Sole Solutions Podiatry, LTD

Patient Information

Name: _____
Last First Middle

Address: _____
Street City State Zip

Home#:_____ **Work#:**_____ **Mobile#:** _____

Preferred Contact Phone#:_____**E-mail:** _____

Age:_____ **DOB**:_____/_____/_____ **SS#:**_____-_____-_____ **Sex:** □M □F

Lives Alone: □Yes □No

Primary Physician:_____ **Phone#:**_____ **Last Visit:**_____

Pharmacy:_____ **Phone#:**_____ **Fax:** _____

Marital Status: □Single □Married □Divorced □Widowed □Separated **Occupation:** _____

Spouse's Name:_____ **Spouse's Preferred Phone#:**_____

Emergency Contact: _____
Name Phone Relationship

If under age 18, guardian's name:_____**Guardian's address** (if different)**:**_____

_____

PRIMARY INSURANCE:_____**Member ID/Policy#:**_____

Group #:_____**Insurance Phone#:**_____**Insured:**_____
SS# of

Insured's Name:_____**Insured:**_____/_____/_____
DOB of
Last First Middle

Insured's Address:_ _____
Street City State Zip

SECONDARY INSURANCE:_____**Member ID/Policy#:**_____

Group #:_____**Insurance Phone#:** _____

Sole Solutions Podiatry
2025 E State St Hermitage, PA 16148
Phone: 724-981-4681 Fax: 724-981-4681
Email: info@solesolutionspodiatry.com

CREDIT CARD AUTHORIZATION FORM

Patient Information:
Name: _____
DOB: _____
Phone: _____
Email: _____

Credit Card Information:
Cardholder Name (as it appears on card): _____
Card Type: [ ] Visa [ ] MasterCard [ ] American Express [ ] Discover
Card Number: _____
Expiration Date: _____ CVV: _____
Billing Address (if different from above): _____
City/State/ZIP: _____

Authorization & Consent:
By signing below, I authorize **Sole Solutions Podiatry** to charge the above credit card for medical services rendered, including any overdue co-pays, deductibles, and other charges related to my treatment. I agree that this authorization remains in effect until canceled in writing by me. I understand that I will be notified before any charges are made.

Signature of Cardholder: _____
Date: _____

For Office Use Only:
Processed by: _____ Date: _____

Medical History

Patient Name:_____DOB:_____

Height:_____Weight:_____Shoe Size:_____

Past Medical History: (check all that apply)

AIDS/HIV □Yes □No
Ear/Nose/throat Problems □Yes □No
Anemia □Yes □No
Arthritis □Yes □No
Headaches □Yes □No
Heart Disease □Yes □No
Bleeding Disorder □Yes □No
High Blood Pressure □Yes □No
Kidney Disease □Yes □No
Stomach ulcer □Yes □No
Circulatory Problems □Yes □No

Diabetes □Yes □No
Peripheral arterial dis. □Yes □No
Eye Problems □Yes □No
Gout □Yes □No
Respiratory dis. □Yes □No
Neurological Disease □Yes □No
Hepatitis/Jaundice □Yes □No
Sickle Cell Anemia □Yes □No
Thyroid issues □Yes □No
Low Blood Pressure □Yes □No
High Cholesterol □Yes □No

Osteoporosis □Yes □No
Alzheimers/dementia □Yes □No
Psychiatric disorder □Yes □No
Artificial Joint □Yes □No
Asthma □Yes □No
Back Problems □Yes □No
Blood Clots □Yes □No
Cancer □Yes □No
Liver Disease □Yes □No
Stroke □Yes □No

Any other relevant medical information?_____

_____

_____

Previous Surgeries/Hospitalizations: (check all that apply)

		Year			Year			Year
Appendectomy	□Yes □No	_____	Back Surgery	□Yes □No	_____	Tooth Extraction	□Yes □No	_____
Knee Replacement	□Yes □No	_____	Hip Replacement	□Yes □No	_____	Hysterectomy	□Yes □No	_____
C-section	□Yes □No	_____	Foot surgery	□Yes □No	_____	Hernia repair	□Yes □No	_____
Cataract Removal	□Yes □No	_____	Plastic Surgery	□Yes □No	_____		□Yes □No	_____

No past surgeries □ check here

Other surgeries not listed _____

Medications: (please list all medication you currently take) if you have a list, please provide a copy

1. _____
2. _____
3. _____
4. _____
5. _____

Allergies: □ No Known Drug Allergies

Adhesive Tape	□Yes □No	Local Anesthetic	□Yes □No	Sulfa	□Yes □No	Penicillin	□Yes □No
Iodine	□Yes □No	Latex	□Yes □No	Seafood	□Yes □No	Codeine	□Yes □No

