

GENERAL MEDICAL HISTORY, continued

Patient Name _____

Personal

Family Member

- | | | |
|--|--|------------------------------|
| <input type="checkbox"/> yes <input type="checkbox"/> no | Heart Disease | <input type="checkbox"/> yes |
| <input type="checkbox"/> yes <input type="checkbox"/> no | Hepatitis | |
| <input type="checkbox"/> yes <input type="checkbox"/> no | High Blood Pressure | <input type="checkbox"/> yes |
| <input type="checkbox"/> yes <input type="checkbox"/> no | Kidney Problems | <input type="checkbox"/> yes |
| <input type="checkbox"/> yes <input type="checkbox"/> no | Liver Disease | <input type="checkbox"/> yes |
| <input type="checkbox"/> yes <input type="checkbox"/> no | Lung/Respiratory Problems | <input type="checkbox"/> yes |
| <input type="checkbox"/> yes <input type="checkbox"/> no | Menopause | |
| <input type="checkbox"/> yes <input type="checkbox"/> no | Mental Illness | <input type="checkbox"/> yes |
| <input type="checkbox"/> yes <input type="checkbox"/> no | Migraine Headaches | |
| <input type="checkbox"/> yes <input type="checkbox"/> no | Osteoporosis | <input type="checkbox"/> yes |
| <input type="checkbox"/> yes <input type="checkbox"/> no | Phlebitis/Clots | <input type="checkbox"/> yes |
| <input type="checkbox"/> yes <input type="checkbox"/> no | Psoriasis | <input type="checkbox"/> yes |
| <input type="checkbox"/> yes <input type="checkbox"/> no | Rheumatic Fever | |
| <input type="checkbox"/> yes <input type="checkbox"/> no | Shortness of Breath | |
| <input type="checkbox"/> yes <input type="checkbox"/> no | Sinus Problems | |
| <input type="checkbox"/> yes <input type="checkbox"/> no | Stomach Ulcers/ Problems | |
| <input type="checkbox"/> yes <input type="checkbox"/> no | Stroke | <input type="checkbox"/> yes |
| <input type="checkbox"/> yes <input type="checkbox"/> no | Thyroid Problems | |
| <input type="checkbox"/> yes <input type="checkbox"/> no | Tuberculosis | |
| <input type="checkbox"/> yes <input type="checkbox"/> no | Varicose Veins | |
| <input type="checkbox"/> yes <input type="checkbox"/> no | Venereal Disease | |
| <input type="checkbox"/> yes <input type="checkbox"/> no | Weight Change: (recent) _____ lbs. gain/loss | |

MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins _____

SURGERIES: List surgeries you have had and dates. _____

INJURIES: List serious injuries and dates. _____

ALLERGIES:

- | | | | | |
|--|--|-------------------------------------|----------------------------------|---------------------------------|
| <input type="checkbox"/> Adhesive Tape | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Demerol | <input type="checkbox"/> Iodine |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Local Anesthetics | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Food | |
| <input type="checkbox"/> Sulfa | <input type="checkbox"/> No known drug allergies | <input type="checkbox"/> Other | _____ | |

SOCIAL HISTORY

- | | | |
|--|--|--------------------|
| Do you smoke? | <input type="checkbox"/> yes <input type="checkbox"/> no | How much? _____ |
| Are you a past smoker? | <input type="checkbox"/> yes <input type="checkbox"/> no | Years smoked _____ |
| Drink alcohol? | <input type="checkbox"/> yes <input type="checkbox"/> no | How much? _____ |
| Recreational drug user? | <input type="checkbox"/> yes <input type="checkbox"/> no | Type _____ |
| Women only: Pregnant or possibly pregnant? | <input type="checkbox"/> yes <input type="checkbox"/> no | |

**PUGET SOUND FOOT & ANKLE CENTER
FINANCIAL POLICY**

Thank you for choosing us as your podiatric physicians. We are committed to your treatment being successful, as you are our first and foremost concern. As part of our service, we try to contain the cost of health care. In an effort to do this, we have implemented a Financial Policy.

Please read our **Financial Policy** and sign prior to any treatment. To avoid any misunderstandings, please contact us should you have any questions about our policy.

INSURANCE: If you provide us with your insurance information, we will submit the claim to your insurance company. To do this we must have *complete and accurate* insurance information and a copy of your identification card or claim form. Your insurance policy is a contract between you and your insurance company, therefore you are responsible for payment whether or not your insurance company pays. ***It is your responsibility to contact your insurance company regarding pre-authorizations, obtaining required referrals, second opinions, etc.*** Failure to do so may reduce the amount of benefits paid by your insurance, and the balance will then become your responsibility to pay. All co-payments must be paid at the time of service. Please inform us of any changes in your insurance coverage and be prepared to show your insurance card at each visit.

NO INSURANCE: If you do not have insurance or the proper referral required by your insurance, please be prepared to fully cover the fees for each visit at the time of treatment.

PAYMENT: ***Please pay co-payments at the time of your visit.*** We accept cash, check, Visa or MasterCard credit card payments. An extended payment plan may be arranged to make monthly payments if desired by contacting our billing manager. There will be a \$25.00 charge for ***returned checks*** that will be added to your balance. ***Delinquent accounts*** will be referred for collection at the discretion of the office manager.

MINOR PATIENTS: The adult or the parent (custodial guardian) accompanying a minor is responsible for payment of services. For unaccompanied minors, non-emergency treatment will be denied unless prior authorization from the parent or guardian has been made for the treatment and charges. Young adults (age 18 and over) are legally responsible for their accounts unless a parent (or guardian) accompanies them to the initial appointment and signs the Financial Policy, regardless of insurance coverage.

MISSED APPOINTMENTS: Please help us serve you better by keeping scheduled appointments. If it is necessary to cancel, please call our office 24 hours in advance. This allows us to accommodate our other patients. We reserve the right to charge for missed appointments.

ORTHOTICS: Orthotics are a non-covered service by some insurance plans. Please check with your insurance company *prior* to the examination and casting for orthotics to determine your benefits. A deposit of \$150.00 is requested at the time of examination and casting.

REFERRALS: If your insurance plan requires you to have a referral from your primary care physician *prior* to obtaining the services of a specialist, those services may not be covered (or will be reimbursed at a lower rate) unless a referral form has been provided by your primary care doctor. You have the right, of course, to choose the services without the referral. However you will be held financially responsible for these services.

I have read and agree to the terms set forth in the above financial policy.

Signature: _____ **Date:** _____