B I R M I N G H A M • P O D I A T R Y

Dr. John Roberson Jr., DPM - *Dr. Jamie Cleckler, DPM* - *Dr. Geoffrey Dye, DPM* - *Dr. Natalie Giammanco, DPM*
(Birmingham & 119) (Birmingham & Clanton) (Birmingham) (Cullman)

Date__________________ Patient____________________________________ DOB_______________________

Social Security #___________________________ Gender: (Male) (Female) (Transgender) Age_____________

Address____

Home Phone _________________________ Cell_________________________ Work________________________

Email____ Email Correspondence Permitted? (Yes) (No)

Race_____________________________ Language____________________ Marital Status: (Single) (Married) (Other)

Responsible Party for patient <18 _________________________________Number__________________________

Primary Care Physician__________________________

Date Last Seen__________________________________
*required for some podiatric services to be billed to insurance

Pharmacy_______________________________________

Phone Number___________________________________

Emergency Contact Information :

Name & Relationship_____________________________

Phone Number__________________________________

Do you have a surrogate decision maker? (Yes) (No)

Name_______________________________

Number_______________________________

How did you hear about us? (Internet) (Phonebook) (Friend)

Physician referral from: _________________________

Primary Insurance_____________________________

Policy Holder's Name___________________________

Policy Holder's DOB_____________________________

Relationship to Policy Holder: (Self) (Spouse) (Parent)

Secondary Insurance___________________________

Policy Holder's Name___________________________

Policy Holder's DOB____________________________

Relationship to Policy Holder: (Self) (Spouse) (Parent)

Tertiary Insurance_____________________________

Policy Holder's Name___________________________

Policy Holder's DOB____________________________

Relationship to Policy Holder: (Self) (Spouse) (Parent)

Signature____________________________________

NAME: ____

SOCIAL HISTORY

Do you Smoke? (Y) (N) # per day: _____ Years: _____ Do you drink caffeine: (Y) (N) How many cups per day? _______
Do you use Recreational Drugs? (Y) (N)
Do you drink Alcohol? (Y) (N)
If so, how often? (Once a month or less) (2-4 times per month) (2-3 times per week) (4 or more times per week)
Do you Exercise Regularly? (Y) (N)

ALLERGIES

_____Adhesive tape _____Aspirin _____Codeine _____Seafood _____Sulfa
_____Demerol _____Iodine _____Latex _____Lortab _____Penicillin
_____Local Anesthetics _____Other:______________________________ _____No known allergies

CURRENT MEDICATIONS ***WITH DOSAGE

Please List Medications even if you only know one or two. Thanks!

_________________________ _______________________________ __________________________
_________________________ _______________________________ __________________________
_________________________ _______________________________ __________________________
_________________________ _______________________________ __________________________

FAMILY MEDICAL HISTORY

Please check if anyone in your family has had the following:

_____Diabetes _____Heart Disease _____Gout _____Bleeding ulcer _____Rheumatoid Arthritis

_____Peripheral Vascular Disease (PVD) _____Other:____

SURGICAL HISTORY

_____Appendectomy _____Gallbladder _____Hysterectomy _____Foot/Ankle _____C-Section
_____Eye _____Heart _____Thyroidectomy _____Tonsillectomy _____Back
_____Knee _____Hip _____Other:____
**If knee or hip replacement, indicate here: (Y) ______________________

NAME:____

PODIATRIC HISTORY

Are you here due to an injury? If so, *we need the injury date to file insurance*. INJURY DATE:___________

Shoe Size: ______Have you seen a Podiatrist before? (Y) (N) If yes, who? __________________________

What are you seeing us for? ____

_____Ankle Pain _____Flat Feet _____Diabetic/Foot Ulcer _____Athlete's Foot
_____Heel/Arch Pain _____Fungal Nail _____Bunions _____Ingrown Nails
_____Tired Feet _____Corns/Callouses _____Achilles Tendon Pain _____Poor Coordination
_____Toe Pain _____Wart _____Leg Pain _____Neck Pain
_____Back Pain _____Foot/Leg Cramps _____Coldness in the legs or feet that is uncomfortable
_____Non/Poor healing sore on the leg/foot _____Change in skin color or cellulitis
_____Pain in feet or legs with exercise _____Feet/Toes/Legs Burn
_____Feet/Toes Numb or Tingling _____Difficulty walking or running

PAST MEDICAL HISTORY

Please check to indicate if you have had any of the following:

____AIDS/HIV ____Ear Problems/Hearing ____Kidney Disease/Problems ____Anemia ____Epilepsy
____Neuropathy ____Heart Condition/Problems ____Fainting ____ Rash ____Gout
____Arthritis ____Swelling ____Psychiatric Care ____ Asthma ____Stroke
____ Varicose Veins ____ Back problems ____Diabetes ____Liver Disease/Problems
____Tuberculosis ____ Respiratory Disease ____Headaches/Migraines ____Bleeding Disorder
____MVP ____Sinus Problems ____Hypertension (high blood pressure)
____Hypotension (low blood pressure) ____Peripheral Vascular Disease (PVD) ____Cancer-Type: _________________

*****DIABETICS, PLEASE LIST LAST A1C ____________Date?_______ AND last BLOOD SUGAR ______________.**

TREATMENT CONSENT

I hereby give permission for the doctor and clinical staff to administer and perform agreed upon procedures, injections, and x-rays the Podiatrist deems necessary.

