NARROWS PODIATRY, LLC NEW PATIENT INFORMATION

Name_____

Address_____

City_____State_____Zip Code_____

Home Phone_____Cell Phone_____

Work Phone_____Email Address_____

Date of Birth_____/_____/_____SSN_____-_____-_____Sex: Male or Female

INSURANCE INFORMATION

Primary Insurance Company_____

Name of Insured (policy holder)_____

Relationship to Insured (self, spouse, parent)_____

Insured Date of Birth_____/_____/_____Insured SSN_____-_____-_____

Contract or ID #_____

Group #_____Effective Date_____

Co-Pay_____Responsible Party_____

Secondary Insurance Company_____

Name of Insured (policy holder)_____

Relationship to Insured (self, spouse, parent)_____

Insured Date of Birth_____/_____/_____Insured SSN_____-_____-_____

Contract or ID #_____

Group #_____Effective Date_____

Co-Pay_____Responsible Party_____

Quality Measures & Medical History

Patient: _____ **Date:** _____ **Date of Birth:** _____

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

Primary Care Physician: _____ **Date Last Seen (Approx.)** _____

Preferred Pharmacy and location _____

Name and number of an emergency contact person _____

How did you hear about us? _____

Diabetic? Yes/No? _____**If so, do you take Insulin? Yes/No?** _____

Flu shot in the past year? Yes/No? _____**Do you take a blood thinner? Yes/No?** _____

LIST ANY KNOWN ALLERGIES:

_____

_____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? YES/NO? _____

IF YES, PLEASE LIST THEM BELOW OR PROVIDE A COPY TO THE NURSE

_____

_____

_____

_____

Social History:

Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Separated
How many children do you have? _____
Employment: ☐ Full time ☐ Part time ☐ Unemployed ☐ Retired ☐ Disabled
Do you drink alcohol? ☐ Yes ☐ No
Smoking History: ☐ Current smoker ☐ Former smoker
If current smoker, how much do you smoke per day? ☐ Less than 1 pack ☐ More than one pack

Medical History:

☐ Acne ☐ Alzheimer's ☐ Arthritis ☐ Asthma ☐ Back Pain ☐ Cancer
☐ Cardiovascular History ☐ COPD ☐ Depression/Anxiety ☐ Diabetes ☐ Blood Clots
☐ Fibromyalgia ☐ GERD ☐ Gout ☐ Headache ☐ Hepatitis ☐ Kidney Disease
☐ Liver Disease ☐ Lung Disease ☐ Multiple Sclerosis ☐ Neck Pain ☐ Neuropathy
☐ Obesity ☐ Parkinsons ☐ Seizures ☐ Sleep Apnea ☐ Stroke ☐ Thyroid Disease
☐ Urinary Infections ☐ Stomach Ulcer ☐ Anemia ☐ High Blood Pressure
☐ Heart Disease ☐ Sciatica ☐ Poor Circulation ☐ Hearing Disorders
☐ Psychiatric Disorders ☐ Dialysis ☐ Raynaud's Disease Other _____
Do you have any vascular grafts? Yes/No? _____
Do you have any joint implants? Yes/No? _____
Do you have replacement heart valves? Yes/No? _____

Family History: **Mother / Father**

Arthritis	☐ M	☐ F	Foot Problems	☐ M	☐ F
Asthma	☐ M	☐ F	Heart Attack	☐ M	☐ F
Cancer, any type	☐ M	☐ F	Heart Disease	☐ M	☐ F
Dementia-Depression-Anxiety	☐ M	☐ F	High Blood Pressure	☐ M	☐ F
Diabetes	☐ M	☐ F	High Cholesterol	☐ M	☐ F
Emphysema	☐ M	☐ F	Mental Disorders	☐ M	☐ F
Eye Disorder, cataracts, blind	☐ M	☐ F	Migraines	☐ M	☐ F
			Skin Disorders	☐ M	☐ F
			Stroke	☐ M	☐ F

Surgical History:

☐ C-Section ☐ Gall Bladder ☐ Hernia Repair ☐ Hip Replacement ☐ Hysterectomy
☐ Kidney Removal ☐ Knee Arthoscopy ☐ Knee Replacement ☐ Back Surgery
☐ Neck Surgery ☐ Shoulder Surgery ☐ Carpel Tunnel Surgery ☐ Bladder Sling
☐ Appendectomy ☐ Elbow ☐ Clavical ☐ Kidney ☐ Tubes in Ears ☐ Adnoids
☐ Tonsils ☐ Bunion ☐ Toenail ☐ Breast ☐ Fibroids ☐ Finger
☐ Hemorrhoids ☐ Oral/Dental
Other _____

If you are a new patient, what type of problem are you seeing the podiatrist for today?

