Asheville Podiatry Associates, P.A.

Patient Last Name ______________________________ **First** _____________________ **Middle** ______

Mailing Address ____

City ____ **State** ____________ **Zip Code** _______________

Contact Phone ______________________________ **Circle one: CELL HOME**

E-mail Address ____ **Want Patient Portal App? Yes No**

Date of Birth _____/_______/______ **Age**______ **Sex: M** or **F**

Race (circle) African American Indian Caucasian/White Asian Other Declined

Ethnicity (circle) Hispanic Non-Hispanic **Marital Status (circle)** S M W D P

How did you hear about our office? Physician Google Patient/Other Who? _________________________

Employer ____ **Occupation** ___________________________

Preferred Pharmacy & Address____

Required Primary Insurance ___________________________________**ID** ________________________

Who Is Insurance Subscriber? (circle) Self Child Spouse Partner Other ____________________

Name Of Subscriber ____**Subscriber DOB** ____/____/______

Required Secondary Insurance __________________________________**ID** ________________________

If patient is a minor, Who is responsible for the patient bill, please complete:

Responsible Party Name ____ **DOB** _____/____/______

Responsible Party Address ____

Responsible Party Telephone # ______________________________

Please Note: We do not make payment arrangements. All **Copay** and **un-met deductibles** are due at the time of service. It is the patient / guardian's responsibility to know and understand their individual health insurance coverage.

X____ **Date** ___________________

Signature of patient, parent/guardian or POA **12/20/2023**

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Asheville Podiatry Associates, P.A.

Name: ______________________________ **Date:** ____________________

Complaint: ______________________________ **(CIRCLE 1) RIGHT LEFT BOTH**

Pain level (scale of 1-10) on an average day: __________

How long has this been bothering you? ______ Days _______Weeks ________Months ________Years

Please CIRCLE the answers to the questions below.

Did the problem start: gradually suddenly?
Is the problem: worsening improving staying the same?
What type of pain are you having? Sharp dull aching throbbing burning numbness tingling
Is the pain: constant intermittent?
Is the problem worse with: weight bearing non-weight bearing both?
What previous treatment have you received for this problem?

Medication (which one) ______________________________
Different shoes padding shoe inserts rest surgery
Other treatment ______________________________
Did these treatments help? Yes No

Primary care physician(s)______________________________ **Phone #** ____________________

Date Last Seen ____________________ **Send Medical Records to Doctor CIRCLE: YES NO**

Past/Current Medical History:

Constitutional

___ Recurrent Fever
___ Weakness
___ Fatigue
___ Weight gain
___ Weight loss
___ Change of appetite
___ Headaches

Respiratory

___ Cough
___ Wheezing
___ Shortness of breath
___ Sleep apnea
___ Snoring
___ Lung Disease/COPD
___ Asthma

Musculoskeletal

___ Foot/Toe/Leg pain
___ Arthritis
___ Back pain/neck pain
___ Unequal leg length
___ Muscle Cramps
___ Falls
___ Osteoporosis
___ Gout

Cardiovascular

___ Chest pain
___ Palpitations
___ Poor circulation
___ Atrial Fib
___ Varicose Veins
___ DVT
___ High blood pressure
___ High Cholesterol

Endocrine

___ High blood sugar
___ Low blood sugar
___ Overactive Bladder
___ Excessive thirst
___ Diabetes **Type** I II
___ Thyroid problems
___ Cold/Heat intolerance

Skin

___ Dry skin
___ Itching
___ Skin Lesions
___ Scars/Keloid
___ Rash
___ Foot Odor

Immune System

___ Immune Disorders
___ Chemotherapy
___ Radiation
___ Transplant
___ AIDS / HIV +
___ Lupus
___ Cancer **Type** __________

Neurological

___ Abnormal balance
___ Numbness/Tingling
___ Restless Leg
___ Seizures
___ Stroke

Gastrointestinal

___ Nausea
___ Vomiting
___ Diarrhea
___ Heart burn/GERD
___ Stomach problems
___ Stomach ulcer

Hematology

___ Bleeding/ Bruising
___ Anemia
___ Liver disease
___ kidney disease
___ Hepatitis

Psychiatric

____ Depression
____ Anxiety
____ Bipolar
____ Schizophrenia
____ Insomnia
____ ADHD

____ **Misc. not listed**
____
____

OVER

Social History

Use of Alcohol... _____ Never _____Rarely ___Moderate _____Daily

Use of Tobacco... _____ Never _____ Previously, but quit _____ Packs per day

Use of Vaping.... _____ Never _____Rarely ___Moderate _____Daily

Use of Drugs.... _____ Never _____ Past

Family History: Do you have any relatives with similar foot problems? Yes No

Please circle: Mother Father Grandparents Other___________________

Please list all surgeries (tonsillectomy, appendectomy, etc.)

