



Podiatry Care Plus

Dr. Aree Saed, DPM
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PATIENT INFORMATION

FIRST NAME		LAST NAME		M.I.	DATE OF BIRTH / /
SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	HOME NUMBER		CELL NUMBER		EMAIL
ADDRESS					
CITY		STATE		ZIP CODE	
EMERGENCY CONTACT		RELATIONSHIP		PHONE NUMBER	
IF THE PATIENT IS A MINOR , PLEASE INDICATE WHO IS AUTHORIZING TREATMENT OR ACCEPTING FINANCIAL RESPONSIBILITY				RELATIONSHIP TO THE CHILD	

RESPONSIBLE PARTY

<input type="checkbox"/> SELF	FIRST NAME	LAST NAME
ADDRESS		
CITY	STATE	ZIP CODE
EMPLOYER	RELATIONSHIP	PHONE NUMBER

INSURANCE INFORMATION

DO YOU HAVE INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO	PRIMARY CARD HOLDER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER			
PRIMARY POLICY HOLDER NAME	PRIMARY INSURANCE COMPANY		PRIMARY ID NUMBER	
DO YOU HAVE SECONDARY INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO	SECONDARY CARD HOLDER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER			
SECONDARY POLICY HOLDER NAME	SECONDARY INSURANCE COMPANY		SECONDARY ID NUMBER	

Patient Signature (or Signature of Legal Representative):	Date:
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PATIENT INTAKE

(Please complete all sections to the best of your ability. Our staff is here to help with any questions you may have.)

CURRENT HEIGHT	CURRENT WEIGHT	SHOE SIZE
OCCUPATION		
PRIMARY CARE PHYSICIAN	DATE OF LAST VISIT	PCP PHONE
PHARMACY	LOCATION	

Reason for Visit:

- Reason for your visit: _____
- How long has this been a problem? _____
- Type of Pain: (please circle)
 Burning - Tingling - Sharp - Dull Ache - Throbbing - Shooting- Stabbing – Numbness
- When does it occur? (please circle)
 Morning - Afternoon - Evening - Off and On - All Day
- Do your legs swell? YES NO
- Do you have back problems or have had back injury? YES NO
- List current sports and/or activities: _____

Pain Assessment:

- When is it painful? (please circle)
 Upon Standing - During Walking - After Walking - During Sports - Worse with Activity - Lying in Bed
 Worse When Standing - With Shoes - Without Shoes - A.M. - P.M. – Always
- How painful is your condition? (If 0 = 'NO Pain' and 10 = 'the worst pain')
 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
- Have you had foot and/or ankle care before?
 YES NO

If yes, by whom? _____ When: _____

Patient Signature (or Signature of Legal Representative):	Date:
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ALLERGIES: Do you have a history of any Allergies, Skin reactions or Illness following the administration of any of the following?

- Adhesive Tape Anesthesia Aspirin Codeine Dairy Products Iodine/Shellfish/Contrast
 Morphine Penicillin Latex NONE Other:

MEDICAL HISTORY: Have you ever had any of the following? (Please check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Alzheimer's/Dementia | <input type="checkbox"/> Dialysis M W F or T TH SA | <input type="checkbox"/> Nerve Condition |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> GERD (Reflux) / GI Ulcers | <input type="checkbox"/> Osteoporosis/osteopenia |
| <input type="checkbox"/> Arthritis - Osteoarthritis/Rheumatoid | <input type="checkbox"/> Gout | <input type="checkbox"/> Phlebitis (blood clots in legs) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Poor Circulation/PVD |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Hepatitis AB C/Liver Disease | <input type="checkbox"/> Seizures/Epilepsy |
| <input type="checkbox"/> Bleeding/Clotting problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> CAD (coronary artery disease) | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> STD's (sexually transmitted disease) |
| <input type="checkbox"/> Cancer - Type: | <input type="checkbox"/> HIV/Aids/ARC | <input type="checkbox"/> Sickle Cell Trait/Disease |
| <input type="checkbox"/> Cardiac arrest | <input type="checkbox"/> Kidney/Renal Disease | <input type="checkbox"/> Stroke/TIA's |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Lung Disease/Pulmonary Embolus | <input type="checkbox"/> Thyroid (Hypo/Hyper) |
| <input type="checkbox"/> Diabetes - Type: 1 - 2 | <input type="checkbox"/> Lyme's Disease | <input type="checkbox"/> Other: |

