Foothill Podiatry Clinic of Grass Valley, Inc.

Please take a moment to review, making sure all fields are accurate and complete. Thank you!

(530) 477-7200

Patient Name:_____

Parent/Guardian Name: (if patient is under the age of 18) _____

Date of Birth:_____**SSN:**_____

Gender: (Circle) Male Female Decline to Specify **Height:** _____ **Weight:**_____ **Shoe size:**_____

Race: (Circle) **American Indian Alaskan Native Asian Native Hawaiian White African American Mexican American Other Declined to Specify**

Ethnicity: (Circle) **Hispanic Non-Hispanic Declined to Specify**

Language: (Circle) **English Spanish Indian Russian Other**

Mailing Address: _____
Street Number City State Zip

Preferred Phone #: _____ (Circle) **Home Cell Work**

OK to leave a message? (Circle) **Yes No Text? Detailed Message? Yes No Ok to txt? Yes No**

Email Address: _____

Primary Care / Referring Physician:_____

Would you like our records to be shared with your Primary Care Physicians? (Circle) **Yes No**

Employer Name: _____ **Phone #:** _____

Insurance carrier:_____**Subscriber #:**_____

Pharmacy:_____

Foothill Podiatry Clinic has my permission to discuss my medical condition with the following persons:

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Please let us know how you heard about our office:_____

I understand that Foothill Podiatry Clinic follows the Health Insurance Portability and Accountability Act (HIPPA) of 1996. This is to keep my protected health information (PHI) private. I understand that the office HIPPA policy is available to me upon request. My signature below authorizes the release of any medical information necessary to process claims and request that payment of all assigned benefits be made to the provider of services. I understand that I am financially responsible for the non-covered benefits, deductibles, and co-payments at the time of service. I have read and understand financial policy. Should the account be referred to a collection agent, the undersigned shall pay all collection expenses. ***FPC reserves the right to charge a $50 fee to individuals who have missed or have failed to cancel their appointment more than 24 hours in advance. This fee will need to be collected prior to making another appointment. ***

Signature:_____ **Date:**_____

Insured or Authorized Person

Foothill Podiatry Clinic ~ Medical History Form

Patient Name:_____ **Date of Birth:**_____

What is your chief complaint today? _____
How long has this problem been bothering you?_____
Is this a work-related injury? (circle) **Y or N** If applicable, what was the date of injury?_____
Have you had any falls in the last year? (circle) **Yes No** If yes, when? _____

MEDICAL HISTORY: (check all that apply)

AIDS/HIV	____	Diabetes	____	High Blood Pressure	____
Heart condition	____	Gout	____	High Cholesterol	____
Arthritis	____	Parkinson's	____	Thyroid condition	____
Asthma	____	Neuropathy	____	Psychiatric Ailment	____

Others _____

ALLERGIES: Check here ____ if you have **NO known drug allergies**

Medication Allergies: _____

Other Allergies (ex: latex or tape): _____

CURRENT PRESCRIPTION MEDICATIONS: (or attach a list of medications/vitamins)

_____ _____ _____

_____ _____ _____

_____ _____ _____

SURGERIES: (Any surgeries or Fractures of feet or ankles)

_____

_____

_____

SOCIAL HISTORY:

Are you a current nicotine user? (circle) **Yes No Previous** If you're a previous user, when did you quit? (circle) **<1 month 1-3 months 3-6 months 6-12 months 1-5 yrs 5-10 yrs >10 yrs**

If applicable, how often do you use nicotine? (circle) **Every Day Some Days**

If you smoke cigarettes, how many a day? (circle) **5 or less 6-10 11-20 21-30 31 or more**
How soon after you wake up in the morning do you smoke your first cigarette? (circle)
within 5 mins 6-30 minutes 31-60 minutes after 60 minutes

Foothill Podiatry Clinic ~ Financial Policy

Thank you for choosing Foothill Podiatry Clinic (FPC) as your podiatric care provider. We are committed to your treatment being successful.

INSURANCE: For the convenience of our patients, Foothill Podiatry Clinic is contracted with the following insurance plans: Hills Physicians - Blue Shield HMO, Blue Cross HMO, Health Net HMO, United Healthcare HMO, Blue Shield PPO, Blue Cross PPO, PHCS, Champ VA, Tricare, Aetna, Cigna, United Healthcare PPO, and Medicare.

MEDICARE: FPC participates with Medicare. You are responsible for paying your 20% co-insurance and any amounts applied to your annual deductible.

SUPPLEMENTAL PLANS: FPC will submit a claim to your supplemental insurer on your behalf. You will be responsible for any balance left over because of your insurance policy's co-payments and/or deductibles.

HMO PLANS: All HMO plans require a referral and/or pre-authorization from your primary care physician before you are seen in our office. If this is not obtained, you may be responsible for full payment at the time of service.

PARTNERSHIP: This plan requires a referral and/or pre-authorization from your primary care physician before you are seen in our office. If this is not obtained, you may be responsible for full payment at the time of service.

NON-CONTRACTED INSURANCES: FPC will courtesy bill your insurance if it is not on our contracted list. However, you will be responsible for full payment at the time of service, as your insurance company will send payment directly to you as reimbursement.

SELF PAY/CASH: If you do not have insurance, you are required to pay the full amount due at the time of service.

MISSED APPOINTMENTS: FPC reserves the right to charge you a **$50.00 fee** if you have missed an appointment or have failed to cancel your appointment more than 24 hours in advance. **This fee will need to be collected prior to making another appointment.**

PAYMENTS: We accept personal checks, cash, VISA, Mastercard, Discover, and money orders.

BAD CHECKS: FPC has a bad check fee of **$35.00** payable in cash or cashier check in addition to the face value of the bad check. FPC prosecutes offenders to the maximum extent of the law.

IMPORTANT!!! You are the beneficiary of your insurance plan and are bound by that contract with your insurance company. If that company deems you ineligible for benefits or denies coverage of a procedure or service as a non-covered benefit, you are responsible for the payment. If your insurance coverage changes, please provide us with the new information as soon as possible. If you fail to give us your current insurance information, you may be responsible for full payment for services rendered.

SIGNATURE:_____ **DATE:**_____

(Responsible Party)