FOOT HEALTH CENTER OF MERRIMACK VALLEY, P.C.

451 Andover St., Suite 209, North Andover, MA 01845 Tel: 978-686-7623

1565 Main St. #102, (Villa Roma Dr), Tewksbury, MA 01876 Tel 978-640-1010

WELCOME TO OUR OFFICE

First Name	Middle Initial	Last Name	Generation Jr Sr I II III	Gender (circle) M F
Date of Birth	Age		Marital Status (circle) ___ Single ___ Married ___ Widowed ___ Divorced	
Street Address:		City	State	ZIP
Home Phone:	Work Phone:		Cell Phone:	
Email Address:				
Primary Care Physician:	**Date of Last Visit:** Month: Year:		Location	Hospital Affiliation
Referring Physician	Location			
Pharmacy Information: Name	**Address: Street & City**		**Phone #**	
Primary Language:	Race:		Ethnicity: □ check box if Latino or Hispanic	
Contact Preferences (check one): □ Phone □ Mail □ Email **If via Phone - ok to leave message with** □ Patient Only □ Patient and/or Spouse □ Anyone				
How did you find out about our Practice? (circle one) **Internet/Google** **Facebook** **Friend/Family** **Insurance Company** **Doctor Referral (who)? _____** **Other _____**				
Legal Representative/Responsible Person				
Emergency Contact:	Phone #:		Relationship to Patient:	

OFFICE POLICY REGARDING INSURANCE

To preserve the best possible relationship with you, our patient, and to prevent any misunderstanding, we hope the following explanation of our office policy regarding insurance and payment for services is helpful.

1.) We expect and appreciate payment for office visits at the time of service. We will accept cash, check, MasterCard, Visa, or debit cards.

2.) For any insurance plan that requires authorization from a primary care physician, (e.g. HMO, PPO, etc.), it is your responsibility, (as patient or guardian), to be sure that this office receives all necessary referrals or authorizations PRIOR to treatment. If the insurance carrier denies any charges due to lack of referral authorization, you, (the patient), are responsible for all charges incurred.

3.) If any type of supplies are dispensed during the course of treatment, (e.g. arch supports, accommodative pads, creams, surgical shoes, etc.), payment is due at the time of service. We cannot bill you or the insurance company for these supplies.

4.) I have read, and understand and agree to the above office policies and understand that I am financially responsible for any balance due on my account.

5.) I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

X _____ _____ _____

(Signature of patient or Responsible party, if patient is a minor) Relationship to patient Date

(NEXT PAGE PLEASE)

MEDICAL INFORMATION

Have you ever had, or been treated for, any of the following?

HEART
__ Angina
__ Arrhythmia
__ Heart Attack
__ Heart Disease
__ Heart Murmur
__ High Blood Pressure
__ High Cholesterol
__ Mitral Valve Prolapse
__ Pacemaker
__ Rheumatic Fever
__ Stroke

RESPIRATORY
__ Asthma
__ Emphysema
__ Tuberculosis

ARTHRITIS
__ Gout
__ Osteoarthritis
__ Rheumatoid Arthritis

HEENT
__ Headaches
__ Glaucoma
__ Hearing Problems

VASCULAR
__ Anemia
__ Blood Clots
__ Foot or Leg Cramps
__ Leg Pain when Walking
__ Poor Circulation
__ Prolonged Bleeding
__ Stroke

__ Varicose Veins

GASTROINTESTINAL
__ Acid Reflux (GERD)
__ Bowel Disorders
__ GI or Rectal Bleeding
__ Hiatal Hernia
__ Stomach Problems
__ Ulcers

NEUROLOGICAL
__ Epilepsy/Seizures
__ Parkinson's Disease

PSYCHOLOGICAL
__ Alcohol Dependence
__ Anxiety
__ Depression
__ Drug Dependence
__ Psychiatric Care

MISCELLANEOUS
__ Back Problems
__ Bladder Problems
__ Cancer (type:_____)
__ Frequent Infections
__ Healing Problems
__ Hepatitis (Liver Disease)
__ HIV
__ Kidney Problems
__ Muscle Disease (Polio)
__ Prostate Problems
__ Thyroid Disease
__ Unexplained Weight Loss
__ Dialysis

OTHER
__DIABETES
___ Insulin
___ Non- Insulin
Last HGA1C#

Do You have a family history of the following: Bleeding Disorder Arthritis Stroke Diabetes Circulation problems Neurological Disorders

Height: _____ Weight: _____ Shoe Size _____

Chief Foot Problem: _____

How long have you had this problem? _____

What surgeries or operations have you had? _____

_____

What **medications** are you now taking? _____

Do you take **aspirin** on a daily basis? _____

Are you **allergic** to any of the following?

___ Adhesive Tape ___ Codeine ___Iodine ___ Latex ___Novocain ___ Penicillin ___Tetanus

Do you have any other **allergies** or sensitivities? __ Yes __ No If Yes, What? _____

Do you smoke? ___Yes ___No If Yes, how many packs per day? ____ **Former Smoker**: Yes __ No ___

Do you drink alcohol? ___Yes ___No If yes: _____Daily _____Socially

Are you pregnant? _____ Yes ____No

Flu Shot: __ Yes ___No Date of last Flu Shot: Month____ Year _____

Pneumonia Shot: __ Yes ___No Date of last Shot: Month____ Year _____

I hereby give my permission to Foot Health Center of Merrimack Valley P.C. to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot condition and authorize, to the extent necessary, disclosure of medical information to assist in processing my insurance claim and to communicate with the treating physicians. Furthermore, I assign all payment of medical benefits provided by my insurance company policy for medical/surgical care to Foot Health Center of Merrimack Valley.

By signing below I am also giving permission to use electronic systems to view, electronically prescribe for and verify some and/or all of my medications.

Signature:_____ Date: _____

(Patient or the person authorized to consent for the patient)

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I. Acknowledgement of Practice's *Notice of Privacy Practices*:

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understands the Notice of Privacy Practices (NPP) and agree to its terms.

_____ _____ _____

Name of Patient | Date of Birth | Signature of Patient/Parent/Guardian | Date

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain pieces of my health information to a Personal Representative of my choosing, since such person is involved with my healthcare or payment relating to my healthcare. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my healthcare.

Print Name:_____ **DOB or other identifier:** _____

Print Name:_____ **DOB or other identifier:** _____

III. Request to receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me as I have listed below:

Home telephone number:

__ok to leave a message with detailed information - OR - __Leave message with call back number only

Work telephone number:

__ok to leave a message with detailed information - OR - __Leave message with call back number only

Cell telephone number:

__ok to leave a message with detailed information - OR - __Leave message with call back number only

Fax telephone number:

__ok to fax at number listed here: _____

Email:

__ok to email address Practice has on file

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1. The above authorizations are voluntary and I may refuse to their terms without affecting any of my rights to receive healthcare at the Practice.

2. These authorizations may be revoked at any time by notifying the Practice in writing at the Practice's mailing address marked to the attention of "HIPAA Compliance Officer."

3. The revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.

4. If you request it, a copy of the information described in this form can be obtained at the front desk.

5. This form was completely filled in before I signed it and I acknowledge that all of my questions were answered to my satisfaction and that I fully understand this authorization form.

6. This authorization is valid as of the date I have signed below and shall remain valid until changed or revoked.

_____ _____

Name of Patient (PRINTED) | Signature of Patient | Date