Accent Podiatry Associates, PC - 610-810-0800

Patient Name: _____ Date of Birth: _____

Personal Information

Height:	Weight:	Shoe Size:	Sex:
Address:	City:	State:	Zip Code:
Social Security Number:		Email address:	
Home Phone Number:		Cell Phone Number:	
Emergency Contact:		Phone Number:	Relationship:

Health Care

Insurance Company:		Insurance ID#:
Policy Holder:	Policy Holder SSN:	Policy Holder Address:
Primary Care Physician:		Primary Care Phone Number:
Preferred Pharmacy:		Pharmacy Location:

Foot Problem

Reason for visit:		When did problem begin?
Is this the result of an accident? YES / NO		Job related? YES / NO
Have you seen a doctor for your feet before? YES / NO	If so, When?	Doctor's name:
Are you diabetic? YES / NO		What is your occupation?
Do you smoke? YES / NO	If so, how long have you been a smoker?	Relationship:

Patient Name: _____ Date of Birth: _____

Reason for visit_____ Referred by_____

Personal History

Review of Systems: Do you currently have any problems in the following areas? If "yes" please **circle and explain** the problem you are having.

YES	NO	System	Common Problems	Explanation, or additional problem
		Skin	Rash, Warts, Fungus	
		Head	Headaches, Stroke,	
		Pulmonary	Asthma, Lung Problem	
		Cardiovascular	Heart Disease, Gout, High Blood Pressure, Kidney Problems, Diabetes	
		GI	Stomach Problems,	
		Musculoskeletal	Muscle Cramps, Swelling	
		Neurological	Tremor, Nervous Problems	

List current medication (or supply a list):

_____

_____

_____

Medication allergies: _____

Past Surgical History:

_____

_____

_____

Family History (circle all that apply)

Diabetes High Blood Pressure Heart Disease Stroke Asthma

Gout Bleeding Problems Arthritis Cancer

Additional Comments

_____

_____

_____

Acknowledgement of Consent to Medical Treatment

The undersigned certifies that s/he has read (or have read to me) the provided policies and information, understands it, accepts its terms, and has (if requested) received a copy of. I hereby agree to all terms and conditions set forth.

Signature of patient or authorized representative		Date	Time
Relationship	Witness	Date	Time

Communication Consent

It is the office policy of Accent Podiatry Associates, PC and staff not to release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. Whenever returning telephone calls and the answering machine picks up, we do not leave a
message if the name or telephone number is not on the recorded message to identify the residence. Also, information will not be left with an unauthorized person who may answer the telephone.

I authorize Accent Podiatry Associates, PC. and/or their staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes:

Home Telephone_____ ❑ yes ❑ no

Answering Machine _____ ❑ yes ❑ no

Work Telephone_____ ❑ yes ❑ no

Voice Mail_____ ❑ yes ❑ no

Cell Phone and/or Voice Mail _____ ❑ yes ❑ no

Pager_____ ❑ yes ❑ no

Fax medical records for referrals
to another entity _____ ❑ yes ❑ no

If you would like to have information released to someone other than yourself please complete the following:

Please list names of authorized people:
Spouse:_____ ❑ yes ❑ no
Parent:_____ ❑ yes ❑ no
Other names (please list relationship such as boyfriend, fiancé, girlfriend, sister, etc.)
❑ yes ❑ no

_____

_____

Printed Name_____
Patient/Guardian
Signature:_____Date:_____

Consent to Medical Treatment

1) Assignment of Insurance Benefits / Promise to Pay

I hereby assign and authorize payment directly to the Physician Clinic all insurance benefits, sick benefits, injury benefits due because of liability of a third-party, or proceeds of all claims resulting from the liability of a third party, payable by any party, organization, et cetera, to or for the patient unless the account for the Physician Clinic, outpatient visit or series of outpatient visits is paid in full upon discharge or upon completion of the outpatient series. If eligible for Medicare, I request Medicare services and benefits. I further agree that this assignment will not be withdrawn or voided at any time until the account is paid in full. I understand that I am responsible for any charges not covered by my insurance company.
I understand that I am obligated to pay the account of the Physician Clinic in accordance with the regular rates and terms of the Physician Clinic. If I fail to make payment when due and the account becomes delinquent or is turned over to a collection agency or an attorney for collection, I agree to pay all collection agency fees, court costs and attorney's fees. I also agree that any patient or guarantor overpayments on the above Physician Clinic visit may be applied directly to any delinquent account for which I or my guarantor is legally responsible at the time of the collection of my overpayment. I consent for the Physician Clinic to appeal on my behalf any denial for reimbursement, coverage, or payment for services or care provided to me.

