Medicine and Surgery of the Foot and Ankle
J. JOHN HOY, D.P.M., P.S.
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If you would like to fill out these forms electronically, please go to Adobe Fill & Sign mobile app or https://get.adobe.com/reader/ and download Adobe Acrobat Reader DC. Please sign the forms by creating a hand signature instead of typing it in. Thank you.

Welcome to Our Practice!

Patient Information

Name_____

SSN_____

Address_____

City_____

County_____State_____Zip_____

Home (____)_____

Mobile (____)_____

E-mail_____

(for appt reminders and survey)

Date of Birth_____Gender:_____

Employer_____

Address_____

City_____State____Zip_____

Work phone (____)_____

Emergency Contact_____

Phone (____)_____

Pharmacy Name_____

Address_____

Primary Insurance_____

Type: HMO PPO POS EPO Private Other

Relation to Insured: Self Spouse Child Other

Start Date_____End Date_____

ID #_____Group #_____

Employer Name_____

Secondary Insurance_____

Type: HMO PPO POS EPO Private Other

Relation to Insured: Self Spouse Child Other

Start Date_____End Date_____

ID #_____Group #_____

Employer Name_____

Primary care provider_____

Clinic Name/Address_____

City_____State_____Zip_____

Phone (____)_____

Fax (____)_____

OK to send chart notes to doctor? YES NO

How did you hear about us? _____

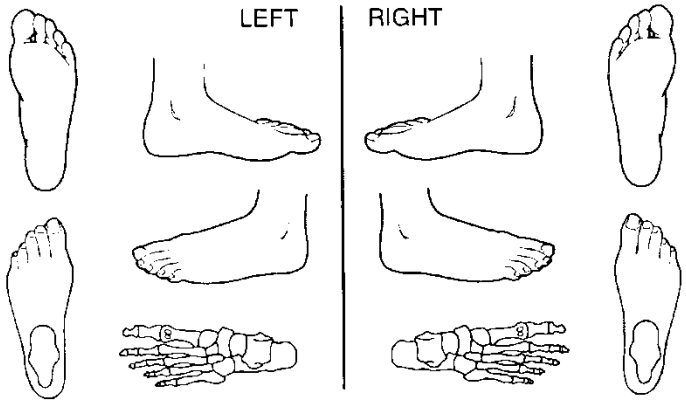
Demographic information (for government reporting)

Do you identify as (circle one): Non-Hispanic/Latino or Hispanic/Latino

Please indicate your preferred language:_____

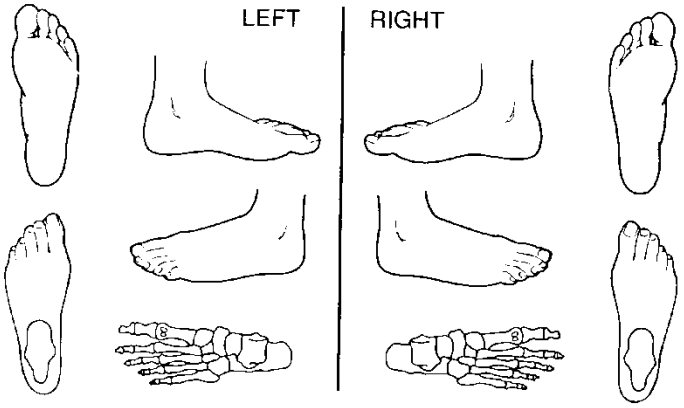
Please circle the heritage(s) with which you identify:

Black/African American
Asian
White
Native American/Native Alaskan
Native Hawaiian/Other Pacific Islander
Decline to specify



Description:

1. Please mark the location of your first problem or pain on the diagram above and describe it in the space next to it (how it started, how it progressed, if it radiates, what makes it better or worse).
2. How long ago did the problem or pain start? (circle): _____ days/weeks/months/years ago
3. How severe is the pain on a scale of 0 (no pain) to 10 (worst imaginable pain): _____
4. How would you describe the pain or discomfort? (circle): shooting throbbing sharp burning itching aching tenderness dull tingling electrical numbness Other:_____
5. Is it present while (circle): walking not walking Other:_____
6. What have you or other doctors done in the past to treat the problem?