Other allergies not listed_____

Social History:

Use of Alcohol: □ Never □ Rarely □ Moderate □ Daily How Long? _____
Use of Tobacco: □ Never □ Quit, date_____□ Currently, Packs a day?_____Years_____
Chewing Tobacco: □ Never □ Quit, date_____□ Currently, Packs a day?_____Years _____
Illicit Drug Use: □Yes □No
Currently Pregnant:□Yes □No Number of Child Births _____

Family History (list medical history of immediate family)**:**

Diabetes	□Yes □No	Osteoporosis	□Yes □No	Alzheimers/dementia	□Yes □No
Anemia	□Yes □No	Arthritis	□Yes □No	Gout	□Yes □No
Asthma	□Yes □No	Heart Disease	□Yes □No	Bleeding Disorder	□Yes □No
High Blood Pressure	□Yes □No	Sickle Cell Anemia	□Yes □No	Cancer	□Yes □No
Kidney Disease	□Yes □No	Liver Disease	□Yes □No	Stomach ulcer	□Yes □No
Low Blood Pressure	□Yes □No	Stroke	□Yes □No	Circulatory Problems	□Yes □No

Sole Solutions Podiatry, LTD

ASSIGNMENT AND RELEASE/CONSENT

I, the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to Sole Solutions Podiatry, LTD all medical and surgical benefits, if any, otherwise payable to me for services rendered. I hereby authorize the release of all medical information necessary for the processing of insurance. I understand that I am financially responsible for copayments and any charges not paid by insurance. Copies of this agreement are to be considered valid as an original signature. This policy remains in effect unless revoked by me in writing.

*_____

I certify that the information on these forms is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures as deemed necessary in the diagnosis and/or treatments of my podiatric ailments.

*_____

I permit Sole Solutions Podiatry to access any medical records via the Sharon Regional, UPMC Horizon and Edgewood Surgical Center Electronic Systems to aid in my treatment and processing of my insurance claim/billing.

*_____

MEDICAL HISTORY ATTESTATION

To the best of my knowledge, my medical history on this form is complete and the questions have been accurately answered. It is my responsibility to inform the doctor's office of any changes in my medical history, including but not limited to allergies, past medical history, medications, etc.

*_____

Signature of Patient/Parent or Guardian Date

Sole Solutions Podiatry, LTD

Office Policy

(Effective November 1, 2019)

1. Payment for services is required in full at the time services are rendered. This includes co-pays, deductibles, non-covered services, co-insurances, and any services/additional fees deemed not payable by your insurance company. We will bill your insurance company for services performed; you will be responsible for the remaining difference. Payment arrangements are available upon request and with prior approval by our office. The following company will process all insurance claims/billing on behalf of Sole Solutions Podiatry:

   South Bay Billing
   (877) 278-1999
2. If your insurance company requires a referral or authorization to see Sole Solutions Podiatry, you must obtain the referral/authorization prior to the visit or you will be financially responsible for the services provided.
3. Any patient under the age of 18, must be accompanied by a parent, guardian or legal representative.
4. Copies of your medical records are available upon request. A minimum of two weeks notice is required and a fee may be associated with the compiling and copying of your file up to $50.00. This fee is based on the amount of records requested and is at the discretion of management.
5. It is your responsibility to provide us with your correct insurance information. If it is determined that you did not present the correct insurance identification card at the time of service, you will be responsible for the charges incurred if denied by your insurance company.
6. If your treatment involves other entities such as hospitals, laboratories, rehabilitation facilities, etc., you will be billed separately.
7. There will be a $35.00 fee for a returned check issued to Sole Solutions Podiatry, LTD.
8. A $25 No Show / Cancellation Fee will be applied for the patient that does not reschedule or cancel the appointment with a 24 hour notice.
9. You may be discharged from the practice after 3 no show/no call or 5 consistent cancellations of scheduled appointments.
10. A $50 fee may be assessed for the completion of any disability forms, personal credit life insurance forms, attending physician statements, letters of medical necessity or other miscellaneous forms. Must allow up to 2 weeks for processing.
11. **Opioids/narcotics are only prescribed for a short period of time for patients who have conditions of an acute fracture or post-surgery scheduled from this office. If there is a need for more, you will be referred to pain management. If you are currently being treated by a pain management clinic, this will need to be disclosed to our office and you will need to discuss any further pain management with your pain management team.**

Patient Authorization

I certify that I have insurance with the company(ies) disclosed and assign directly to Sole Solutions Podiatry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all charges whether or not they are paid by my insurance. I authorize the use of my signature on all insurance claims.

