Eric J Plumley DPM
38 North Breiel Blvd.
Middletown, OH 45042

Today's Date _____

PATIENT INFORMATION

First Name _____ Last _____ _____ Middle Initial _____

Address _____ City _____ State _____ Zip _____

Home Phone (_____)_____ Cell Phone (_____)_____ SS#_____

Employer _____ Occupation _____ Work Phone (_____) _____

Date of Birth _____ Age _____ Height _____ Weight _____ Shoe Size _____

Marital Status _____ Spouse Name _____ # of Children _____

How did you hear about us? _____ Email_____

Whom may we contact in case of an emergency? _____ Phone (_____)_____

INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance Company _____ (Please present insurance card to the receptionist)

Subscriber's First Name _____ Last _____ Middle Initial _____

Subscriber's Relationship to Patient _____

Subscriber's ID# _____ Subscriber's Date of Birth _____

Subscriber's Employer _____

Does your insurance plan require a copay? ☐ Yes ☐ No **Co-Pay Amount $** _____

Does your insurance plan require a referral from your Primary Care Physician? ☐ Yes ☐ No

SECONDARY INSURANCE

Insurance Company _____ (Please present insurance card to the receptionist)

Subscriber's First Name _____ Last _____ Middle Initial _____

Subscriber's Relationship to Patient _____

Subscriber's SS# _____ Subscriber's Date of Birth _____

Subscriber's Employer _____

Does your insurance plan require a copay? ☐ Yes ☐ No **Co-Pay Amount $** _____

PATIENT NAME_____ Date_____

REASON FOR VISIT TODAY _____

_____

Current Health/Medical Conditions:

_____

ALLERGIES - Have you ever had any adverse side effects or allergies to:

- ☐ Penicillin
- ☐ Codeine
- ☐ Latex
- ☐ Other _____
- ☐ Local Anesthesia
- ☐ Iodine
- ☐ Metal/Jewelry
- ☐ Adhesive Tape
- ☐ No known Allergies

Do you smoke?

- ☐ No
- ☐ Yes How long _____ Packs per day ____
- ☐ Quit When _____ How long _____ Packs per day ____

Do you drink alcohol?

- ☐ No
- ☐ Yes How many drinks per week _____
- ☐ Quit When _____

***MEDICATIONS AND *DOSAGE** (you may provide us with a list to copy)

_____

_____

Previous Surgeries and Dates _____

_____

Have you ever had a problem with any of the following:

- ☐ Recent Fever
- ☐ Weight Change
- ☐ Eyes
- ☐ Ears
- ☐ Nose
- ☐ Throat
- ☐ Heart
- ☐ Circulation
- ☐ Blood Pressure
- ☐ Arthritis
- ☐ Gout
- ☐ Cancer
- ☐ Skin Ulcers
- ☐ Rashes
- ☐ Back Pain
- ☐ Hip Pain
- ☐ Knee Pain
- ☐ Other _____
- ☐ Diabetes
- ☐ Thyroid
- ☐ Steroid Use
- ☐ Psychiatric Disorders
- ☐ Bleeding
- ☐ Bruising
- ☐ Clotting
- ☐ Anemia
- ☐ Lungs
- ☐ Asthma
- ☐ Seizures
- ☐ Kidneys
- ☐ Bladder
- ☐ Stomach
- ☐ Liver
- ☐ Immune Disorder

Medical problems that run in the family: ☐ Diabetes ☐ Heart or Circulation problems

Other health problems in family: _____

Preferred Pharmacy/location: _____ Phone Number:_____

Primary Care Physician:_____ Phone Number:_____

***Signature of patient confirming above information is accurate** _____

FINANCIAL POLICY

We are committed to providing you with the highest quality medical and surgical care. In return, we ask you to be equally committed to being fully responsible for paying our fees. This will help in reducing our billing and administrative burdens, leaving more time for helping you. This dual commitment is the foundation of our relationship. Our goal is to maximize the quality of your care and minimize misunderstandings regarding fees and payments.

We accept many different insurance plans, however, all health plans are not the same and do not cover the same services.

