Joel D. Foster DPM, PC
Welcome to Our Office

This sheet provides us with information vital to your health and will aid our office in accurately filling your insurance forms. Be assured that this information will remain strictly confidential. Please take a moment to complete this form.

PATIENT INFORMATION   TODAY'S DATE_____________

Patient's full name____

MARITAL STATUS (circle) Single Married Widowed Divorced   Gender: (circle) Male Female

Social Security No.___________________________ Birth Date____________ Age__________________

Street Address_______________________________ Home Phone________________________________

City, State, Zip ______________________________Email _____________________________________

Cell Phone _________________________________ Work Phone_______________________________

Employer__________________________________ Occupation________________________________

Employer Address____

RESPONSIBLE PARTY OR NAME INSURANCE UNDER

Name____

Social Security No.______________________ Birth Date_______________ Home Phone______________

Street Address__________________________ City, State, Zip_____________________________________

Employer_____________________________ Employer Address__________________________________

MEDICAL INFORMATION

Family Doctor_____________________________________ Last visit to family doctor_________________

Pharmacy information (name and location) ____

In case of emergency, please call (Name/Relationship)_________________________Phone____________

MEDICAL INSURANCE

HMO_________ PPO________ CO-PAY $___________

Primary Company___________________________ Secondary Company___________________________

Subscriber________________________________ Subscriber____________________________________

Certificate#_______________________________ Certificate#__________________________________

Group#___________________________________ Group#_______________________________________

REFERRAL INFORMATION

Please take a moment to tell us how you found out about our practice. Please check as many as necessary.

My family doctor, Dr.___________________________ Patient from this practice_____________________

Another doctor, Dr._____________________________ Telephone book (which one?)_________________

Friend, co-worker_______________________________ Web site or web search______________________

Radio/TV(which station?)______________________ Insurance web site or directory ________________

Other ____

Joel D. Foster DPM
Podiatric Medicine and Surgery

Patient Name ______________________________

Patient History

Please Circle any medical conditions that you have or have had. Aids/HIV Arthritis Asthma

Blood Disorders Chemical Dependency Diabetes Cancer
Kidney Disorders Heart Disease Hepatitis/Jaundice Gout
High Blood Pressure High Cholesterol Liver Problems Neuropathy
Low Blood Pressure Lung Problems Psychiatric Disorders Stroke
Thyroid Problems Tuberculosis Ulcers Epilepsy/Seizures

Please circle any allergies that you are aware of Adhesive tape Aspirin Codeine Demerol Iodine
Local Anesthetic Penicillin Seafood Sulfa Other ____

Please list any medications that you are taking ____

____

____

Please list any surgeries that you have had. ____

____

____

Do you or have you recently had any of the following?

Eyes: cataracts, blurred vision, impaired vision, blindness, wear glasses or contacts, other _____________________

____

Ears, Nose, Mouth, Throat: tinnitus (ringing in ears), halitosis (chronic bad breath), diminished hearing, deafness, difficulty swallowing, other ____

Cardiovascular: congestive heart failure, MI(heart attack), palpitations, high blood pressure, CVA(stroke), angina/chest pain, blood clots, varicose veins, lymph edema, other heart problems_____________________________

____

Respiratory: asthma, shortness of breath, sleep apnea, snoring, sinus congestion/infections, other breathing problems ____

Gastrointestinal: nausea, vomiting, diarrhea, blood in stool, ulcers, reflux, other ______________________________

____

Genitourinary: painful urination, blood in urine, frequent urination, impotence, STDs, other _______________________

____

Musculoskeletal: back pain, joint pain, muscle pain, bone pain, scoliosis, other___________________________________

____

Integumentary: dermatitis, eczema, tinea (athlete's foot), psoriasis, rash, or other ________________________________

____

Neurological: anesthesia, paraesthesia (decreased or unusual sensations), neuropathy, seizures, tremors, other ____

Psychiatric: anxiety, depression, binging, paranoia, other psychiatric concerns ____________________________________

____

Endocrine: diabetes mellitus, fatigue, or unexplained weight loss or gain, other ____________________________________

____

Immunologic: allergies, gout, rheumatic disease, other ____

Do you smoke or use tobacco products? YES NO Cigarettes Pipe Cigar Chewing Tobacco
Do you drink alcohol? YES NO How much and how often? ____

List any medical conditions that run in your immediate family (specify which family member).___________________

____

JOEL D. FOSTER DPM, PC

AUTHORIZATION TO RELEASE MEDICAL BENEFITS

I authorize the release of all medical information necessary to process insurance claim(s) and I hereby assign and authorize direct payment of all medical and/or surgical benefits, including major medical, private insurance and other health plans to Joel D. Foster DPM PC.