Insurance Authorization

I request that payment of authorized insurance benefits be made either to me or my behalf to Sole Solutions Podiatry for all services.

CONSENT TO TREAT

I authorize Sole Solutions Podiatry to render services to myself at any of the following locations: UPMC Horizon, Sharon Regional, Edgewood Surgical center, Wound Care Center / Nursing Home / Office or Home. My signature signifies that I have read and fully understand this Financial Policy and agree to abide by all its terms.

*

Signature of Patient/Parent or Guardian Date

***** NO ALTERATIONS TO THIS POLICY MADE BY PATIENTS OR GUARDIANS WILL BE ACCEPTED*****

Sole Solutions Podiatry, LTD

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(Effective November 1st, 2019)

Your health information is confidential and protected by Sole Solutions Podiatry. We may need to use your protected health information to carry out treatment, payment, healthcare operations and/or other purposes (referrals, continuation of care, etc.). Our Notice of Privacy Practices provides a more complete description of permitted uses and disclosures.

***Patient Name**: _____ Date of Birth: _____ /_____ /_____
(please print)

Name and relationship of authorized representative (if applicable):

Name: _____ **Relationship**:_____
(Please Print) (Please Print)

I acknowledge I was provided a copy of the Notice of Privacy Practice and I have read (or had the opportunity to read) and I understood the Notice.

I understand this practice serves the right to change the terms of the Notice of Privacy Practices and to make changes regarding all protected health information controlled by this practice. If changes to the policy occur, the practice will provide me with a revised Notice of Privacy Practices upon request.

***Signature**_____ ***Date**:_____

Sole Solutions Podiatry, LTD

Doctor of Podiatric Medicine, Fellow of the American College of Podiatric Medicine
2025 E. State St. Hermitage, PA 16148 P: 724-981-4681 F: 724-981-6681

Medical Information Release Form

(HIPAA Release Form)

***Name**: _____ ***Date of Birth**: _____/____/_____

Release of Information: (please check below)

[ ] I authorize the release of information including the diagnosis, records;

Examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ]Child(ren)_____

[ ] PCP_____

[ ] Other_____

[ ] Information is not to be released to anyone.

*This ***Release of Information*** will remain in effect until terminated by me in writing.*

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*) _____ between (*time*) _____

*Signed: _____ *Date: ____/____/_____

Staff Witness:_____ Date: ___/____/_____

APPOINTMENT CANCELLATION/LATE ARRIVALS/NO SHOW POLICY

Thank you for trusting your podiatric medical care to Sole Solutions Podiatry. When you schedule an appointment with us, we set aside enough time to provide you with the highest quality care. If you need to cancel or reschedule an appointment, we would appreciate the courtesy of a call to our office as soon as possible, no later than 24 hours prior to your scheduled appointment. Failure to do so may prevent another patient from getting much needed treatment. Please refer to our Appointment Cancellation/Late Arrival and No Show Policy outlined here:

- Effective January 1st, 2023, any established patient who fails to show or cancels/reschedules an appointment that has **not contacted our office within 24 hours** of said appointment, will be considered a **No Show and charged a ($25.00) fee.**
- Any established patient who fails to show or cancels/reschedules an appointment without a 24 hour notice a **second time, will be charged a ($50.00) fee**.
- If a **third No Show** or cancellation/reschedule without a 24 hour notice should occur, **the patient may be discharged from Sole Solutions Podiatry.**
- **Any new patient who fails to show for their initial visit will not be rescheduled.**
- The fee is charged to the patient, not the insurance company, and is the sole responsibility of the patient. **This fee must be paid before another appointment can be made.**
- As a courtesy, we make personal reminder calls in addition to the automated reminders for appointments. If you do not receive a reminder call or text message for any reason, the above Policy will remain in effect.
- We understand that delays can happen, however, we must respect the time of other patients and doctors. If you are running late, please notify the office. If a patient is 20 minutes past their appointment time, we may reschedule your appointment.

We understand there may be times when an unforeseen emergency occurs including obligations for work or family that may prevent you from keeping your scheduled appointment. In the event of an actual emergency where prior notice could not be given, consideration will be given and a one-time exception may be granted.

You can reach our office 24 hours a day, 7 days a week at 724-981-4681.

If you call after regular business hours (Monday through Friday, or over the weekend), please leave a detailed message along with your phone number and we will call you back as soon as possible.

I have read and understood Sole Solutions Podiatry's Appointment Cancellation/Late arrival/No show policy and agree to its terms.

_____. _____.

Patient Name Date of Birth

_____. _____.

Signature of Patient/Parent or Guardian Date