Description:

1. Please mark the location of your next problem or pain on the diagram above and describe it in the space next to it (how it started, how it progressed, if it radiates, what makes it better or worse).
2. How long ago did the problem or pain start? (circle): _____ days/weeks/months/years ago
3. How severe is the pain on a scale of 0 (no pain) to 10 (worst imaginable pain): _____
4. How would you describe the pain or discomfort? (circle): shooting throbbing sharp burning itching aching tenderness dull tingling electrical numbness Other:_____
5. Is it present while (circle): walking not walking Other:_____
6. What have you or other doctors done in the past to treat the problem?

PATIENT:_____

1. Please go through the list of medical problems to your right and check off all the ones you have. (**Your** diagnoses)
2. Do any illnesses run in your family? What are some diseases that your brothers and sisters, parents or grandparents have? (list below)
3. Please list below the medications that you are taking. Include the dosage if you know it. Include over-the-counter and herbal.
4. Are you allergic to any medications, foods, iodine, Neosporin, latex or local anesthetics? Please list below along with the effects:
5. Have you had any surgeries? Please list, along with when they were done and if there were any complications:
6. Have you had any hospitalizations? Please list what for and when?
7. What type of work do you do?
8. What activities do you do on your feet?
9. Please give your height_____, weight_____, shoe size_____
10. Please indicate your smoking status (circle one):

Never smoker	Light tobacco smoker
Former smoker	Heavy tobacco smoker
Current some day smoker	Unknown if ever smoked
Current every day smoker	Smoker, current status unknown

REVIEW OF SYSTEMS/PROBLEM LIST:

- ❑ ALL SYSTEMS NEGATIVE EXCEPT AS NOTED

CARDIOVASCULAR

- ❑ HIGH BLOOD PRESSURE
- ❑ CHEST PAIN
- ❑ HISTORY OF HEART ATTACK
- ❑ CORONARY BYPASS / STENT
- ❑ CONGESTIVE HEART / FAILURE
- ❑ DYSRHYTHMIA
- ❑ PACEMAKER/AICD

COAGULATION

- ❑ ANEMIA
- ❑ CLOTTING PROBLEMS

COMFORT

- ❑ CHRONIC PAIN
  PAIN LEVEL 0 - 10 _____

HEPATIC / RENAL

- ❑ HEPATITIS
- ❑ LIVER DYSFUNCTION
- ❑ RENAL DYSFUNCTION
- ❑ BLADDER PROBLEMS
- ❑ HEMO/PERITONEAL DIALYSIS

METABOLIC / DIGESTIVE

- ❑ DIABETES - DIET/ORAL/INSULIN
- ❑ THYROID PROBLEMS
- ❑ HEARTBURN
- ❑ CHANGE IN WEIGHT
- ❑ ULCER

MUSCULOSKELETAL

- ❑ NECK/BACK PROBLEMS
- ❑ ARTHRITIS
- ❑ ARTIFICIAL JOINTS

NEUROSENSORY

- ❑ HISTORY OF SEIZURES
- ❑ HISTORY OF STROKE
- ❑ PARESIS/PARALYSIS
- ❑ PERIPHERAL NEUROPAHTY
- ❑ DEPRESSION/ANXIETY

RESPIRATORY

- ❑ SMOKER _____YEARS
- ❑ QUIT SMOKING _____
- ❑ EMPHYSEMA
- ❑ ASTHMA
- ❑ TUBERCULOSIS
- ❑ SHORTNESS OF BREATH AT REST
- ❑ COPD
- ❑ SLEEP APNEA

SOCIAL HISTORY

- ❑ ALCOHOL _____
- ❑ AMOUNT _____
- ❑ LAST DRINK _____
- ❑ RECREATIONAL DRUGS _____

OTHER

- ❑ CANCER
- ❑ PREGNANT

Payment Policy

Thank you for choosing J. John Hoy, DPM, PS, as your foot and ankle care provider. We are committed to providing you with quality and affordable health care. Please read the following office payment policy and feel free to ask us any questions that you may have. Once you accept this policy, kindly sign in the space provided. A copy will be provided to you.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full* is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full* for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments, balances and deductibles. All co-payments, balances and deductibles* must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments, balances and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your amount due at each visit.

3. Non-covered services. Please be aware that some, and perhaps all, of the services you receive may be uncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full* at the time of visit.

