PREMIER FOOT and ANKLE ASSOCIATES, PC

Drs. Timothy C. Stringer, DPM Laura A. Guerin, DPM

1981 State Hill Road

Wyomissing, PA 19610

Phone: 610-670-2277 Fax 610-670-5246

WELCOME! Please complete the New Patient forms completely and accurately. The thoroughness and completeness of this information is very important and improves our ability to assist you with your problem.

Please return this paperwork to our office via fax, mail or bring it along when you arrive for your appointment. We will need to see a photo ID (drivers license) and your insurance card(s).

Please arrive 15 minutes prior to your scheduled appointment.

Appointment day and date: _____

Appointment time:_____

Your arrival time: _____

How did you hear about Premier Foot and Ankle Associates?

____ Family Member_____

____ Friend/Co-worker _____

____ Internet _____

____ Physician Referral_____

____ Reading Eagle/Newspaper _____

____ Yellow Pages/Yellow Book _____

____ Other _____

Premier Foot and Ankle Associates, PC

Patient Information

Name: _____ Today's Date: _____

Social Security#:_____ Birthdate:_____ Age: _____ Sex: M / F

Address:_____ Apt#:_____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Marital Status: ____Single ____Married ____Widowed ____Divorced Spouse/Partner's Name _____

*Primary Language:_____*Ethnicity: _____ Hispanic or Latino _____ Not Hispanic or Latino ____ Declined to Specify

*Race: _____Asian _____American Indian or Alaska Native ____African American ____Caucasian

_____Native Hawaiian or other Pacific Islander ____ Declined to specify ***(Government Mandated Information)**

Emergency Contact:_____ Phone #:_____

Employment Status: [ ] Full time [ ] Part Time [ ] Retired [ ] Non employed [ ] Student

Primary Physician:_____ Date last seen: _____ Phone #_____

Pharmacy:_____ Location:_____

Employer Name:_____ Employer Phone #:_____

Employer Address:_____

Insurance Information

Insurance:_____ Are you the insured? [ ] Yes [ ] No

Name of Insured:_____ Relationship to Insured: [ ] Self [ ] Spouse [ ] Child [ ] Other

Insured Birthday: _____

Privacy Information Preferences

Can we send mail to the address on file? [ ] Yes [ ] No

Can we call the phone number on file? [ ] Yes [ ] No

Can we leave a voicemail on the machine? [ ] Yes [ ] No

Who can we leave messages with? [ ] Wife [ ] Husband [ ] Daughter [ ] Son [ ] Other: Name(s)_____

Do you want to be exempt from public reporting? [ ] Yes [ ] No

Will you allow us to send internet based delivery of reminders and newsletters? [ ] Yes [ ] No

Medical Information

What is the reason for your visit today?:_____
Is it the result of a work injury or accident?_____ How long has it bothered you?:_____
On a scale of 1-10(1 being no pain and 10 being the worst) what is your pain level?: _____/10
The pain quality is?: [ ] Constant [ ] Throbbing [ ] Sharp [ ] Dull [ ] Shooting [ ] Burning [ ] Tingling [ ] Numbness

Medical History

Please check any of the following conditions that you have now and/or have had in the past:

[ ] Acid Reflux	[ ] Diabetes	[ ] HIV
[ ] Anemia	[ ] Dementia	[ ] Kidney Disease
[ ] Anxiety Disorder	[ ] Depression	[ ] Liver Disease
[ ] Arrhythmia	[ ] Emphysema	[ ] Neuropathy
[ ] Arthritis	[ ] Epilepsy/Seizures	[ ] Pacemaker
[ ] Asthma	[ ] Fibromyalgia	[ ] PVD/Circulation Problems
[ ] Atrial Fibrillation	[ ] Gout	[ ] Psoriasis
[ ] Back Pain/Problems	[ ] Heart Attack	[ ] Psychiatric Disorder/Care
[ ] Bleeding Disorders	[ ] Heart Disease	[ ] Pulmonary Embolism/PE
[ ] Blood Clots/DVT	[ ] Heart Murmur	[ ] Rheumatoid Arthritis
[ ] Cancer: Type:_____	[ ] Heart Valve Disease	[ ] Sleep Apnea
[ ] Cerebral Palsy	[ ] Hepatitis	[ ] Stomach Ulcers
[ ] COPD	[ ] High Blood Pressure	[ ] Stroke
[ ] Congestive Heart Failure/CHF	[ ] High Cholesterol	[ ] Thyroid Disease: [ ] Hypo [ ] Hyper

