



# WOUND & LIMB PRESERVATION CENTER

Date \_\_\_\_\_

Patient \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex:  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Marital Status:  Single  Married  Widowed  
 Separated  Divorced

Patient SS# \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Phone \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Occupation \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Subscriber Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature \_\_\_\_\_

Relationship \_\_\_\_\_ Date \_\_\_\_\_

### MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. \_\_\_\_\_ for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

\_\_\_\_\_ Work \_\_\_\_\_ Ext \_\_\_\_\_

Best time and place to reach you \_\_\_\_\_

### IN CASE OF EMERGENCY, CONTACT:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints.)

\_\_\_\_\_

\_\_\_\_\_

Have you ever been to a Podiatrist before?  Yes  No

If yes, please list.

Name \_\_\_\_\_

Is there any personal or family history of diabetes?  Yes  No

Your occupation \_\_\_\_\_

Cigarette/Tobacco use \_\_\_\_\_

Years smoked \_\_\_\_\_

Athletic activities in which you participate (please list and indicate frequency)

Please indicate which foot problems you now have or have had in the past.

Ankle Pain  Yes  No

Athlete's Foot  Yes  No

Bunions  Yes  No

Corns and Calluses  Yes  No

Cramps or Numbness in Feet or Legs  Yes  No

Flat Feet  Yes

Foot or Leg Cramps  Yes

Heel Pain  Yes

Ingrown Toenails  Yes

Plantar Warts  Yes

Swelling in Ankles or Feet  Yes

Tired Feet  Yes



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Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- |                                   |                              |                             |                       |                              |                             |                          |                              |                             |
|-----------------------------------|------------------------------|-----------------------------|-----------------------|------------------------------|-----------------------------|--------------------------|------------------------------|-----------------------------|
| AIDS/HIV                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Diabetes              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Psychiatric Care         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Allergies to Anesthetics          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ear Problems          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Radiation Treatment      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Allergies to Medicine or Drugs    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Epilepsy              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rash                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anemia                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Eye Problems          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Respiratory Disease      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Angina                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Fainting              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rheumatic Fever          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Arthritis                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Foot or Leg Cramps    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Shortness of Breath      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Artificial Heart Valves or Joints | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Gout                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sinus Problems           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Headaches             | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Special Diet             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Back Problems                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Disease         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stroke                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bleeding Disorders                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hemophilia            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Swelling in Ankles, Feet | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hepatitis or Jaundice | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Swollen Neck Glands      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chemical Dependency               | <input type="checkbox"/> Yes | <input type="checkbox"/> No | High Blood Pressure   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tired Feet               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chest Pain                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney Problems       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tuberculosis             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chronic Diarrhea                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Liver Disease         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ulcers                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Circulatory Problems              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Low Blood Pressure    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Varicose Veins           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|                                   |                              |                             | Nervous Problems      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Venereal Disease         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|                                   |                              |                             | Phlebitis             | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Weight Loss, unexplained | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Surgeries you have had \_\_\_\_\_

Hospitalization other than for the surgeries listed \_\_\_\_\_

Family physician \_\_\_\_\_ Last visit date \_\_\_\_\_

Are you now, or have you been, under any other doctor's care for any reason over the past two years?  Yes  No

If yes, please explain \_\_\_\_\_

Include prescriptions, over-the-counter medications and vitamins \_\_\_\_\_

Pharmacy Name(s) \_\_\_\_\_

Pharmacy Phone(s) \_\_\_\_\_

Do you take oral contraceptives?  Yes  No

- Adhesive/Tape
- Anticoagulant Therapy
- Aspirin
- Codeine
- Demerol
- Iodine
- Local Anesthetics
- Novocaine
- Penicillin
- Seafoods
- Sulfa

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

## Patient Intake Form

<b>Medications</b>			
List all known prescriptions, over the counters, herbals, and vitamin/mineral/dietary (nutritional) supplements. <i>Attach list if more room is needed.</i>			
Medication	Dose	Frequency	Prescribed By

<b>Surgeries/Hospitalizations</b>	
Type of Surgery / Hospitalization	Date

**Medical Information**

How would you rate your overall health?  Excellent  Good  Fair  Poor

List any vaccines you've had in the last year:

Allergies:

Have you experienced any of these symptoms recently? (Check all that apply)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Chest Pain                      | <input type="checkbox"/> Dizziness                           | <input type="checkbox"/> Fever/Chills/Sweats          |
| <input type="checkbox"/> Pain with Meals                 | <input type="checkbox"/> Vision Changes                      | <input type="checkbox"/> Difficulty Speaking          |
| <input type="checkbox"/> Nausea/Vomiting                 | <input type="checkbox"/> Memory Problems                     | <input type="checkbox"/> Numbness/Tingling            |
| <input type="checkbox"/> Poor Balance/Falls              | <input type="checkbox"/> Unusual Weakness                    | <input type="checkbox"/> Change in Appetite           |
| <input type="checkbox"/> Difficulty Swallowing           | <input type="checkbox"/> Shortness of Breath                 | <input type="checkbox"/> Confusion/Brain Fog          |
| <input type="checkbox"/> Unusual Pain<br>w/Menstruation  | <input type="checkbox"/> Change in Bowel<br>Habits/Control   | <input type="checkbox"/> Increased Pain at Night/Rest |
| <input type="checkbox"/> Unexplained Weight<br>Gain/Loss | <input type="checkbox"/> Change in Bladder<br>Habits/Control | <input type="checkbox"/> Other:                       |
| <input type="checkbox"/> Self-Injury                     | <input type="checkbox"/> Suicidal Ideation                   |   |

**Women's Health History**

Pregnancy Complications:

Date of Last Menstrual Cycle:

Possibly Pregnant:  Yes  No

Number of Pregnancies:

Number of Live Births:

Age of Menopause:

**Lifestyle**

**Tobacco Use:**  Yes  No

If yes, packs per day:

Number of Years:

Have you ever stopped?  Yes  No

If so, for how long?