***For Diabetic Patients only:** Last Finger Stick Reading: _____ Last A1C Reading: _____ *

MEDICATIONS: Please list any medications you are currently taking, including over-the-counter medications:

Medication	Dosage

SURGICAL HISTORY: Please list any hospitalizations, surgeries, fractures or major illnesses you have experienced:

Type of Surgery	Year or Date

SOCIAL HISTORY:

- Do you drink alcohol? Yes No Daily Weekly Infrequently Recovering Alcoholic
 Do you smoke currently? Yes No How many packs per day? _____
 Have you smoked previously? Yes No When did you quit? _____
 Are you sexually active? Yes No
 Do you or have you used illicit/recreational drugs Yes No
 Are you currently pregnant? Yes No If yes, what is your due date?

FAMILY HISTORY: Please indicate if your mother (M) or father (F) have had any of the following conditions:

- Anesthesia Problems M F Arthritis M F Cancer M F Diabetes M F
 Heart Problems M F Hypertension M F Stroke M F Thyroid Disorder M F

Patient Signature (or Signature of Legal Representative):	Date:
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REVIEW OF SYSTEMS

If you are experiencing any of the following, please circle

Head: Chronic headaches, concussions, dizziness, loss of consciousness.

Eyes: Glasses, contacts, double vision, blurred vision, blindness, cataracts.

Ears: Decreased or loss of hearing, ringing in the ears, chronic earaches.

Nose: Drainage or infection, blockage, bleeding, sinusitis.

Throat: Chronic tonsillitis, laryngitis, difficulty swallowing, loss of speech.

Cardiovascular: Chest pain, shortness of breath, palpitations, murmur, heart valve disease, anemia, leg cramps.

Respiratory: Bronchitis, pneumonia, difficulty breathing, wheezing, chronic cough.

Gastrointestinal: Nausea, diarrhea, constipation, weight gain or loss, blood in stool, black stool, excessive gas, loss of appetite.

Genitourinary: Chronic kidney or bladder infections, pain with urination, dark or bloody urine, discharge from penis or vagina.

Gynecologic: Irregular or painful periods, absence of periods (if not in menopause), vaginal discharge.

Other:

I am not currently experiencing any of the symptoms listed above

Patient Signature (or Signature of Legal Representative):	Date:
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ACKNOWLEDGEMENT AND CONSENT TO TREAT

Consent for Treatment:

I consent to any treatments or procedures that may be performed on an outpatient basis, including emergency treatments and services. This may encompass, but is not limited to, medications, injections, medical photography, laboratory tests, and X-ray examinations. I understand that these services will be provided according to the general and specific instructions of Dr. Aree Saed, the staff, and other healthcare providers at Podiatry Care Plus who are involved in my care.

I certify that the information above is true and correct to the best of my knowledge. I have been informed that If I am uncertain about any question on the form, I should ask the doctor or a member of the office staff for assistance. By signing below, I hereby authorize Podiatry Care Plus, LLC to obtain medication history from community pharmacies and/or pharmacy benefit managers for the purpose of ongoing treatment.

Patient's Printed Name: Patient Signature (or Signature of Legal Representative):	Date:
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SUMMARY NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient, and our common practices in dealing with patient health information.

Uses and Disclosures of Health Information:

We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information to obtain payment for our services or to allow insurance companies to process claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation, and training of students.

