Tomsho Family Foot Care
Podiatric Medicine and Surgery

105 5th Street SE, Suite 4
Barberton, OH 44203
330.753.7772

PATIENT INFORMATION:

Last Name: _____ First Name / M.I.: _____

Address: _____ City/State:_____ Zip: _____

Home Phone: ( ) _____ Cell:( ) _____ Work: ( ) _____

Email: _____

Social Security #: _____ - _____ - _____ Date Of Birth: ___/___/_____ Sex : M F

Employer/Occupation: _____

Emergency Contact (Name/Phone Number): _____

PRIMARY DOCTOR**:** _____

INSURANCE INFORMATION:

- Primary Insurance Company: _____

Subscriber's Name: _____

Social Security #: _____ - _____ - _____ Date Of Birth: ___/___/_____ Sex : M F

Employer: _____ Work Phone : ( ) _____

- Secondary Insurance Company: _____

Subscriber's Name: _____

Social Security #: _____ - _____ - _____ Date Of Birth: ___/___/_____ Sex : M F

Employer: _____ Work Phone : ( ) _____

I understand and agree that (regardless of my insurance status), I am responsible for the balance on my account for any professional services rendered. I certify that the information on this sheet is true and correct to the best of my knowledge and will notify you of any changes to the information above.

I authorize the use of this form as my signature on file to be used to submit insurance claims on my behalf and authorize this office to act as my agent in helping obtain payment from my insurance companies. I authorize payment directly to this office.

SIGNATURE: _____ DATE: _____

Tomsho Family Foot Care
Podiatric Medicine and Surgery

105 5th Street SE, Suite 4
Barberton, OH 44203
330.753.7772

Height_____ **Weight** _____ **Shoe Size** _____

Please state your chief complaint for your visit today:

_____

_____

Duration:

_____

Allergies & Reaction *please list any metal allergies

_____

_____

Medications & Dosages:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Operations & Surgeries:

_____

_____

Injuries:

_____

_____

Past Medical History:

__Bleeding Disorder __Diabetes __Gout ___Thyroid Disease
__HIV/Hepatitis __GI/Ulcers __Lung Disease ___Hypertension
__Poor Circulation __Cancer __Heart Disease

Family History:

__Diabetes __Lung Disease __Poor Circulation __Cancer __Heart Disease

Social History:

Do you smoke? Y or N How many packs per day? ____
Do you drink alcoholic beverages? Y or N
Do you drink coffee? Y or N
Do you have history of recreational drug use? Y or N

How did you hear about our office: _____

Marital Status: S____ D____ W____ M_____ SPOUSE NAME _____

Pharmacy Name: _____ Location: _____

Tomsho Family Foot Care
Podiatric Medicine and Surgery

REVIEW OF SYSTEMS
PLEASE CHECK IF CONDITION RELATES TO YOUR HEALTH

CONSTITUTIONAL
- ☐ Weight Loss
- ☐ Fatigue
- ☐ Fever
- ☐ Nausea
- ☐ Chills

EYES
- ☐ Glasses/contacts
- ☐ Eye Pain
- ☐ Double Vision
- ☐ Blindness
- ☐ Cataracts

EAR/NOSE/THROAT
- ☐ Difficulty Hearing
- ☐ Ringing in Ears
- ☐ Vertigo
- ☐ Sinus Trouble
- ☐ Sore Throat

CARDIOVASCULAR
- ☐ Murmur
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Dizziness
- ☐ Fainting Spell
- ☐ Shortness of Breath
- ☐ Ankle Swelling
- ☐ High Blood Pressure
- ☐ Poor Circulation

ENDOCRINE
- ☐ Type 1 Diabetes
- ☐ Type 2 Diabetes
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Osteoporosis

RESPIRATORY
- ☐ Cough
- ☐ Wheezing
- ☐ COPD
- ☐ Difficulty Breathing

GASTROINTESTINGAL
- ☐ Heartburn
- ☐ GERD/reflux
- ☐ Constipation
- ☐ Diarrhea
- ☐ Abdominal Pain
- ☐ Nausea/Vomiting

IMMUNOLOGIC
- ☐ Hives
- ☐ Hayfever
- ☐ Eczema
- ☐ Psoriasis
- ☐ Nickle Allergy
- ☐ Titanium Allergy