**Alcohol Use:**  Yes  No

If yes, drinks per day/week:

Beer  Wine  Liquor

Have you been told you're drinking is a concern?

Yes  No

**Drug Use:**  Yes  No

Marijuana:  Yes  No

Ever used needles:  Yes  No

Notes:

**Diet:**  Balanced  Vegetarian  Diabetic  Low Carb  Low Fat  Low Salt

How would you rate your diet?  Good  Fair  Poor

Would you like nutritional advice?

Yes

No

**Exercise:** Do you exercise regularly?

What kind of exercise?

Yes  No

Duration:

Frequency:

**Sleep:** How many hours, on average do you sleep a night?

Trouble falling asleep?  Yes  No

Trouble staying asleep?  Yes  No

Additional information or concerns you would like to address with us:

By my signature below, I certify that the information I have provided above is complete, accurate and truthful to the best of my knowledge.

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Date

## OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require that you read and sign prior to any treatment.

All patients must complete our Information and Insurance form before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE  
WE ACCEPT CASH, CHECKS, AND CREDIT CARDS  
WE OFFER AN EXTENDED PAYMENT PLAN

**Regarding Insurance** – We may accept insurance benefits on your first visit after verification of benefits. However, we require 20% of the bill paid at the time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you bring all insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event that we do accept assignment of benefits, we require that you be pre-approved on our extended payment plan. If your insurance company has not paid your account in full within 45 days, the balance will automatically transferred to your extended payment plan. Please be aware some of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance.

**Adult and Minor Patients** – Adult patients are responsible for full payment at time of service. The parents or guardians are responsible for full payment of a minor. For unaccompanied minors, non-emergency treatment will be declined unless charges have been pre-authorized to an approved credit plan, credit card, payment by cash or check at time of service.

**Missed Appointments** – Please cancel at least 24 hours in advance. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. I have read the Financial Policy. Please let us know if you have any questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy.

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Co-Responsible Party

\_\_\_\_\_  
Date



# Consent to Treat & Release of Medical Records

## Authorization for Treatment

I \_\_\_\_\_ the undersigned, hereby provide my informed consent to receive medical treatment and services from WOUND & LIMB PRESERVATION CENTER , hereinafter referred to as "the Provider." I understand that this consent encompasses any and all medical treatments, procedures, and services that the Provider deems necessary or advisable for my health and well-being.

- Nature of Treatment: I understand that the Provider will offer me appropriate medical treatment and services to address my health condition(s) to the best of their abilities. The specific treatments and services will be determined based on the diagnosis and assessment by the Provider.
- Risks and Benefits: I have been provided with information regarding the potential risks, benefits, and alternatives associated with the proposed treatments and services. I understand that the Provider has answered my questions and addressed my concerns to my satisfaction.
- Consent for Medical Records: I authorize the Provider to obtain and release my medical records as necessary for the continuation of my care and treatment, in accordance with applicable laws and regulations.
- Right to Refuse Treatment: I understand that I have the right to refuse any treatment or service recommended by the Provider. I acknowledge that by refusing recommended treatment, I may jeopardize my health.
- Privacy and Confidentiality: I understand that my medical information will be treated confidentially and in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable laws and regulations.
- Payment Responsibility: I agree to be responsible for payment for the medical services rendered to me by the Provider, including any services not covered by insurance. I understand that I may request an estimate of charges before any non-emergency treatment.
- Advance Directives: I have been informed of my right to create advance directives, such as a living will or durable power of attorney for healthcare, and the Provider's policy regarding such directives.
- Telemedicine: I understand that telemedicine services may be provided, and I consent to receive medical care through telemedicine if the Provider deems it appropriate.
- Minors and Dependents: For patients under 18 years of age or dependent adults, I represent that I have the legal authority to provide consent for their treatment. The undersigned warrants and represents that attached hereto are originals or certified copies of any applicable powers of attorney, health care surrogate forms or court orders appointing the undersigned as the legal guardian of the patient.



## Release of Information

This authorization, or copy of the same, authorizes the release to the Provider of any medical information necessary for treatment and/or to process claims for services rendered by the Provider. The patient or authorized patient representative agrees to execute any documents and perform any acts that Provider may reasonably request with regards to services.

## Term

This patient consent and authorization given to the Provider as set forth above will remain in full force and effect per episode of care until terminated in writing by patient or authorized patient representative. This termination will not be effective until the facility receives this request writing.

I have had the opportunity to ask questions and clarify any concerns related to my treatment. I understand the information provided to me, and I freely and voluntarily consent to the proposed medical treatment and services.

## Patient Consent:

\_\_\_\_\_  
Signature of Patient or Patient's Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Representative's Relationship to Patient