PODIATRY WELCOME SHEET

PATIENT INFORMATION

Name ____

Address ____

City ____

State ______________________ Zip __________________________

Date of Birth ____

Social Security Number _______________________________________

☐ Married ☐ Widowed ☐ Single ☐ Divorced

Phone Number ____

Primary Care Physician ____

Date of last visit to Primary Care Physician _________________________

MEDICAL HISTORY

Check all that apply:

☐ Diabetes ☐ High Blood Pressure ☐ Poor circulation

☐ Heart Disease ☐ Thyroid disease ☐ Stroke

☐ Cancer ☐ Respiratory disease ☐ Bleeding disorders

☐ Liver disease ☐ Kidney disease ☐ High Cholesterol

☐ Other ____

ALLERGIES

List any known food / drug allergies below

____

____

MEDICATIONS

Please bring a list of your current medications or list them below

____

____

____

____

If you need additional space, please use the back of this form.

INSURANCE INFORMATION

Please provide your medical insurance information below

MEDICARE NUMBER ________________________________

OTHER INSURANCE ________________________________

ID / GROUP NUMBER ________________________________

PLEASE BRING A COPY YOUR INSURANCE CARDS WITH YOU TO YOUR APPOINTMENT. THANK YOU.

AT HOME FOOT CARE AUTHORIZATION / CONSENT TO TREAT

Assignment and Release of Information

I certify that I (or my dependent) have health insurance coverage with the health insurance carrier named on this sheet. I assign directly to At Home Foot Care, 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 for by my insurance. I hereby authorize At Home Foot Care to release all information necessary to secure the payment of benefits. I authorize the use of this signature below on all insurance submissions.

Medicare Authorization

I request that payment of authorized Medicare benefits be made on my behalf to At Home Foot Care for any services furnished to me. I authorize any holder of medical information about me to release to 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 authorize release of medical information necessary to pay the claim. If I have supplemental insurance coverage, my signature also authorizes releasing of the information to the secondary insurer or agency. In Medicare assigned cases, the physician 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 non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Consent for Treatment

I hereby give consent to all associated physicians of At Home Foot Care to provide podiatry services to myself or my dependent named on this Welcome Sheet. Services may include nail debridement, administering of injectable medications for procedures, dressing changes, debridement of calluses and other lesions, and other authorized services deemed medically necessary by an associated physician.

Privacy Notice

I acknowledge that At Home Foot Care will conduct all business in compliance with all applicable federal, state, and local statutes, regulations, rules, and policies including the Health Insurance Portability and Accountability Act (HIPAA). A Notice of Privacy Practices may be requested from At Home Foot Care delineating practice guidelines.

____
Signature of Patient / Responsible Party Date

WE LOOK FORWARD TO SEEING YOU!

IF YOU HAVE ANY QUESTIONS PLEASE CALL (210) 852-2427

Thank you! ☺