JESS P. PRICE, DPM, P.C

NEW PATIENT INFORMATION/UPDATE

Date: _____

Name: _____ **Phone:** (____)_____

Email: _____ **Social Security:** _____

Date of Birth: _____ **Age:** _____ **Male** **Female**

Full Time AZ resident? (Circle one) YES/NO

AZ Address: _____

City: _____ **State:** _____ **Zip code:** _____

Other Address: _____

City: _____ **State:** _____ **Zip code:** _____

Employer: _____ **Occupation:** _____

Work Phone: (____) _____

Family Doctor: _____ **Phone:** (____) _____

Pharmacy Name: _____ **Phone:** (____) _____

Cross Streets: _____ **City:** _____

Emergency Contact
Name: _____ **Phone:** (____) _____

Were you referred by you primary doctor? (Circle one) YES/ NO

Were you referred by one of our patients? (Circle one) YES/ NO

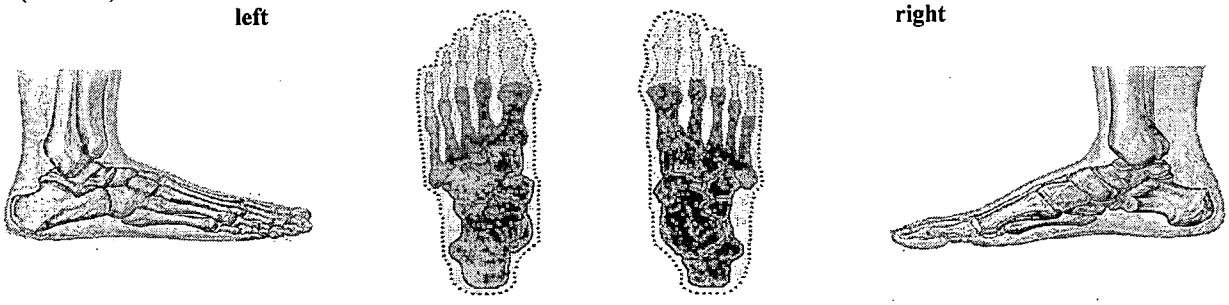
If no, how did you hear about us? _____

CHIEF COMPLAINT/ REASON FOR COMING TO THE CLINIC: _____

_____

(CIRCLE)

left **right**



How long has this been a problem? _____

Prior home or professional treatment: _____

MEDICAL HISTORY

Do you have or have you ever had any of the following

_NONE

- □ **Acid Reflux**
- □ **Anemia**
- □ **Arthritis-type**

_____

- □ **Arrhythmia**
- □ **Asthma**
- □ **Anesthesia difficulties**
- □ **Bleeding Disorders**
- □ **Blood Clots**
- □ **Bowel Disorders**
- □ **Bronchitis**
- □ **Chest pain**
- □ **Chronic Pains**
- □ **Circulation Disorders**
- □ **Diabetes- type**

_____

- □ **Color changes of skin**
- □ **Depression**
- □ **Dialysis**
- □ **Emphysema**
- □ **Epilepsy**
- □ **Fibromyalgia**
- □ **Glaucoma**
- □ **Gout**
- □ **Hearing Deficit**
- □ **Heart Attack**
- □ **Heart Disease**
- □ **Heart Murmur**
- □ **Hernia-type**
- □ **High Blood Pressure**
- □ **History of alcohol dependency**
- □ **Irritable Bowel Syndrome**
- □ **HIV (AIDS)**
- □ **Cancer-type**

_____

- □ **Kidney Disease**
- □ **Keloid (Scar Formations)**
- □ **Kidney Stones**
- □ **Leg Pain (Cramps)**
- □ **Lung Disease**
- □ **Migraine Headaches**
- □ **Muscle Disease**
- □ **Other**

_____

- □ **Pacemaker**
- □ **Phlebitis**
- □ **Pneumonia**
- □ **Hepatitis-type**

_____

- □ **Prostate Disease**
- □ **Psoriasis**
- □ **PVD**
- □ **RSD**
- □ **History of drug dependency**
- □ **Sickle Cell Anemia**
- □ **Sinus Problems**
- □ **Stomach Problems**
- □ **Stroke**
- □ **Thyroid Disease**
- □ **Tuberculosis**
- □ **Varicose Veins**
- □ **Venereal Disease**
- □ **Vision Problems**
- □ **Shortness of Breath**
- □ **Ulcers-type**

_____

PAST SURGICAL HISTORY AND HOSPITALIZATIONS

Operations/ Serious Injuries	Approximate date	Physician	Hospital

SOCIAL HISTORY

	YES	NO	
Do you smoke?	□	□	If yes, number of packs per day _____ How many years? _____ Years Quit _____
Do you drink alcohol?	□	□	Estimate # of drinks per day/week/month _____

FAMILY HISTORY

Any family members with...	YES	NO	Who?
Diabetes	□	□	
Anesthesia Difficulties	□	□	
Foot Problems	□	□	

VITALS

	YES	NO	
Do you have metal in your eyes/body?	☐	☐	If yes, location? _____
Do you have stents?	☐	☐	If yes, type and location? _____
FEMALE PATIENTS: Are you pregnant?	☐	☐	LMP? _____

Height: _____ Weight: _____ Shoe Size: _____

ALLERGIES

☐ **NO KNOWN DRUG ALLERGIES**

	YES	NO		YES	NO
Aspirin	☐	☐	Latex	☐	☐
Codeine	☐	☐	Local Anesthetics	☐	☐
General Anesthetics	☐	☐	Penicillin	☐	☐
Iodine/Shellfish	☐	☐	Sulfa Drugs	☐	☐
Metals	☐	☐	Other _____	☐	☐