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression
- ☐ Mood Swings
- ☐ Family Stress

MUSCULOSKETAL
- ☐ Joint Pain/Swelling
- ☐ Stiffness
- ☐ Muscle Pain
- ☐ Back Pain
- ☐ Foot Cramps
- ☐ Difficulty Walking
- ☐ Loss of Balance

SKIN
- ☐ Rashes
- ☐ History of Ulcers
- ☐ Itching/Burning Feet

NEUROLOGICAL
- ☐ Loss of Strength
- ☐ Numbness
- ☐ Tremors
- ☐ Memory Loss

FEMALE ONLY
- ☐ Irregular Menses
- ☐ Menopause

SIGNATURE:
DATE:

Tomsho Family Foot Care
Podiatric Medicine and Surgery

105 5th Street SE, Suite 4
Barberton, OH 44203
330.753.7772

PRIVACY CONSENT AND ACKNOWLEDGEMENT OF MEDICAL PRIVACY NOTICE

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

Consent for care: I, with my signature, authorize Barberton Podiatry, Inc, and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and my include (but limited to) preventive, diagnostic, palliative care, counseling, surgical, dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

Consent for release of information: I also authorize this practice to furnish information of the identified insurance carrier(s) for any and all payment activities. I further consent to the use for any practice operational needs as identified in the Medical Privacy Notice.

Consent for assignment of benefits: I consent to assign all payments for these services to this practice. I understand that I am responsible for all co-payments, amounts applied to deductibles and any coinsurance amounts, as required by my contract with my insurance plan and state regulation. I further understand that my contract with my insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware that I may be responsible for all charges that are incurred.

Consent for photographs: I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that Barberton Podiatry, Inc. will retain ownership rights to these photographs, videotapes, digital, or other images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law. Images that identify me will be released and/or used outside the institution only upon written authorization from me or my legal representative.

Consent and acknowledgement of Medical Privacy Notice: I have had a chance to review the Medical Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

I understand that this practice may refuse me services if I refuse to sign this consent. I may revoke this consent at any time, but the practice may refuse further services at that time.

Patient/Guardian Signature: _____ Date: _____

Name Printed: _____ If not patient, relationship: _____

Tomsho Family Foot Care
Podiatric Medicine and Surgery

105 5th Street SE, Suite 4
Barberton, OH 44203
330.753.7772

Financial Policy

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

INSURANCE: We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. You must show your most current insurance card at every visit. If you do not have a current card, you will be rescheduled. You are responsible for knowing what services are covered by your insurance carrier. Please contact your insurance company with any questions you may have regarding your coverage. You are ultimately responsible for your bill.

MEDICARE: We are a participating Medicare provider. We accept Medicare benefit amounts. Medicare as well as your secondary insurance (if any) will be billed for you. 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 copayments, which are usually 20% of the allowed amount of an item or service.

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company. Please be aware that not all secondary plans cover all services provided. It is your responsibility to understand your individual plan coverage.

SELF PAY: Please inquire about self-pay/ cash discounts. Payment in full is due prior to being treated if you do not have health insurance.

NON-COVERED SERVICES AND PRODUCTS: Please be aware that some of the services and/or products you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for full payment of these services and/or products at the time of service. All products dispensed from the office are not returnable. All sales are final.

REFERRALS/AUTHORIZATIONS: If your insurance company requires an authorization or referral to be seen by or have services performed by our physician, if is your responsibility to obtain this authorization from the insurance company or your primary care physician. It is not the responsibility of Tomsho Family Foot Care to obtain authorization on your behalf. If payment is denied because of failure to obtain an authorization or referral, the bill will be your responsibility. We are required to follow the guidelines of your managed care plan which may mandate a referral from your primary care physician prior to seeking specialty care, such as podiatry. Therefore, you are financially responsible for the services received, unless your referral is presented at the time of this visit. You will also be given the option to reschedule your appointment.

