ADVANCED PODIATRY

Appointment & Payment Policy

Patients are seen by Dr. Gagnon *based on appointment time, not arrival time*. If you arrive early, he will see you as soon as he can but patients with appointments before you will be given priority. If you need to reschedule, contact the office as soon as possible. A $50 fee may be charged for patients who continually miss appointments.

Copays are due at each visit ***Balances are due upon receipt of your statement***

I have read & understand the above Policy: _____ _____
Signature **Date**

Credit Card Policy

A credit/debit or HSA (Health Savings Account) card on file is for account balances. Once insurance processes your claim, we will text or call you if a balance exists, and with your permission, process the payment. Payments will show on your bank statement or via a text notification you have setup with your financial institution.

Does your HSA need a detailed receipt? [ ] Yes

Credit Card # _____ Exp: _____ Security Code: _____

(Please show the card to the receptionist if you prefer not to record the information here)

Authorization for Credit Card: _____ _____
Patient Signature **Date**

Patient Information

Patient's Name: _____
First Name **Middle Initial** **Last Name**

Address: _____

Home Phone: _____ Cell Phone: _____ Preferred Contact: [ ] Home [ ] Cell

Would you like a texted appointment reminder?* [ ] Yes [ ] No (*Crestwood Patients Only)

Social Sec #: _____-_____-_____ Date of Birth: _____ Email: _____

Sex: Male Female **Marital Status:** Married Never Married Widowed Divorced Separated Other

Race: Caucasian African-American Hispanic Asian Other: _____

Retired [ ] or Employed by: _____ Phone: _____

Employer's Address: _____
Street **City** **State** **Zip Code**

Pharmacy Name & City: _____

Referred by: Friend (Who?_____) Primary Dr. Family Internet Saw Sign Ins Co Immediate Care Orland Twnshp

Subscriber (Are you the Insured?) [ ] Yes [ ] No If no, please fill out below information

Insured's Name: _____ Date of Birth: _____ Phone: _____

Relation to Patient: _____ Address (if different than patient): _____

Emergency Contact & Person designated to receive your Protected Health Information

Name: _____ Phone: _____ Relationship: _____

ADVANCED PODIATRY

Present Illness/Injury (Is today's visit the result of an accident/work injury? [ ] Yes [ ] No)

Foot/Ankle Problems (Current or past): Please circle all that apply Ankle Pain - Athlete's Foot – Bunions - Corns/Calluses Cramps in Feet/Legs - Flat Feet - Heel Pain - Ingrown Nails - Tired Feet - Plantar Warts – Numbness/Swelling in feet, legs, toes

Describe foot/ankle problem: _____

How long have you had this problem? _____ **Were you treated for this previously?** [ ] Yes [ ] No

If yes, when and by whom: _____

I am currently seeing a physician for another medical condition? [ ] Yes [ ] No **Reason:** _____

Primary Care Physician: _____**City:** _____ **Phone:** _____

Height: _____ **Weight:** _____ **Shoe Size:** _____ (Circle one: Narrow Med Wide Extra-Wide)

Smoking status? (Circle one) Never smoked Former smoker Current every day smoker Current some day smoker

Do you drink alcohol/beer? [ ] Yes [ ] No **If yes, how often:** 1-2/day 3+/day 1-2/wk 3+/week

At work, do you: Sit Stand Walk

Allergies (RX and Over-the-Counter)

Circle any allergies: **NONE** Latex – Penicillin – Sulfa – Codeine – Iodine - Adhesive/Tape – Vicodin – Aspirin/NSAIDS

List additional allergies: _____

Medications

Current prescription and over-the-counter drugs (with dosages): **[ ] None**

(We can obtain your prescriptions from our EMR system - if you ***do not*** authorize us to do this, please initial _____)

List others below or provide a list to copy

_____ _____ _____

_____ _____ _____

_____ _____ _____

Family History (Circle all that apply) – Patient's parents and brothers/sisters

Anxiety/Depression	Emphysema	Liver Disease	Psoriasis/Skin Prob
Arthritis	Epilepsy	Neurologic Disorder	Respiratory Disease
Asthma	Gastrointestinal/Reflux/Ulcers	Neuropathy	Stroke
Cancer	Heart Disease	Osteoporosis	Varicose Veins
Cholesterol Problems	High Blood Pressure	Poor Circulation	
Diabetes	Kidney Disease/Dialysis	Prostate Problems	

ADVANCED PODIATRY

Medical History

Do you have a pacemaker? [ ] Yes [ ] No **Implants?** [ ] Yes [ ] No **Artificial Joints?** [ ] Yes [ ] No

If Yes, Describe: _____

Please *circle all* that apply to you in *each* row. If none apply, circle **None**

General: Chills Fatigue Fever Weakness Weight Gain/Loss **None**

Respiratory: Asthma COPD Cough Emphysema Shortness of Breath **None**

Cardiac: Cramps Heart Disease/Murmur High BP Heart Attack Heart Valve Rheumatic Fever Varicose Veins **None**

GI: Constipation Diarrhea Hepatitis Jaundice Liver Disease Nausea/Vomiting Stomach Ulcers **None**

M/S: Arthritis Gout Joint Stiffness Low Back Pain Paralysis Toe Walking Weakness **None**

Psychiatric: Depression Disorientation Memory Loss **None**

Skin: Athletes Foot Dryness Eczema Fungal Nails Ingrown Nails Itching Lumps Rash Warts **None**

Neurologic: Burning Charcot Neuroma Numbness Strokes Tingling Tremors Unsteady Gait **None**

Endocrine: Diabetes (Age of Onset: _____ & Last A1C: _____) Thirst Thyroid **None**

Hematology: Anemia Bleed Easily Blood Clots Chemotherapy **None**

Urinary: Burning/Pain on Urination Dialysis Frequent Urination Kidney Problems **None**

Surgery / Injury History

Any problems with anesthesia? [ ] Yes [ ] No **Describe:** _____

Surgeries/Injuries (In last 5 years – include the year):_____

_____

_____

Treatment Consent / Assignment of Benefits / HIPAA / Payment for Services

I request and give permission for treatment of my foot/ankle condition(s) by Dr. Mark J. Gagnon (and whomever he may designate as his assistants) as he feels necessary. I understand that information relating to my medical condition may be released to my insurance company for claims purposes and that this information may include my insurance ID number and social security number, as well as other personal information. I hold harmless Dr. Mark J. Gagnon for any action taken by present or future insurers as a result of this information.

I was provided a copy of the Notice of Privacy Practices and have read (or had the opportunity to read) & understood the Notice.

I authorize payment for services rendered to *ADVANCED PODIATRY*. I am responsible for any portion not contractually covered by insurance as well as Service Fees ($15/month) on unpaid balances. If my account is sent to Collection, I agree to pay an additional 25% over the unpaid balance including but not limited to filing fees, court costs, collection agency fees, and attorney fees. If I have a credit card on file, I authorize payments of $25 every other week in case of an overdue balance.

I certify that the information I have provided and all above statements are true and correct and my insurance information is current to the best of my knowledge.

_____/_____ _____/_____

Patient or Guardian Signature Date Reviewed by Dr. Gagnon ate