MEDICATIONS

☐ **NONE**

Medication	Dosage	How Often

AUTHORIZATION TO RELEASE PRIVATE HEALTH INFORMATION (PHI)

1) Please check yes or no

Do we have permission to?	YES	NO
Leave a message regarding test results, appointments, etc. on you home/cell answer machine?	☐	☐
Leave a message at you place of employment?	☐	☐
If yes, please list the phone numbers _____, _____, _____	☐	☐

2) Please check (√) one only

☐ I only want my medical information released to myself

☐ I give Jess P Price, DPM and staff authority to release medical information regarding my care. This authority will be in effect for one (1) year

Name	Relationship

Patient Signature: _____ **Date:** _____

JESS P. PRICE, DPM, P.C

Patient Name _____ **Date** _____

Insurance Information:

PRIMARY INSURANCE

Name_____ Group#_____

Policy Holder _____ Date of Birth _____

ID# _____

Employer _____ SS# _____

Relationship to Policy Holder: ____SELF ____SPOUSE ____CHILD

SECONDARY INSURANCE

Name_____ Group#_____

Policy Holder _____ Date of Birth _____

ID# _____

Employer _____ SS# _____

Relationship to Policy Holder: ____SELF ____SPOUSE ____CHILD

	YES	NO
Is this a work related injury? If yes, date of injury _____	☐	☐
Is you injury related to an auto accident? If yes, date of accident _____	☐	☐
How did you injury occur? _____	☐	☐

AUTHORIZATION TO TREAT/RELEASE OF INFORMATION:

1.) I hereby give my permission to Dr. Jess Price to administer treatment and to perform procedures as may be deemed necessary in the diagnosis and treatment of the extremity condition. I also hereby assign to the above named physicians all benefits provided by my insurance company policy or policies for medical or surgical care. I understand that I am financially responsible for any balance due on my account. I also authorize the above physicians to release all information required in the processing of my claims.

PRINT NAME_____

SIGNATURE_____ **DATE**_____

PATIENT FINANCIAL POLICY

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.

Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept Visa, MasterCard, Discover, cash or check.

Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.

We have made prior arrangements with insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement, we will prepare and sent the claim for you on an unassigned basis. This means your insurer will sent the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.

All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services, however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

You must inform the office of all insurance changes and authorization referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.

There are certain elective surgical procedures that require prepayment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.

Past due accounts are subject to collection proceedings. All fees including , but not limited to collection fee, attorney fees and court fees shall become your responsibility in addition to the balance due this office.

There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

Signature of Patient/Responsible Party:_____

Printed name of Patient/Responsible Party:_____ **Date:**_____

NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. You have the right to obtain a paper copy of this Notice upon request.

Patient Health Information: Under Federal Law your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. You health information also includes payment, billing, and insurance information.

How We Use Your Patient Health Information: We use health information about you for treatment, to obtain payment, and for healthcare operations (including administrative purposes and evaluation of the quality of care that you receive). Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment, and Healthcare Operations: Treatment, We will use and disclose your health information to provide you with medical treatment of services. For example; nurses, physicians, and other member of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other healthcare providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care. Payment, We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization form your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan. Healthcare Operations, we will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Special Uses: We may use your information to contact you with appointment reminders. We may also contact you to provide information about your treatment alternatives or other health related benefits and services that may be of interest to you.

Other Uses and Disclosures: We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, We are permitted to give out health information without your permission for the following purposes; Required by Law, We may be required by law to report gunshot wounds, suspected abuse or neglect or similar injuries and events. Research, We may use or disclose information for approved medical research.

Public Heath Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.

Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.

Judicial and Administrative proceedings: We may disclose information in response to an appropriate subpoena or court order.

Law enforcement purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.

Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.

Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.

Worker's Compensation: We may release information about you for workers compensation or similar programs providing benefits for work related injuries or illness.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights: You have the following rights with regard to our health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.

Request Restrictions: You may request restrictions on certain uses and disclosures of you health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.

Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.

Inspect and Obtain Copies: In most cases, you have the right to look at or obtain a copy of your healthcare information. There may be a small charge for the copies.

Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

Accounting of Disclosure: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment or healthcare operations.

Our Legal Duty: We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices: We may change our policies at any time. Before we make a significant change in our policies, we will change ou Notice and post the new Notice in the waiting area and each exam room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints: If you are concerned that we have violated your privacy rights, or if you **disagree** with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person: If you have any questions, requests, or complaints, please contact;

Privacy Officer
5980 S. Cooper Rd. Suite 4
Chandler, AZ. 85249
480-705-7300
Effective Date: April 14,2003

I, _____ hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signature: _____ Date: _____

If not signed, reason why acknowledgment was not obtained: _____

Staff Witness seeking acknowledgment: _____ Date: _____

Agreement and Conditions of Treatment

This is an agreement between **Dr. Jess Price, D.P.M** and me. This summarizes our discussion and understanding of the conditions under which I consent to treatment of my foot and/or ankle problems.

I understand that my physician, **Dr. Price, D.P.M** will use his best skill and judgment to accomplish the desired result, but that **Dr. Price, D.P.M** cannot and does not warrant or guarantee such result: also that his forecast of length of time involved in therapy and/or recovery from surgery, the manner of recovery and the possible complications or untoward results is based upon the usual and average response in cases similar to mine, but that is not a promise since my result response may be different from the usual.

On my part, I agree to full cooperation with **Dr. Price, D.P.M.** and his staff in my full treatment, whether by surgical or non-surgical means. I understand that if I do not follow my doctor's instructions, or the instructions of his staff concerning my care and treatment, including any necessary physical therapy, the outcome of my care and treatment could be put into jeopardy and a bad result may occur.

Print Patient Name: _____

Patient Signature: _____ Date: _____

Witness: _____ Date: _____