____

____

____

____

*** I consent to allow Asheville Podiatry Associates to view / import my medication history. Yes No**

Please list all medications including prescription and over the counter vitamins, minerals and supplements:

Name of medicine	Dosage	Name of medicine	Dosage

Medication Allergies Yes No Please List:

________________________________ ________________________________

________________________________ ________________________________

________________________________ ________________________________

Height: _________ **Weight:** _________

Shoe Size: _________

Asheville Podiatry Associates, P.A.

Thank you for choosing Asheville Podiatry Associates for your foot and ankle care. Please understand that payment of your bill is ultimately your responsibility. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment.

- **Full payment is due at time of service** for all self-pay, co-pays, deductibles and/or percentage, non-covered services and supplies. The Guardian/Adult accompanying a minor is responsible for any payment due at time of service.

Our Office Accepts Cash, Check, and VISA MASTERCARD & DISCOVER Debit/Credit Cards

Regarding Your Insurance
Accurate insurance information must be given at the time of service. Your insurance coverage is a contract between YOU (subscriber) and the insurance company. If your insurance company has not paid your account within 45 days of treatment, the balance **MAY** be transferred to you. It is your (Subscriber) responsibility to know your benefits, including copays, deductibles, and non-covered services. Failure to provide correct insurance at time of service may result in being your responsibility. As a courtesy, we will file your charges to your primary / secondary insurance only.

No Show Appointments
Asheville Podiatry Associates will make every effort to remind patients of their appointment. This is done as a **courtesy**. Patients are ultimately responsible for remembering to keep their appointment. If a patient does not show up for a scheduled appointment or cancels an appointment without 24 hours' notice, our policy is to charge **$50** per visit. **Same day cancellation** is a **$30** charge. ***Please Initial*** ___________

Billing
We are not a billing service. As a courtesy we will file your date of service to your insurance company and YOU are responsible for any patient charges thereafter as a result of your EOB's, WE will balance bill you. Accounts over 60 days may be sent to a collection agency.

Record Requests and Disability Forms
Original medical records and x-rays are the property of Asheville Podiatry Associates. For a copy of an Xray or Medical Records there will be a **$20 prepayment and a 7-business day notice.** All disability and FMLA forms must have the patient portion of the form completed in full and all associated fees paid PRIOR to completion. Please allow **7-10 business days** for completion. ALL requests must include a signed authorization for the release of information. ***Please Initial*** ___________

I authorize the release of any information concerning: me, my child, and / or the individual for whom I am the responsible party, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also authorize payment of insurance benefits, not paid by myself, directly to Asheville Podiatry Associates.

I have read and agree to the above Financial Policy of Asheville Podiatry Associates:

____

Signature of Patient or Responsible Party (Guardian, POA)   Date

OVER

Asheville Podiatry Associates, P.A.

Request for Confidential Communications and
Patient Acknowledgment of Receipt of Notice of
Privacy Practices "**HIPPA**"

Print Name ______________________________

I request Appointment Reminder Calls be made to Phone # ______________________

May we leave a message at above listed number? YES NO

THIS OFFICE DOES NOT TEXT NOR EMAIL REMINDERS OF APPOINTMENTS. If you have the **Patient Portal** you will receive emails, calls and /or text messages for your appointments.

I authorize the following individual(s) to receive communication and information regarding my healthcare:

____

Name Relationship Phone number

____

Name Relationship Phone number

Emergency Contact Name __________________________ Ph # _________________

I acknowledge upon request that I am entitled to a copy of Notice of Privacy Practices and that I have read or had the opportunity to read if I so choose and understand the notice.

____ ________________

Signature of Patient or Guardian Date

12/20/2023