PANEPINTO PODIATRY
FOOT MEDICINE & SURGERY

Today's Date _____

Patient's full name_____ ☐Male ☐ Female Date of Birth _____/_____/_____ Age_____

Social Security#_____-_____-_____ Occupation_____ Your best contact phone number ? ____cell____home_____work

Address_____ Home Phone (_____)_____-_____

City/State/Zip _____ Cell Phone (_____)_____-_____

Work Phone (_____)_____-_____

How did you hear about us?

☐ Referral ☐ Internet ☐ Advertisement ☐ Friend ☐ nolafoot.com ☐ Doctor_____ ☐ Internet

Responsible Party / Parent / Relative **Emergency Contact: (circle) YES NO** **Relationship: Husband, Wife, Son, Daughter, Brother, Sister, Friend, Partner, Other**

Name_____ Date of Birth____/____/_____ Social Security # _____-_____-_____

Home #(____)_____-_____ Cell # (____)_____-_____ Work # (____)_____-_____

_____ _____

Reason for seeing the doctor today? (PLEASE CHECK OFF)

____RIGHT FOOT ____ LEFT FOOT ____ RIGHT AND LEFT FOOT HOW LONG HAS PAIN BEEN PRESENT? ____1___2___3 ___4 ___day___weeks___years

___TOE PAIN(INGROWN OR FUNGUS TOENAIL) ___ OTHER TOE PAIN ___ INJURY ____WORK INJURY ___ BURNING IN FEET ___ CRAMPING IN LEGS OR FEET

___ HEEL PAIN ____ARCH PAIN ____ANKLE PAIN ___ PAIN IN BALL OF FEET ___WART OR CALLUS ____BUNIION PAIN ___ DIABETIC FOOT EXAM

Medical Information

Current Height _____ Current Weight _____ Current Shoe Size _____

Allergies

Please CHECK OFF any medications, food or environmental factor that you are allergic to, and what is your reaction.

☐ **NO KNOWN DRUG ALLERGIES** **Reactions: ___Nausia/Vomit ___ Itching ____Hives ____Difficulty breathing**

___ penicillin ___sulfa drugs (Bactrim) ___amoxacillin ___keflex ___clyndamycin ___cipro ___iodine and/or betadine/shellfish

___asprin___ibuprofen___celebrex___cortisone___percocet___vicoden___demerol___phenergan___tape___other?_____

_____

Medications (REGULATIONS REQUIRE A LIST OR COPY AND DOSAGE OF YOUR MEDICATIONS TO BE UPDATED EACH VISIT)

List all prescription medications as well as over the counter medications, vitamins & dietary supplements AND DOSAGE:

_____

_____

_____

_____

_____

PHARMACY NAME, ADDRESS AND PHONE NUMBER: (___)____-_____ _____

Referring (Primary) Physician (& location) _____

IF INSURANCE COMPANY REQUIRES A REFERRAL FROM YOUR PRIMARY CARE PHYSICIAN IT MUST BE OBTAINED PRIOR TO VISIT OR APPOINTMENT WILL BE RESCHEDULED

Date of Last Visit _____/_____/_____

***DIABETIC PATIENTS: INSURANCE RULE: REQUIRES NAME AND ADDRESS OF YOUR PRIMARY CARE PHYSICIAN. YOU MUST HAVE BEEN SEEN BY YOUR PRIMARY PHYSICIAN WITHIN THE LAST SIX (6) MONTHS OF TODAYS DATE.**

Medical History

Check any of the following you currently have or have had a problem with in the past:

☐Anemia
☐Arthritis
☐Asthma
☐Bleeding Disorder
☐Breathing Problems
☐Cancer-type:_____
☐Congestive Heart Failure
☐Diabetes – Insulin Dependent
☐Diabetes – Non-Insulin dependent
☐Gout
☐Heart Disease
☐Hepatitis
☐High Cholesterol
☐High Blood Pressure
☐HIV
☐Joint Replacement
☐Hip (☐R ☐L)
☐Knee (☐R ☐L)
☐Kidney Disease
☐Liver Disease
☐Mitral valve Prolapse
☐Neuropathy
☐Phlebitis (blood clots)
☐Stomach Problems
☐Thyroid disorder

Last blood sugar test? _____ Do you know your HBA1C_____

Other: _____

Surgical History

Please list any major surgeries and their approximate dates:

___ CATARACT /EYE __TONSILS____THYROID____HEART___STOMACH___APPENDIX___GALLBLADDER___HERNIA___HYSTERECTOMY
___BREAST___WRIST___SHOULDER___KNEE___FOOT____OTHER_____

Social History

Do you smoke? ☐Yes ☐No If yes, how many packs/day? _____ #of years_____ QUIT how many years ago? _____
Do you drink alcohol? ☐Yes ☐No If yes, amount and frequency: ___SOCIAL____ MODERATE____HEAVY

Family History of Disease

List any major medical conditions in your immediate family (such as heart disease, diabetes, or cancer)

___HEART DISEASE____DIABETES___CANCER___KINDNEY DISEASE___STROKE___OTHER _____

CURRENT PROBLEM LIST / REVIEW OF SYMPTOMS: CHECK HERE _____ if you have NO CURRENT MEDICAL SYMPTOMS BELOW.

