233

PATIENT FINANCIAL POLICY *Update August 2021*

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with the front office staff. **You are going to be receiving a complete total foot and ankle evaluation**. If you receive a bill, please make sure that you have your explanation of benefits ("EOB") handy when you call the office and speak to the billing person. We cannot help you unless you have that EOB available. Please initial this area _____, to indicate that you understand your financial responsibility.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.

- Unless other arrangements have been made in advance by you or your health insurance carrier, **payments for office services are due at the time services are rendered.** We will accept Visa, MasterCard, cash or check. **If you do not pay your co-pay at the time of your visit a $10 billing fee will be added.**

- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim to your primary insurance and your secondary insurance if you are a Medicare patient. **We will not file claims for two primary insurances.** We will help you with your second primary insurance if we can. As a courtesy, we will also file your insurance claim for you if you assign the benefits to the doctor directly. In other words, you agree that, if the insurance company does not pay the practice within a reasonable period of time, it will be your responsibility to make the payment.

- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those insurers and plans with which we have an agreement and will require you to pay the co-pay and/or

coinsurance/deductible at the time office services are rendered.

- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim to the insurer for you on an unassigned basis. This means that your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time office services are rendered.

- **We try to determine if we are in the network of providers for your insurance plan. Sometimes we are told we are in the network of providers, but when we send the claim in to the insurance company we are told we are not in the network. It is your responsibility to make sure we are in your insurance network. If we are not in your insurance network, then you are fully responsible for payment based upon the explanation of benefits from the insurance company.**

- All health plans are not the same and do not cover the same services. In the event that your health plan determines that a service is "not covered", or that you do not have authorization for a service, you will be responsible for the complete charge for that service. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges for any office services rendered. Patients are encouraged to contact their plan for clarification of benefits prior to office services being rendered.

- You must inform the office of all insurance changes in plans and/or authorization/referral requirements. In the event the office is not informed of a change in your insurance and/or your authorization/referral requirements, you will be responsible for any charges that your insurer denies.

- For most services performed in the hospital, we will bill your health insurance plan. Any balance due is your responsibility.

- There are certain elective surgical procedures for which we require prepayment. You will be informed in advance if your procedure is a procedure requiring prepayment. In such a case, payment will be due one week prior to the surgery.

- **Past due accounts are subject to collections proceedings. A fee of 25% of balance due will be applied to final billing sent into collections. All costs incurred by the office, including, but not limited to, collection fees, attorneys' fees, court fees, and the monetary value of any time that the office manager and/or physicians spend going to court to collect amounts owed, shall be your responsibility in addition to the balance due to this office. Initial _____**

- **In the event that you dispute any of the charges for services rendered, and the office successfully defends against your claims, you shall be responsible not only for the balance due to this office, but also for all costs incurred by the office in defending against your claims, including, but not limited to, attorneys' fees, costs, court fees, and the monetary value of any time that the office manager and/or physicians spend going to court to defend against your claims. Initial _____**

- **There is a service fee of $25 for all returned checks. Your insurance company does not cover this fee. If a check is returned to the office you will no longer be able to use a check for payment.**

Signature of patient/responsible party: _____

Printed name of patient/responsible party: _____

Date _____