Eric J Plumley DPM
3913 Roosevelt Blvd
Middletown, OH 45044

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 SS# _____ 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: _____ 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