2) Patient Consent for E-Prescribing (Electronic Prescribing)

I have been made aware and understand that medical practices and office may use an electronic prescription system, which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see my information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

3) Notice of Privacy Practices

Required pursuant of Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I have received a copy of the Physician Clinic's Notice of Privacy Policies. I hereby consent to the use and disclosure of my protected health information as described in the Notice of Privacy Practices. This will include all of my protected health information generated during hospitalization and out patient treatment at the Physician Clinic, including but not limited to treatment of mental health, drug and alcohol abuse, communicable diseases such as HIV/AIDS, developmental disabilities, genetic testing, and other types of treatment received.

4) General Consent for Tests, Treatment and Services

I agree and understand that all physicians (including fellows, residents, and interns), dentists, oral surgeons and podiatrists involved in my care in any way are responsible and liable for their own acts and omissions and the Physician Clinic is not responsible or liable for the acts and omissions of the aforementioned. Services may be performed by independent contractors who are not employed by the Physician Clinic. I am aware that the practice of medicine is not an exact science and further understand that no guarantee has been or can be made as to the results of the treatments, care or examinations in the Physician Clinic.
I have been informed of the treatment procedures considered necessary for me and that the treatments/procedures will be directed by a physician and my be performed by such physician and/or one or more additional physicians, fellows, residents, interns, and employees of the Physician Clinic. I understand that one or more physicians, fellows, residents, and/or interns at the Physician Clinic may

treat me or participate in my treatment. I understand that no guarantee or assurance has been made regarding (1) which physicians and/or fellows, residents, or interns will treat me or participate in my treatment and/or (2) the results that may be obtained from treatment.

5) Advance Directive Acknowledgement
Federal law requires that patients be provided information about their rights to make advance health care decisions, including Living Will, Durable Medical Power od Attorney or designation of surrogate decision made for healthcare decisions. If you have already completed any of these documents please inform your physician and the Physician Clinic.

6) Research Studies
Please inform your physician and the Physician Clinic if you are currently a participant in any research study or project and whom the physician may contact with questions about the study.

7) Consent to Photo/Video
I consent to the photographing, videotaping and/or video monitoring, including appropriate portions of my body, for medical record documentation purposes, provided said photographs or videotapes are maintained and released in accordance with protected health information regulations.

8) Consent to Photograph at the time of Registration
I, or my authorized legal representative, hereby give consent to the medical practice to take my photograph at the time of registration. I understand this photograph will be stored in the medical practice's ambulatory medical record electronically as my photo identification.

9) Email
I hereby consent to provide my e-mail address, so that representatives from the Physician Clinic can e-mail information to me about health education or disease prevention and up-to-date information about the Physician Clinic, its affiliated physicians, and our services. I understand I will be able to change my preference at any time.

10) Cell Phones
I hereby consent to provide my telephone number(s), including my wireless telephone number(s), so that representatives from the Physician Clinic, its successors or assigns can contact me in any manner including but not limited to manually placing a call, using an automatic telephone dialing system or an artificial or prerecorded voice, by texting, or by emailing, regarding any matter, including but not limited to my medical treatments, prescriptions, insurance eligibility, insurance coverage, scheduling, billing or collection matters. This consent includes any updated or additional contact information that I may provide. I understand that I will be able to change my preference at any time.

11) Videotaping/Recording
I understand and agree not to photograph, videotape, audiotape, record or otherwise capture imaging or sound on any device. I also understand it is my responsibility to assure those accompanying me comply with this requirement.