Please remember that medical insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some insurance companies pay fixed allowances for certain procedures, and other pays a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance.

In order to control the cost of billing, we request that the co-pay portion of your office visit be paid at the time of the visit.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

To the extent necessary to determine liability of payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record.

This assignment will remain in effect until revoked by me in writing. A signed photocopy of this Assignment will be considered as valid as an original.

Signature of Beneficiary_________________________________ Date ______________

DISCLOSURE OF PROTECTED HEALTH INFORMATION TO ANOTHER PARTY

I also authorize Joel D. Foster DPM PC to use and/or disclose certain protected health information (PHI) about to the party or parties listed below:

Family Member:____________Relationship______________phone number__________
Family Member:____________Relationship______________phone number__________

Check applicable information:
_____Medical Information
_____Testing /Radiology/MRI Results
_____Billing/Insurance Information
_____Authorized to leave message on voice mail
_____Other, Describe____

When my information is used or disclosed pursuant to this authorization, it may subject to disclosure by the recipient and may no longer be protected by the federal HIPPA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at 6 NW Sycamore St. Suite A Lees Summit, MO 64086.

Signature of Beneficiary______________________________Date__________________

.

JOEL D. FOSTER DPM, PC

I hereby give my consent for Dr. Joel D. Foster DPM, PC to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPHO).

With this consent, Joel D. Foster DPM, PC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPHO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others. However, our policy is not to leave detailed messages regarding Protected Health Information or anything related to treatment or healthcare operations.

With this consent, Joel D. Foster DPM, PC may mail to my home or other alternative location any items that assist the practice in carrying out TPHO, such as appointment reminder cards and patient statements.

By signing this form, I am consenting to Joel D. Foster DPM, PC use and disclosure of my protected health information to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Joel D. Foster DPM, PC may decline to provide treatment.

Signature of Patient or Legal Guardian Signature of Patient or Legal Guardian

Patient's Name Date

FINANCIAL POLICY

As insurance coverage decreases and the patient's financial responsibility increases, we understand the need for clear communication of our financial policies. To better service the needs of our patients, we have added valuable tools to help you meet your increased medical expenses.

1. We will continue to look to insurance companies for their payment, and assist you in receiving proper reimbursement for our services. Unfortunately, most insurance no longer covers services fully and most current insurances plans chosen by our patients require significant out-of-pocket expenses to be paid by the patient.
2. Our staff has been trained to be able to communicate with you and answer your questions regarding payment and insurance reimbursement.
3. It is your responsibility to verify that all requirements of your insurance plan are met. We will assist you with pre-certification for procedures ordered by our office, but it is ultimately your responsibility to verify whether any care you receive is covered by your insurance. This office is not responsible for the expense of treatment, which is not paid by your insurance. With continuous changes in coverage, it is important for you to verify your benefits and be aware of all restrictions and expenses of your plan.
4. In accordance with the requirements of most insurance contracts, we will require payment of office co-payments at the time of service. Any person being seen for treatment or service will be required to pay the necessary co-payment at the time of service. Your insurance company will be notified when this contractual payment is not paid at the time of the appointment.
5. For patients owed balances, we will offer payment plans to assist you in meeting your financial obligations to our office. You must advise us of any payment you receive from insurance or any third party for our services and forward this amount to our office immediately.
6. If we are a contracted provider on your insurance plan, we will file a claim with your carrier and you will be billed when they have responded to our claim. Upon receipt of their response, payment or denial, you will receive a statement for the amount your insurance company notifies us is your responsibility.
7. If our doctors are not contracted providers for your insurance plan, we will file a claim with the information you provide and you will be billed for the entire amount. You will receive monthly statements and we will look to you for payment. You will be responsible for working with your insurance company to insure prompt payment.
8. If you do not have current insurance card with you, you will be billed for the entire amount and asked for payment at the time of service. It is your responsibility to give us your card at each visit (if requested). We will not be able to file your insurance without a copy of your insurance card.
9. If you have an insurance plan that requires a referral, we will require that the referral be here before we can see you. We will do our best to assist you in obtaining the referral, but to expedite matters it is best for you to contact your primary care physician and have the fax the referral over to us or bring the referral in with you.

I understand these policies and accept responsibility for payment of my account.

Responsible Party Signature______________________________ Date_______________

Responsible Party Name ____________________ Patient Name______________________

Joel D Foster DPM PC