- MANAGED CARE PATIENTS/PRIVATE INSURANCE:
  If you are in a managed care plan (HMO, PPO, IPA) with whom we participate, we abide by our contract with them. In either managed care plans or private plans, we will bill your insurance company; however, you are responsible for paying any co-pays required by your plan at the time of treatment. In 30-45 days, your insurance company will send you an Explanation of Benefits (EOB) that tells you what your balance is, if any, to our office.
- MEDICARE PATIENTS:
  We accept assignment for Medicare, however, that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any co-payments, which are usually 20% of the allowed amount for an item or service.
- UNINSURED PATIENTS:
  Payment is due at the time of service.
- ALL PATIENTS:
  ~For your convenience, we will accept VISA, MasterCard, AEX, cash or check.
  ~There is a service fee of $10.00 for all returned checks

I have read, understand and accept all responsibilities associated with this financial policy.

Acknowledgement of Receipt of Notice of Privacy Practices

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

DURABLE MEDICAL EQUIPMENT POLICY

In the event that the patient leaves the office with an item recommended in the care and treatment of their foot condition (inclusive of, but not limited to, custom made foot orthoses, ankle/foot orthoses, night splints, walking boots, pads, etc.), it is understood that such items are non-returnable and non-refundable. It is the policy of this office to help obtain insurance benefits regarding a patient's individual coverage of these items by contacting the insurance company. This is a courtesy service which we are happy to provide; however, Eric J Plumley DPM is **not** held responsible for the accuracy of the information received. Information received by phone is not a guarantee of payment and, if any doubt exists as to eligibility, it is highly recommended that you check your plan booklet for a detailed outline of your benefits or make a personal phone call to your insurance company. ***Please note, if these items are denied by insurance due to coverage limitations, the patient hereby accepts responsibility for the cost.***

SIGNATURE ON FILE & PERMISSION TO TREAT

I request that payments of authorized benefits be made on my behalf or for any services furnished me by **Eric J Plumley DPM**. I authorize any holder of information about me to release any information needed to determine these benefits or the benefits payable to related services to the insurance agent. I recognize my financial obligation of any co-insurance, co-pays or deductibles and non-covered services that may be required. I give permission to Dr. Plumley and his staff to evaluate and treat my foot/ankle condition.

Sign below that you have read and understand the above sections Financial policy Privacy practices, Durable Medical Equipment Policy, Signature/Permission to Treat

_____

Print Name

_____ _____

Signature of Patient/Guardian Today's Date

Dr. Eric J Plumley Patient Questionnaire

PATIENT NAME:_____ **DOB:**_____ **DATE:**_____

18 years and older: MIPS

BMI: Current Height: _____Current Weight: _____

DIABETES: Are you diabetic? **YES OR NO** HgA1C if available_____

Date of your last Diabetic Eye Exam? _____ Performed by?_____

Date of your last Diabetic Foot Exam? _____ Performed by? _____

TOBACCO USE: Do you smoke? **YES OR NO**

BLOOD PRESSURE: Do you have High Blood Pressure? **YES OR NO**

IMMUNIZATIONS: A. Did you receive the Influenza Vaccine? **YES OR NO**

If **YES**, date received:_____

If **NO**, reason why not previously received: _____

B. Did you receive the Pneumonia Vaccine? **(65 yrs and older) YES OR NO**

If **YES,** date received:_____

ADVANCED CARE PLANNING: Do you have a Living Will, DNR or Power of Attorney for healthcare? **YES OR NO**

If **YES,** name and relation to administrator _____

50 years and older: PERIPHERAL ARTERY DISEASE QUESTIONNAIRE

1. **YES OR NO** Do you have high cholesterol, or are you on cholesterol medication?
2. **YES OR NO** Do you have a history of aortic aneurysm?
3. **YES OR NO** Do you have a history of diabetes, high blood pressure or aortic aneurysm?
4. **YES OR NO** Have you ever had a stroke, mini-stroke or heart attack?
5. **YES OR NO** Do you experience aching, cramping or pain in your legs, thighs or buttocks when you walk or exercise?

   If **YES**, does the pain improve with rest? **YES OR NO**

6. **YES OR NO** Do you experience cramping, tightness, "Charlie horses" or pain in the legs or feet when lying down?