4. Proof of insurance. All patients must complete our patient information forms before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If required, obtaining the proper referral from your Primary Care Physician is your responsibility. Patients presenting to our office without a valid referral will be asked to pay in full*. This payment will be held for 48 hours and will become non-refundable if the proper referral is not obtained by then.

***5. Payment in full.** If payment in full is required according to any of the conditions above, $75 pre-payment is required for new patients and $25 for established patients before being seen by the doctor, with the remainder due at the end of the visit.

6. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the balance of a claim. Your insurance company may also need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

7. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

8. Nonpayment. Invoices are sent out every 30 days and payment is due within 14 days of receipt. Your prompt payment will assist us in keeping the cost of healthcare down. A rebilling fee will be charged for each additional invoice sent out after 30 days. Partial payments will not be accepted unless otherwise approved by our Billing Department. Our returned check fee is $20. Please be aware that if a balance remains unpaid, we may refer your account for collection activity and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by certified mail that you have 30 days to find alternative podiatric care. During that 30-day period, our physician will only be able to treat you on an emergency basis. If collection costs or legal fees are incurred by Dr. Hoy as a result of late payment or nonpayment, you will be responsible for all of those collection costs and legal fees.

9. Billing inquiries and disputes. All verbal or written correspondence must be directed to the Billing Department as indicated on the invoice. Do not contact the clinic on billing matters as they have been instructed to refer such matters to the Billing Department. If you have still have a billing dispute after contacting the Billing Department, you must submit the reasons for your dispute in writing to the Billing Department within 14 days of speaking to the Billing Department. Dr. Hoy will respond to you in writing within 14 days of receiving your written dispute. His response will be final and failure to pay the entire outstanding bill within 7 days of receipt of his response will be considered Nonpayment under paragraph 8.

10. Missed appointments. Our policy is to charge $30.00 for missed appointments not canceled within a reasonable amount of time or for an understandable reason. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your scheduled appointment.

11. Forms and Documents. It is our policy to charge $10.00 for completion of all forms, such as disability applications, etc. We also charge a customary fee for copies of medical records and x-rays.

12. Fees. Our fees are based on the medical record and are representative of the usual and customary charges for our area.

13. Inpatient visits. If a patient is treated by Dr. Hoy in any inpatient facility, such as an assisted living facility, this form must be co-signed by the nurse or other staff person responsible for the patient's care at the time of Dr. Hoy's visit.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns. I have read and understand the payment policy and agree to abide by its guidelines.

_____/_____ _____/_____

Signature of patient or responsible party/Signature of facility staff (if applicable) Date

Authorization for Treatment, Assignment of Insurance, and Release of Medical Information

I, the undersigned, do hereby authorize J. John Hoy, DPM, PS to render treatment and/or therapy to myself that has been deemed medically necessary in order to treat the condition(s) I have requested from himself and his staff.

In considering the amount of medical expenses to be incurred, I, the undersigned have insurance and/or employee health care benefits coverage with the enclosed caption, and hereby assign and convey directly to J. John Hoy, DPM, PS all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from said doctor and clinic.

I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments and understand that these balances are due within 90 days from the date of an insurance payment and/or denial. I have read and signed the Payment Policy. If outside collections are necessary, I will be responsible for all collection and legal fees. I hereby authorize the doctor to release all medical information necessary to process this claim within HIPAA guidelines. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to said doctor and clinic any plan documents, insurance policy and settlement information upon written request from said doctor and clinic in order to claim such medical benefits, reimbursement or applicable release. I authorize the use of this signature on all my insurance or employee health benefit claim submissions. I acknowledge that a copy of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Manual and financial policies and procedures is available to me in the office for my reference.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plans on any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above name doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies.

Further, in response to any reasonable request for cooperation, I agree to cooperate with said doctor and clinic in an attempt by said doctor and clinic to pursue such claims, choose in action or right against my insurers and employee health care plan including, if necessary, bring suit with said doctor and clinic against insurers and employee health care plan in my name but at said doctor's and clinic's expense. This assignment will remain in effect until revoked by me in writing. Photo of this assignment is to be considered as valid as the original. I have read and fully understood this agreement.

_____/_____	_____/_____
Signature of patient or responsible party /Signature of facility staff (if applicable)	Date

_____
Relationship of Insured to Minor