____ ___________________________

Signature of Patient, Parent, Guardian, or Representative Date

If Representative, Relationship to the patient: ____

NAME:____

RELEASE OF INFORMATION

Voicemail messages can be left at the following numbers with test results, appointments, etc.:

_______________________________________ _______________________________________

I give Birmingham Podiatry, PC permission to release my medical information to:

***This includes appointment information! Name must be listed to make, cancel, and inquire about appointments!

(Name and Relation)

_______________________________________ _______________________________________

_______________________________________ _______________________________________

NOTICE OF PRIVACY PRACTICES/ACKNOWLEDGEMENT OF RECEIPT

The Privacy Act generally requires healthcare providers to take responsible steps to limit the use, request, and disclosure of protected health information to the minimum necessary to accomplish the intended purpose of treatment, payment, healthcare operations, protection of others and disclosures required by law. This could include disclosures about notifiable diseases, sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), and HIV.
I acknowledge that I have received, or declined a copy of, Birmingham Podiatry's Notice of Privacy Practices.

I authorize the use of the phone numbers I provided, and any future numbers assigned to me, for calls, texts, and emails to to contact me regarding my care and my account by my medical provider and his business associates.

Signature: ______________________________________ Date: ___________________________

BIRMINGHAM PODIATRY, PC

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Birmingham Podiatry, PC and its staff to disclose my individually identifiable health information as described below. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Birmingham Podiatry, PC will use all information obtained to provide caring and quality medical care to you. As part of our standard of treatment, and pursuant to further healthcare options, we may need to share your information with a facility such as a hospital, laboratory, diagnostic service, or other healthcare provider. We may also need to share information with your insurance provider in order to expedite payment for your services provided by our practice. Any outside entity such as an attorney, disability request, or insurance company, other than your health plan provider, will need written consent to obtain information from your file.

I understand that I may revoke this authorization at any time by notifying Birmingham Podiatry, PC in writing. If authorization is revoked it will not have any effect on any actions taken before receipt of my revocation.

Birmingham Podiatry, PC will not condition my treatment on whether I provide authorization for the requested use or disclosure.

______________________________	______________________________
Signature of Patient or Legal Representative	Date
______________________________	______________________________
Printed Name	Relationship to Patient (If Applicable)

*** You may refuse to sign this authorization***

FINANCIAL POLICY

Thank you for allowing us the opportunity to serve you. Our goal is to provide you with high quality Podiatry care and a great experience with our practice. With that in mind we want to let you know up front that there are times when your insurance may not cover charges associated to your care. Please read the following to better understand your financial responsibility.

Insurance: We participate in most insurance plans. If you are not insured by a plan we participate with, or do not have insurance at all, payment in full is expected at each visit.

Annual Deductibles/Copays: Many insurance plans now have deductibles as well as a co-pay/co-insurance. If either or both apply to your coverage, they will be collected at the time of service, including the deductible and co-insurance imposed by Medicare.

Non-Covered Splints/Services: Please be aware that some of the services you receive may not be covered or considered medically necessary by Medicare or other insurers. You are responsible for payment of these products/services which may include splints, shoes, or shower bags needed after procedures.

Referrals/Authorizations: For some managed care insurance plans (such as HealthSpring, some VIVA, Tricare, and others) referrals are required by your primary care physician in order for your insurance to approve your visit with us. You are essentially responsible for making sure that referral is received. If the required referral is not received you are financially responsible for all services provided.

Missed Appointments without Sufficient Notification: All missed appointments not cancelled or rescheduled at least 24 hours in advance may be charged a $40 fee. No-show appointments place a hardship on Birmingham Podiatry as well as patients that may have needed to be seen but could not due to that appointment time being taken.

PLEASE INITIAL STATING UNDERSTANDING OF THE MISSED APPOINTMENT POLICY: ______________

Patient Due Balances: You will be sent up to three statements by mail for your patient due balance, after insurance pays/denies. After the third and final notice, your account may be forwarded to our collections agency. All cost incurred including, but not limited to, reasonable collection agency fees not to exceed 30%, attorney fees, and court costs shall be your responsibility in addition to the balance due to the office for services rendered. We accept cash, check, Visa, MasterCard, and Discover.

Insufficient Funds Checks: An additional $30 will be added to your account for any returned checks. Also, we will no longer be able to accept future checks from you from that time forward.

Assignment of Benefits:

Statement for Payment of Medicare Benefits: I request that payment of authorized Medicare benefits be made to either me or on my behalf to Dr.__________________________________ or to Birmingham Podiatry (the Supplier) for any services or items furnished to me by the physician or supplier. I authorize any holder of medical information about me to release to Healthcare Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Statement for Payment of MEDIGAP Benefits: I request that payment of authorized MEDIGAP benefits be made either to me or on behalf to Dr.______________________________ for any services furnished to me by the physician/supplier, I authorize any holder of medical information about me to release to (name of MEDIGAP insurer) Birmingham Podiatry any information needed to determine these benefits or the benefits payable for related services.

I have read the above policy regarding my financial responsibility to Birmingham Podiatry, PC. I understand that I am responsible for payment of deductibles, co-pays, co-insurances, and/or non-covered services, splints, or medical supplies. I authorize RELEASE OF MY MEDICAL INFORMATION to my insurance carrier and/or requesting physicians to provide continuity of care and aid in the payment of my medical claims.

Patient Signature: ____Date: ________________________

***Patient signature may be replaced by responsible party for the patient*

I understand that Birmingham Podiatry, PC is not a Medicaid provider. I am responsible for my primary insurance copay and deductibles.

________ ***Medicaid patients only, please initial*