[ ] Others not listed: _____

Are you pregnant?: [ ] Yes [ ] No Are you nursing?: [ ] Yes [ ] No
Last Flu Shot Date: _____ Did you get the pneumococcal vaccination?: [ ] Yes [ ] No
Have you fallen in the last 12 months?: [ ] Yes [ ] No If so, were you injured from the fall?: [ ] Yes [ ] No

Surgical History

Please list all prior surgical procedures:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Vitals

Height: _____ Weight: _____ Blood Pressure: _____
Shoe Size: _____ Shoe Width: _____

Social History

Do you smoke?: [ ] Never [ ] Former Smoker [ ] Current Smoker If yes, how many packs per day_____
How long have you smoked?: _____
Do you drink alcohol?: [ ] No [ ] Yes If yes, please check: [ ] Social/occasional [ ] Weekly [ ] Daily
Do you or have you used drugs?: [ ] No [ ] Yes If yes, please describe:_____
Have you ever had a past substance abuse problem?: [ ] No [ ] Yes If yes, please describe:_____
What is your occupation?:_____ Does it involve mostly [ ] Standing or [ ] Sitting
Do you exercise regularly?: [ ] No [ ] Yes If yes, please specify: _____
Do you have an advanced directive?: [ ] No [ ] Yes

Family History

Is there any family history of these conditions?: If so, please indicate family member:

[ ] Alzheimer's/Dementia	_____	[ ] Heart disease	_____
[ ] Cancer	_____	[ ] High Blood Pressure	_____
[ ] Diabetes	_____	[ ] Rheumatoid Arthritis	_____
[ ] Gout	_____	[ ] Stroke	_____
[ ] Other (specify)	_____		

[ ] Please check if no significant family history

Allergies

[ ] Please check if no known allergies

Allergy	Type of Reaction	Allergy	Type of Reaction
1. _____	_____	5. _____	_____
2. _____	_____	6. _____	_____
3. _____	_____	7. _____	_____
4. _____	_____	8. _____	_____

Medications

Please list all medications you are currently taking including prescriptions, over the counter meds, vitamins and herbal supplements: Please attach a list if needed. [ ] Please check if you are taking NONE presently

1. _____	6. _____	11. _____
2. _____	7. _____	12. _____
3. _____	8. _____	13. _____
4. _____	9. _____	14. _____
5. _____	10. _____	15. _____

Review of Systems

Please check if you currently have any of these symptoms or check none:

Constitutional/General:	[ ] Fever/Chills [ ] Fatigue [ ] Weight loss [ ] Nausea	[ ] None
Cardiovascular:	[ ] Chest pain/pressure [ ] Fainting [ ] Leg Swelling [ ] Palpitations	[ ] None
Respiratory:	[ ] Shortness of Breath [ ] Cough [ ] Wheezing [ ] Snoring [ ] Chest pain	[ ] None
Gastrointestinal:	[ ] Abdominal pain [ ] Diarrhea [ ] Constipation [ ] Blood in stool [ ] Vomiting [ ] Heartburn [ ] Difficulty Swallowing	[ ] None
Integument:	[ ] Toenail abnormalities [ ] Scaling [ ] Dryness [ ] Itching [ ] Rash [ ] Ulcer	[ ] None
Genitourinary:	[ ] Blood in urine [ ] Painful urination [ ] Incontinence [ ] Excessive urination [ ] Decrease in urination [ ] Hesitancy [ ] Increased urgency	[ ] None
Musculoskeletal:	[ ] Joint Pain [ ] Joint swelling [ ] Joint Stiffness [ ] Muscle weakness [ ] Muscle cramps [ ] Back pain	[ ] None
Neurological:	[ ] Numbness [ ] Tingling [ ] Tremors [ ] Paralysis [ ] Headaches [ ] Seizures	[ ] None

PREMIER FOOT & ANKLE ASSOCIATES, P.C.