   If **YES**, does the pain improve when you stand up? **YES OR NO**

7. **YES OR NO** Do you have numbness and tingling in the lower legs and feet?

8. **YES OR NO** Are your toes pale, discolored or bluish?

9. **YES OR NO** Are your feet cold to the touch?

10. **YES OR NO** Do you have sores or ulcers on your legs or feet that do not heal?

65 years and older: ARE YOU AT RISK FOR FALLING?

1. **YES (2) OR NO (0)** I have fallen in the past year
2. **YES (2) OR NO (0)** I use or have been advised to use a cane or walker to get around safely
3. **YES (1) OR NO (0)** Sometimes I feel unsteady when I am walking
4. **YES (1) OR NO (0)** I steady myself by holding onto furniture when walking at home
5. **YES (1) OR NO (0)** I am worried about falling
6. **YES (1) OR NO (0)** I need to push with my hands to stand up from a chair
7. **YES (1) OR NO (0)** I have some trouble stepping up onto curbs
8. **YES (1) OR NO (0)** I often have to rush to the toilet
9. **YES (1) OR NO (0)** I have lost some feeling in my feet
10. **YES (1) OR NO (0)** I take medicine that can make me feel light-headed or more tired than usual
11. **YES (1) OR NO (0)** I take medicine to help me sleep or improve my mood
12. **YES (1) OR NO (0)** I often feel sad or depressed

***Please add the total number of points for each question answered yes.

Total Points :_____

MA:_____ **Doctor:**_____ **Front:**_____

Dr. Eric J. Plumley DPM

PATIENT E-MAIL AND TEXT MESSAGING REGISTRATION FORM

Due to the changing world of healthcare and technology, Eric J Plumley DPM now has the ability to provide our patients with certain types of information via e-mail and/or text messaging. If you wish to have the opportunity to receive information of this type, please complete the form below.

Eric J Plumley believes strongly in protecting the privacy of our patients. When you provide this information to us, it is only used as a way to communicate with you. In order to protect your privacy, no confidential or personal information will be sent from Eric J Plumley via e-mail or text messaging.

Eric J Plumley does not share the names, e-mail addresses, and/or telephone numbers of patients with any other company, or with any other patient.

Please print all information neatly and legibly.

Name: _____ D.O.B: _____

E-mail address: _____

Cell phone: _____

- Yes, please sign me up to receive e-mail and text messaging confirmations.
- I do NOT wish to be contacted via e-mail. (TEXT MESSAGING ONLY)
- I do NOT wish to be contacted via text messaging. (E-MAIL ONLY)
- I do NOT wish to be contacted by either text messaging or e-mail.

I hereby give Eric J Plumley permission to send messages to me via e-mail and/or text messaging as means of communications as indicated by my selection above.

Signature _____ Date _____

ERIC PLUMLEY, DPM

HIPAA Authorization & Privacy Acknowledgment

Patient Information

Patient Name: _____

Date of Birth: _____

Phone Number: _____

Authorization to Use and Disclose Protected Health Information

I understand that my health information is protected under the Health Insurance Portability and Accountability Act (HIPAA). By signing this form, I authorize **Eric Plumley, DPM** to use and disclose my protected health information as described below.

Authorized Individual

(Permission to Speak With)

I give permission for **Eric Plumley, DPM** to communicate with the following individual regarding my healthcare information, appointments, treatment, or billing matters as applicable:

Name: _____

Date of Birth: _____

Phone Number: _____

Authorized Office or Organization

I give permission for **Eric Plumley, DPM** to communicate with the following office, clinic, or organization regarding my healthcare information as necessary:

Office / Organization Name: _____

Phone Number: _____

Scope of Authorization

This authorization may include, but is not limited to, discussion of:

- Appointments
- Treatment information
- Billing and insurance matters
- Care coordination

This authorization will remain in effect unless revoked by me in writing.

Patient Rights

I understand that:

- I may revoke this authorization at any time by submitting a written request.
- Revocation will not apply to information already disclosed.
- My treatment will not be conditioned upon signing this authorization.

Acknowledgment and Signature

I acknowledge that I have read and understand this authorization and agree to the release of my protected health information as described above.

Patient Signature: _____

Printed Name: _____

Date: _____