Uses and Disclosures Based on Your Authorization:

Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization for:

- Family members or close friends who are involved in your health care.
- Certain limited research purposes.
- Public health and safety.
- Government agencies for audits, investigations, and other oversight activities.
- Authorities to prevent child abuse or domestic violence.
- The FDA to report product defects or incidents.
- Law enforcement to protect public safety or to assist in apprehending criminal offenders.
- Court orders, search warrants, subpoenas, and as otherwise required by law.

Patient Rights:

As our patient, you have the following rights:

- To have access to and/or a copy of your health information.
- To receive an accounting of certain disclosures we have made of your health information.
- To request restrictions on how your health information is used or disclosed.
- To request that we communicate with you in confidence.
- To request that we amend your health information.
- To receive notice of our privacy practices.

If you have questions, concerns, or complaints regarding our privacy practices, please contact our office at **240-295-0405**

I, _____ (name of patient), acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read or had the opportunity to read, and understood the Notice. By signing below, I hereby authorize Dr. Aree Saed, Podiatry Care Plus, LLC, to obtain medication history related to the patient above from Community Pharmacies and/or Pharmacy Benefit Managers for the purpose of continued treatment.

In addition, I authorize the following _____ individuals' access to my personal health information upon request.

Patient Signature (or Signature of Legal Representative):	Date:
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FINANCIAL POLICY

Payment in Full:

Payment in full is due at the time of service unless prior arrangements have been made.

Co-Payments:

Office visit co-payments for our participating HMO/PPO insurances are due at the time of service. For insurance plans with deductibles and co-insurance obligations, applicable amounts due for services rendered are also required at the time of service.

Claim Filing:

If we are a participating provider with your primary health insurance, we are happy to file a claim on your behalf. However, once the insurance company is billed, we allow 60 days for the balance to be paid by your insurance carrier. If the insurance company does not remit payment within 60 days, the balance will be due in full of you. If any payment is subsequently made by your insurance carrier in excess of the balance, we will gladly issue a refund for the overpayment to you within 30 days, provided that you do not have any outstanding accounts with our office.

Patient Responsibility:

An HMO/PPO claim denial due to no referral or authorization is the patient's responsibility. Our office staff will notify and assist you with referral and pre-certification procedures, but the final responsibility lies with the patient to comply with their specific insurance requirements. All referrals must be presented to our office before seeing the doctor.

Insurance Card:

Please present your most recent insurance card each time you visit if we participate with your plan to ensure proper filing of information for claims submission. Otherwise, your visit may not be covered, and you will be responsible for payment. A \$15 service fee will be assessed for re-filing insurance claims due to incomplete or incorrect information provided at the time of the appointment.

Returned Checks:

There is a \$25.00 fee for all returned checks.

Unpaid Balances:

All unpaid balances are subject to a 1.5% interest charge after 30 days. For balances that remain unpaid after 90 days, we will take appropriate collection actions, including registering the amount past due with the EQUIFAX credit rating service. If your account must be forwarded to a collection service and/or attorney due to non-payment, you will be responsible for all collection and/or attorney fees charged by these services.

Missed Appointments:

Please be on time for your appointment. Podiatry Care Plus, LLC reserves the right to charge a fee of **\$50.00** for all missed appointments ("no shows") and for appointments that are not canceled with a compelling reason at least 24 hours in advance. "No show" fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple "no shows" in any 12-month period may result in termination from our practice. If you are 15 minutes late or more for your appointment, you may be asked to reschedule.

Outpatient Surgery:

If you are scheduled for outpatient surgery, there will be a \$150.00 fee for rescheduling or canceling the surgery.

ASSIGNMENT OF BENEFITS

I understand and certify that I (or my dependent) have coverage with _____ and assign directly to Podiatry Care Plus, LLC all insurance benefits payable to me for services rendered. I understand that I am responsible for payment of my deductibles, co-payments, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the release of medical information to my insurance carrier or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions. By my signature, I acknowledge receipt of a copy of this policy and hereby agree to its terms.

Patient Signature (or Signature of Legal Representative):	Date:
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