

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: <input type="checkbox"/> check box if Latino or Hispanic		
Legal Representative/Responsible Person	Contact Preferences (check one): <input type="checkbox"/> Phone <input type="checkbox"/> Mail <input type="checkbox"/> Email If via Phone - ok to leave message with <input type="checkbox"/> Patient Only <input type="checkbox"/> Patient and/or Spouse <input type="checkbox"/> Anyone			
How did you find out about our Practice?				
Emergency Contact:	Relationship to Contact:		Phone #:	

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 <input type="checkbox"/> Angina <input type="checkbox"/> Arrhythmia <input type="checkbox"/> Heart Attack <input type="checkbox"/> Heart Disease <input type="checkbox"/> Heart Murmur <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Pacemaker <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Stroke	ARTHRITIS <input type="checkbox"/> Gout <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Rheumatoid Arthritis <hr/> HEENT <input type="checkbox"/> Headaches <input type="checkbox"/> Glaucoma <input type="checkbox"/> Hearing Problems <hr/> VASCULAR <input type="checkbox"/> Anemia <input type="checkbox"/> Blood Clots <input type="checkbox"/> Foot or Leg Cramps <input type="checkbox"/> Leg Pain when Walking <input type="checkbox"/> Poor Circulation <input type="checkbox"/> Prolonged Bleeding <input type="checkbox"/> Stroke <input type="checkbox"/> Varicose Veins	GASTROINTESTINAL <input type="checkbox"/> Acid Reflux (GERD) <input type="checkbox"/> Bowel Disorders <input type="checkbox"/> GI or Rectal Bleeding <input type="checkbox"/> Hiatal Hernia <input type="checkbox"/> Stomach Problems <input type="checkbox"/> Ulcers <hr/> NEUROLOGICAL <input type="checkbox"/> Epilepsy/Seizures <input type="checkbox"/> Parkinson's Disease <hr/> PSYCHOLOGICAL <input type="checkbox"/> Alcohol Dependence <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Drug Dependence <input type="checkbox"/> Psychiatric Care	MISCELLANEOUS <input type="checkbox"/> Back Problems <input type="checkbox"/> Bladder Problems <input type="checkbox"/> Cancer (type: _____) <input type="checkbox"/> Frequent Infections <input type="checkbox"/> Healing Problems <input type="checkbox"/> Hepatitis (Liver Disease) <input type="checkbox"/> HIV <input type="checkbox"/> Kidney Problems <input type="checkbox"/> Muscle Disease (Polio) <input type="checkbox"/> Prostate Problems <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Unexplained Weight Loss <input type="checkbox"/> Dialysis <hr/> OTHER DIABETES <input type="checkbox"/> Insulin <input type="checkbox"/> Non- Insulin Last HGA1C#
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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 Flu 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
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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

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
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