New Patient Intake Packet

Patient Information

Full Name: _____

Date of Birth: _____ Sex: _____

SSN: _____

Address: _____

City/State/Zip: _____

Home Phone: _____ Cell phone: _____

Email: _____

Preferred Pharmacy: _____

Emergency Contact

Name: _____

Relationship: _____

Phone: _____

Primary Care Provider

Provider: _____

Phone: _____

Insurance Information

Primary Insurance: _____

Member ID: _____

Secondary Insurance: _____

Member ID: _____

Medical History

Check all that apply:

- ☐ Diabetes Type I / Type II
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Disease/Heart Attack
- ☐ Stroke
- ☐ Poor circulation (PAD/PVD)
- ☐ Blood Clots (DVT/PE)
- ☐ Neuropathy
- ☐ Arthritis
- ☐ Gout
- ☐ **None of the above**
- ☐ Thyroid Disease
- ☐ Osteoporosis/Osteopenia
- ☐ Kidney Disease
- ☐ Liver Disease/Hepatitis
- ☐ Cancer
- ☐ Asthma/COPD
- ☐ HIV/AIDS
- ☐ Anxiety/Depression
- ☐ Lymphedema/Chronic Leg Swelling
- ☐ Bleeding Disorder or Blood Thinner Use

Other:

_____

Do you smoke or use tobacco products? Yes / No

Do you drink alcohol? Yes / No

FEMALES: Are you pregnant? Yes / No

Allergies: ☐ **No Allergies**

_____

Current Medications and Dosages: ☐ **No Medications**

_____

_____

_____

Family History ☐ **No Family History Reported**

Mother: Diabetes High Blood Pressure Heart Disease Stroke

Other: _____

Father: Diabetes High Blood Pressure Heart Disease Stroke

Other: _____

Surgical History

Check all that apply:

- ☐ Foot/Ankle Surgery
- ☐ Knee/Hip Replacement
- ☐ Hand/Wrist/Shoulder Surgery
- ☐ Spine/Back Surgery
- ☐ Heart Surgery (CABG/Valve)
- ☐ Pacemaker/Defibrillator Placement
- ☐ Vascular Surgery/Stents/Bypass
- ☐ Carotid Surgery
- ☐ **No Prior Surgeries**
- ☐ Abdominal Surgery (Appendix, Gallbladder, Hernia)
- ☐ Hysterectomy
- ☐ C-section
- ☐ Prostate Surgery
- ☐ Cataract/Eye Surgery
- ☐ Amputation
- ☐ Organ Transplant

Other:

_____

Request For Signature On File

Below is a request to put your signature on file permanently in our office. This means that by signing below, you will not have to sign the release of medical information or release of payment directly to the doctor each time that you come into our office. By doing this, you will be helping us process your insurance claims faster and more efficiently. If you have any further questions, please ask our receptionist.

- I authorize the use of this form on all my insurance submissions.
- I authorize the release of information to all my insurance companies.
- I understand that I am responsible for my bill.
- I understand that I have an agreement with my insurance company and that it is my duty, not the physician's duty, to resolve issues of non-payment. I also understand that my insurance company may not cover medications, medical services, or medical goods that may be prescribed by my physician. Once again, issues of payment are based on an agreement between myself and my insurance company, not the physician.
- I authorize the submitting of a claim for services to my insurance company.
- I authorize payment directly to my physician.
- I permit a copy of this authorization to be used in place of the original.
- I authorize the sending of lab specimens to the laboratory.

Office Policies

- When appointments are not cancelled within 24 hours of your appointment time, you will incur a **$50.00 no show fee**.
- Refills may take up to 72 hours following a request to be processed correctly. Also, if you have not seen the physician in over one month, an appointment may be required prior to filling a script.
- You are required to have referrals completed before seeing the physician. For questions about whether a referral is necessary, please contact your insurance provider.
- If you have Medicare, routine foot care (nail and callus trimming) may not be covered. A waiver must be signed before seeing the physician. If routine foot care is not covered, payment is due at the time of service.
- Services or products which are not covered by your insurance company are to be paid at the time of service/dispensing of the product.
- The physician reserves the right to bill patients directly if his/her insurance company has not paid the physician in a timely fashion (30 days). Patients are expected to call their insurance company to resolve issues of non-payment before the service or item is re-billed.

Patient Name Printed: _____ **Date:** _____

Patient/Representative Signature: _____

HIPAA Patient Privacy Data Release & Consent Form

HIPAA, the Health Insurance Portability and Accountability Act, requires that all medical providers, insurance companies, and others put in place controls to ensure that your personal medical information and privacy data are secured. Lund Podiatry, LLC requests that each patient signs this patient privacy data release and consent form which allows us to share your personal health information (PHI) or electronic protected health information (ePHI) with other medical service providers and specialists as needed to perform your healthcare services.

Release & Assignment

I hereby authorize Lund Podiatry, LLC to release my protected health information to my insurance company, which may include my diagnosis, treatment, and demographic information. I hereby sign to the above all payments for medical services rendered to my dependent or myself. I understand that I am responsible for any amount not covered by insurance. I understand that if any unpaid balance is sent to a collective agency, I will incur a service fee. I consent to treatment of my condition as indicated by my medical history and the physician's diagnosis.

Verbal & Written Communication

Many of our patients allow family members, such as a spouse or parent, to call and request information over the phone or pick up written medical information. This information includes tests, results of procedures, and medical history. Under the requirements of HIPAA, we are not allowed to give information to anyone without a patient's written consent. This will remain in force until revoked or requested in writing by you. I authorize Lund Podiatry, LLC to release all medical information over the phone or in writing about my care to the individuals listed below (this information includes but is not limited to test results, procedure results, medical history, etc.) **If you wish to have your protected health information released to family members, you must review, fill in, and sign this form. Automatic "OPT OUT" if you do not list any individuals below; our office will not release verbal or written communication to anyone other than you, the patient.**

1. Name: _____ Relationship: _____

2. Name: _____ Relationship: _____

3. Name: _____ Relationship: _____

4. Name: _____ Relationship: _____

5. Name: _____ Relationship: _____

HIPAA Patient Privacy Data Release & Consent Form ***CONTINUED***

Preferred Mailing/Email Communication
Lund Podiatry, LLC mails/emails patients different reminders as well as hard copies of reports, per patient request. We ask that you list your current mailing address and email so that we can send you announcements and reminders when due for appointments, labs, etc. If you update your address(es) with the office verbally or in writing, it will override the below address(es) and still allow our office to mail medical information.

Mailing Address: _____

Email: _____

Preferred Phone Communication
Please list all phone numbers you prefer for all personal healthcare communications with Lund Podiatry, LLC. If the phone is transferred to voicemail, our office will leave a detailed voicemail. If you update your phone number(s) verbally or in writing, it will override the below number(s) and still allow our office to leave detailed messages. You have the right to revoke consent, in writing, except where we have already made disclosures based on your prior consent. This consent will remain in force until revoked.

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Other: _____

☐ **Check this box if you choose to "OPT OUT" from receiving detailed voicemails, documentation, or reports via phone, address, or email.**

Note: If you choose to "OPT OUT," our office will still contact you by phone leaving a general voicemail for you to contact our office and will still mail/email posts with any office updates.

Receipt & Acknowledgement
By signing and dating below, you acknowledge receipt of Lund Podiatry, LLC and HIPAA Patient Privacy Data Release & Consent Form and have reviewed these practices and procedures and understand them. It is your right to request a hard copy from Lund Podiatry, LLC.

Patient Name Printed: _____ **Date:** _____

Patient/Representative Signature: _____