Timothy C. Stringer, DPM Laura A. Guerin, DPM

FINANCIAL POLICY:

1. We will submit to the primary and secondary insurance carriers one time each.
2. We will review all claims denied incorrectly or paid unfairly to primary and secondary carriers, one each time.
3. If the insurance carrier still refuses to make a payment or additional payments when requested by this office, OR YOUR INSURANCE COMPANY BECOMES FINANCIALLY INSOLVENT OR BANKRUPT, THE PATIENT WILL AUTOMATICALLY BECOME RESPONSIBLE FOR ANY OUTSTANDING BALANCE. It will then be the patient's responsibility to seek reimbursement from the insurance carrier. EXCEPTIONS: Medicare, Highmark Blue Shield, Capital Blue Cross, Independence Blue Cross, Berkshire Health and InterCounty.
4. Each patient will be sent 3 monthly statements requesting payment of all personal balances. If payment in full is not received within 90 days of the first notification, the account will be turned over to a collection agency. It will become a permanent part of the Guarantor's credit history for 7 years. All costs for collections will be added to your unpaid balance (Court costs, Sheriff costs, Attorney fees, etc)
5. Payment plans are available upon request and are subject to a credit check on the guarantor of the account. Payment plans must be paid in full within 90 days, unless other arrangements have been made between the patient and the office.
6. All returned checks will be subject to $25.00 fee, which will be added to your account.

INSURANCE:
We participate with most insurance plans. You may have a deductible/co-insurance that you would be responsible for.

A. I understand my responsibility for all co-pays, deductible and services NOT covered by insurance and failure to make these payments when requested is basis for legal action and I agree to pay all costs of collection/attorney fees _____(*please initial*)
B. I authorize the release of any medical records to process any claim. I also request payment of government benefits either to myself or the office of Premier Foot & Ankle Associates. _____ (*please initial*)
C. I authorize payment of medical benefits to Dr. Timothy Stringer and Dr. Laura Guerin for services performed. _____ (*please initial*)

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Premier Foot & Ankle Associates 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 by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____ **Relationship:** _____ **Date:** _____

MEDICARE PATIENTS:
At the beginning of each new year, each Medicare patient will be asked to pay any and all monies applied to their annual deductible of $185.00. It is Medicare, not this office, who determines how much of what visit is to be applied towards the annual deductible. All claims and determinations are explained on your explanation of benefits from Medicare. If you have secondary insurance, please check with that plan to see if they pay your Medicare deductible. If they do not, you are responsible for paying such.

MEDICARE AUTHORIZATION: I request payment of authorized Medicare benefits be made either to me or on my behalf to Premier Foot & Ankle Associates, Dr. Stringer and Dr. Guerin for services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests payment be made and authorize release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurance company shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full change and the patient is responsible for only the deductible, co-insurance and non-covered services. Co-insurance and deductible are based upon charge determination of Medicare carrier.

Beneficiary Signature: _____ Date: _____

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CONSENT FORM:

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients consent for uses and disclosures of health information about the patient to carry out treatment, payment or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment for health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationship with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purpose of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use of disclosure of your personal health information, but this must be in writing. Under law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: _____ Signature: _____ Date: _____

COMPLIANCE ASSURANCE NOTIFICATION:

To our valued patient: The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health insurance Portability and Accountability Act(HIPPA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity in performing services to our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure you that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As a part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We realize we are not perfect. Our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank YOU for being one of our highly valued patients!