CLAIM SUBMISSION: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

Tomsho Family Foot Care
Podiatric Medicine and Surgery

105 5th Street SE, Suite 4
Barberton, OH 44203
330.753.7772

PATIENT BILLING: **All co-payments, co-insurance, or deductible amounts must be paid AT THE TIME OF SERVICE**. If you do not have your copay, you may be asked to reschedule. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your portion of insurance benefits at each visit. As a courtesy, our office does verify benefits with your insurance carrier; however, the insurance agreement is a contract between you and your insurance carrier. It is recommended that you verify your benefits with your carrier as well.

PHYSICAN PHONE CALLS: Phone calls with our physician(s) are a billable service, may be billed to your insurance company/companies, and are subject to your insurance benefits. You are responsible for your portion of insurance benefits for physician phone calls.

CUSTOM ORTHOTICS: Orthotics refurbishment is a service that is not covered by insurance, you may be subject to a fee of $50 per refurbishment.

NON-CUSTOM DURABLE MEDICAL EQUIPMENT RETURNS: If a patient is unsatisfied with any non-custom Durable Medical Equipment (DME) item, it must be returned within 30 days per Medicare guidelines. Returns after 30 days will not be permitted. The item will only be accepted as a return if it is in a returnable condition. Any custom DME item may not be returned for any reason. In addition, if your custom order DME product is not picked up from our office within three (3) weeks of notification you will be charged for the balance of the device. This cost will be your responsibility not your insurance companies.

COPY FEE: We will provide copies of patient records at the patient's request. Copies of records may be subject to a copy fee per section 3701.741 of the Revised Code at the time the copies are provided. You will bear the complete financial responsibility for any fee(s) incurred.

CANCELLED/MISSED APPOINTMENT FEE: If you cannot keep your appointment time, please call our office at least 24 hours prior to your scheduled appointment time. There may be a **$25 fee** for any appointment cancelled or rescheduled within 24 hours of the scheduled time. Additionally, there may be a **$25 fee** if you miss a scheduled appointment. If you miss 3 or more appointments, you may be terminated from our office. Repeated late or missed appointments may result in dismissal from our practice. *A missed appointment is determined if you are 15+ minutes late or fail to call prior to the scheduled appointment time to notify the office that you will be late/cannot come in.

COLLECTIONS FEE: You will be sent up to 3 notices for your financial responsibility (co-insurance, deductible, etc.) after payment and/or explanation of benefits (EOB) is received from your insurance company. After the third and last notice, your account may be forwarded to our collection's agency. You bear complete financial responsibility for any fee(s) incurred.

Payment arrangements can be made on a case by case basis if necessary. We accept the following payment methods: Cash, Check or Visa/Mastercard/Discover. An additional $30 service charge will be added to your account for any returned checks from your bank. In the event that the insurance company sends payment to you, the patient, it should be forwarded to our office to be applied to your balance.

PRIVACY STATEMENT: Any information disclosed in your records will remain confidential and will not be used for any other reason except in providing quality care and treatment as well as submit your claim to your insurance carrier and contact you as needed.

PATIENT ACKNOWLEDGE OF NOTICE OF PRIVACY PRACTICES: By subscribing my name below, I acknowledge that I was provided the Notice of Privacy Practices and that I have (or had the opportunity to read if I so chose) and understand the Notice and agree to its terms.

Tomsho Family Foot Care
Podiatric Medicine and Surgery

105 5th Street SE, Suite 4
Barberton, OH 44203
330.753.7772

ACCOUNT BALANCE: If your account balance exceeds $150.00 you may be required to be placed on a payment plan prior to next appointment. You must submit valid credit/debit card information.
If a payment is missed, you may be discharged from the plan.

ASSISGNMENT OF BENEFITS
I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to **TOMSHO FAMILY FOOT CARE** all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, co-insurance, non-covered services and other fees **AT THE TIME OF SERVICE**. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize Release of Medical Information to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

I understand that it is my responsibility to inform the doctor's office if there is any change in my health insurance information.

I have read the above policy regarding my financial responsibility to TOMSHO FAMILY FOOT CARE for medical services provided. I am aware that I am responsible for any balance unpaid by my insurance carrier for myself or the below named person.

PRINT Patient Name: _____ Signature: _____

FINANCIALLY RESPONSIBLE PARTY:
PRINT Name: _____ Signature: _____
Relationship to Patient: _____ Date: _____