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#:**_____ **SS# of Insured:**_____

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

Insured's Address:_____
Street City State Zip

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

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

WORKER'S COMPENSATION Insurance Company:_____ **Claim #:**_____

Mailing Address:_____ **Phone#:**_____

Date of Accident:_____ **Agent's Name:**_____ **Agent's Phone #:**_____

Name of Employer:_____ **Supervisor's Name/Phone:**_____

Brief Description of Accident:_____

Medical History

Patient Name:_____DOB:
Height:_____Weight:_____Shoe Size:

Past Medical History: (check all that apply)

AIDS/HIV	□Yes □No	Diabetes	□Yes □No	Osteoporosis	□Yes □No
Ear/Nose/throat Problems	□Yes □No	Peripheral arterial dis.	□Yes □No	Alzheimers/dementia	□Yes □No
Anemia	□Yes □No	Eye Problems	□Yes □No	Psychiatric disorder	□Yes □No
Arthritis	□Yes □No	Gout	□Yes □No	Artificial Joint	□Yes □No
Headaches	□Yes □No	Respiratory dis.	□Yes □No	Asthma	□Yes □No
Heart Disease	□Yes □No	Neurological Disease	□Yes □No	Back Problems	□Yes □No
Bleeding Disorder	□Yes □No	Hepatitis/Jaundice	□Yes □No	Blood Clots	□Yes □No
High Blood Pressure	□Yes □No	Sickle Cell Anemia	□Yes □No	Cancer	□Yes □No
Kidney Disease	□Yes □No	Thyroid issues	□Yes □No	Liver Disease	□Yes □No
Stomach ulcer	□Yes □No	Low Blood Pressure	□Yes □No	Stroke	□Yes □No
Circulatory Problems	□Yes □No	High Cholesterol	□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. _____

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 all charges whether or 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. To keep medical care and billing costs down, 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 for Sole Solutions Podiatry:

   2025 E. State St.

   Hermitage, PA 16148
2. If it is required by your insurance company to have a referral or authorization to see Sole Solutions Podiatry you must obtain the referral/authorization prior to the visit or you will be financial responsible for the services provided.
3. For a patient under the age of 18, a parent, guardian or legal representative must accompany the patient during each service and will be responsible for all payments incurred.
4. Copies of your medical record are available upon request in writing. A minimum of two weeks is required to receive copies of your medical records. A $50.00 fee will be associated with the compiling and coping of your file.
5. 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 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. 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.
10. You may be discharged from the practice after 3 no show/no call or 5 consistent cancellations of scheduled appointments.
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/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 a revised Notice of Privacy Practices upon request.

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

Sole Solutions Podiatry, LTD

Doctor of Podiatric Medicine, Associate of the American College of Foot and Ankle Surgeons
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) _____

[ ] 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: ___/____/_____