_____

(For Nurse/Doctor Use Only) Blood Pressure:_____

Payment Agreement Policy and Insurance Filing Procedures

By signing this agreement to pay, you the patient agree to the following:

1. I understand that my CO-PAY / CO-INSURANCE / DEDUCTIBLE are due the day services are rendered.
2. I will pay any remaining COPAY, DEDUCTIBLE, NON COVERED SERVICES, OVER THE COUNTER PRODUCTS/SUPPLIES or BALANCE that is left after my health insurance has been exhausted within **90 days** of the balance being due to me.
3. I understand that if I have **Medicare** my annual deductible is due at the time of service and may not be billed. This is generally met within the first 3 months of the year (Jan-March), if the deductible has not yet been fully exhausted, you will be expected to pay it the day service is rendered.
4. If I cannot pay any remaining balance that is due from me "the patient" within the 90 day time frame, I will contact the billing department of Narrows Podiatry at 205-344-6550 to make payment arrangements.
5. I will follow any and all payment arrangements made by me "the patient" with the billing department. I understand that if my account is not paid within 90 days and no payment arrangements have been made with Narrows Podiatry at 205-344-6550, my account may be turned over to Franklin Collections Services for collections.
6. I understand that a fee of 40% will be added to my balance due at the time my account is turned over to Franklin Collections.
7. I understand that there will be a fee of $45.00 if any check written to this office is returned as NON-SUFFICIENT. I understand & agree that in the event of a returned check, I will be responsible for payment in full by cash or credit card. I also understand that I will also not be allowed to write checks to this office in the future.
8. I understand that it is my responsibility to report to this office any change of ADDRESS, TELEPHONE OR INSURANCE.

We will electronically file your primary insurance for you, as Dr. Stephen Stern is PMD/PPO with most insurance companies in Alabama. We will also file your secondary/Tertiary insurance for you as a courtesy. We will not file any claims to third parties, such as AFLAC, DISABILITY, LIFE INSURANCE or WORKMANS COMP companies unless we have an agreement on file with them to do so. We will honor any health insurance's fee scheduled payment that we have an agreement with. You "the patient" will only be responsible for any balance up to that fee schedule. Some insurance policies require all appointments to this office be Pre-authorized. It is essentially up to you "the patient" to notify us if any Pre-authorization or referral that is required by your insurance.

As your Podiatrist, I want to provide you with the best care possible. There may be certain services that I feel necessary for the maintenance of good health that are not covered by your insurance. You will be expected to pay for these services in full. This is always discussed during the office visit by Dr. Stephen Stern or his nurse. For example, I may need to request additional office visits or order orthotics which may be considered non-medical by your insurance company, although I consider them necessary for surgical procedures, diagnostic purposes, or other treatments. For example (orthotics, inserts, pads, arch support, surgical shoes, conformers). Most insurance companies require a medical diagnosis according to the terms of your contract with them. Let me assure you that we will only order or perform the procedures, tests or items that we feel necessary for your treatment and care. If you have any questions about your insurance, someone in our office will be happy to assist you.

I authorize the release of any medical information necessary to process and request payment of benefits to the party that accepts assignment. I also understand there is a minimum charge of $20 to request copies of my medical records.

Signature of Patient: _____ Date: _____

Witness Signature: _____ Date: _____

NARROWS PODIATRY, LLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the notice.

_____ _____

Patient Name (please print) **Date**

_____

Parent or Authorized Representative (if applicable)

_____

Signature

QUESTIONS AND COMPLAINTS

If you think that we may have violated your privacy rights, contact the person named below. You may also submit a written complaint to the U.S. Dept of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Dept of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

Contact Person:

Paula Shields

153 Narrows Pkwy, Suite 102

Birmingham, AL 35242

(205) 437-3236