ALERTNESS:	___chills	___night sweats	___ dizziness	___ fever __ tired
EYES:	___ blurred vision	___ blind	___watery eyes	
EARS,NOSE,MOUTH,THROAT:	___ringing in ears	___sinus congestion	___hearing difficulty	___trouble swallowing
CARDIOVASCULAR:	___chest discomfort	___palpatations		
RESPIRATORY:	___difficulty breathing	___shortness of breath	___sleep apnea	___snoring
GI:	___nausia	___vomiting	___abdominal pain	___blood in stool
GU:	___painful urination	___bood in urine	___frequent urination	___impotence ____STD
MUSCULOSKELETAL:	___neck	___back	___knee	___ muscle pain
ITEGUMENTARY:	___dermatitis	___eczema	___psoriasis	___rash ___dry skin
NEUROLOGICAL:	___numbness feet/legs	___seizures	___tremors	
PSYCHIATRIC:	___anxiety	___depression	___paranoia	___other_____
ENDOCRINE:	___fatigue	___rapid weight loss		
HEMOATOLOGIC/LYMPHATIC:	___leg swelling	___foot swelling	___pitting edema	___inablility to stop bleeding
ALLERGIC / IMMUNOLOGIC:	___gout	___osteoarthritis	___rheumatoid arthritis	___ other_____

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Rory Panepinto, DPM

Consent for Assignment of Benefits and Treatment

I certify that me or my dependents have insurance coverage with the above named carrier and hereby authorize the release of all medical information necessary to process insurance claim(s). I hereby assign and authorize direct payment of all medical and/or surgical benefits, including major medical, private insurance and other health plans to Rory Panepinto, DPM. The above named practice, its agents, and assigns may use my health care information and may disclose such information to above named insurance company (companies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I grant permission for the above named doctors and their assistants to render care in the diagnosis and or treatment of my foot conditions and release related information to my physician and or emergency medical personnel and as required by law.

This Assignment will remain in effect until revoked by me in writing. A signed photocopy of this Assignment will be considered as valid as an original.

Signature of Responsible Party X_____ **Date**_____/_____/_____

Print Name _____

Patient Name (if different form responsible party) _____

Acknowledgement of Receipt of Financial Policy

I acknowledge that I have read and understand the Financial Policy. I understand that Rory Panepinto, DPM is not ultimately responsible for collecting from my insurance or negotiating settlement of claims.

I understand the financial policies and accept responsibility for payment of any balance owed on my account. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature of Responsible Party X_____ **Date**_____/____/_____

Print Name_____

Patient Name (if different from responsible party) _____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices. I have read and understand the notice. By signing this form, I am consenting Rory Panepinto, DPM to disclosure of my Personal Health Information (PHI) to carry out Treatment, Payment and healthcare Operations (TPO).

Signature of Responsible Party X_____ **Date** _____/____/_____

Print Name _____

Patient Name (if different from responsible party) _____

Rory Panepinto, DPM

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FINANCIAL POLICY

As insurance coverage decreases and the patient's financial responsibility increases, we understand the need for clear communication of our financial policies. To better service the needs of our patients, we have added valuable tools to help you meet your increased medical expenses.

1. We will continue to look to insurance companies for their payment, and assist you in receiving proper reimbursement for our services. Unfortunately, most insurance no longer covers services fully and most current insurance plans chosen by our patients require significant out-of-pocket expenses to be paid by the patient.
2. Our staff has been trained to be able to communicate with you and answer your questions regarding payment and insurance reimbursement.
3. It is your responsibility to verify that all requirements of your insurance plan are met. We will assist you with pre-certification for procedures ordered by our office, but it is ultimately your responsibility to verify whether any care you receive is covered by your insurance plan. This office is not responsible for the expense of treatment, which is not paid by your insurance. With continuous changes in coverage, it is important for you to verify your benefits and be aware of all restrictions and expenses of your plan.
4. In accordance with the requirements of most insurance contracts, we will require payment of office co-payments at the time of service. Any person being seen for treatment or service will be required to pay the necessary co-payment at the time of service. Your insurance company will be notified when this contractual payment is not paid at the time of the appointment.
5. For patients owed balances, we will offer credit card, debit cards, and payment plans to assist you in meeting your financial obligations to our office. You must advise us of any payment you receive from insurance or any third party for our services and forward this amount to our office immediately.
6. If we are a contracted provider on your insurance plan, we will file a claim with your carrier and you will be billed when they have responded to our claim. Upon receipt of their response, payment or denial, you will receive a statement for the amount your insurance company notifies us is your responsibility.
7. If Dr. Panepinto is not a contracted provider for your insurance plan, we will file a claim with the information you provide and you will be billed when they have responded to our claim. You will receive monthly statements and we will look to you for payment. You will be responsible for working with your insurance company to insure prompt payment.
8. If you do not have a current insurance card with you, you will be billed for the entire amount and asked for payment at the time of service. It is your responsibility to give us your card at each visit (if requested). We will not be able to file your insurance without a copy of your insurance card.

If you have an insurance plan that requires a referral, we will require that the referral be received in our office before we can see you. We will do our best to assist you in obtaining the referral, but to expedite matters it is best for you to contact your primary care physician and have them fax the referral over to us or bring the referral in with you.

NOTICE OF PRIVACY PRACTICES

I hereby give my consent for Rory Panepinto, DPM to use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment and healthcare Operations (TPO).

I have the right to review the Notice of Privacy Practices prior to signing this consent. Rory Panepinto, DPM reserve the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Panepinto Podiatry, at 1801 Clearview Parkway, Metairie, LA 70001.

With this consent, Panepinto Podiatry may call my home or other alternative location and **leave a message on voice mail or in person** in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others. However, our policy is not to leave detailed messages regarding Protected Health Information or anything related to treatment, payment or healthcare operations.

With this consent, Panepinto Podiatry may **mail to my home or other alternative location** any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Panepinto Podiatry may **e-mail to my home or other alternative location** any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that Panepinto Podiatry restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Panepinto Podiatry may decline to provide treatment.