WELCOME

DERBY CITY FOOT DOCTORS, PLLC

Rhonda Eichenberger, DPM

PATIENT INFORMATION

Patient: _____
First MI Last

Address: _____
Street State Zip

Home Phone:_____ Cell Phone:_____

Sex: Male / Female Age____ Birthdate:_____

Ethnicity: Hispanic / Non-Hispanic Language: _____

Race:_____ Social Security:_____

Marital Status: Single / Married / Widowed / Separated / Divorced

Occupation:_____

Employer Name:_____

Employer Address:_____

Employer Phone:_____

Primary Care Physician:_____

Primary Care Physician Phone:_____

Whom may we thank for referring you? _____

Spouse's Name:_____

Spouse's Social Security: _____

Spouse's Birthdate:_____

RESPONSIBLE PARTY INFORMATION

(IF DIFFERENT FROM THE PATIENT)

Name:_____

Social Security:_____ Birthdate:_____

Address:_____

Home Phone:_____ Cell Phone:_____

In Case of Emergency

Name:_____

Home Phone:_____ Cell Phone:_____

Relationship to Patient:_____

FAMILY HISTORY

Has anyone in your *IMMEDIATE FAMILY* ever had one of the following conditions (circle all that apply):

Diabetes

Hypertension

Cancer (Type)_____

Other Medical Condition_____

TODAYS VISIT

What is the chief complaint for which you came to be treated today? (Include any foot, ankle, knee, thigh, and/or hip complaints):_____

_____

_____

What date did it start? _____

What treatment(s) have been tried? _____

_____

INSURANCE INFORMATION

Primary Insurance Company:_____

Identification Number: _____Group Number:_____

Subscriber Name:_____

Birthdate:_____ Social Security:_____

Is this patient covered by additional insurance? (circle one) Yes / No

Secondary Insurance Company:_____

Identification Number: _____Group Number:_____

Subscriber Name:_____

Birthdate:_____ Social Security:_____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with:_____

_____

and assign directly to Derby City Foot Doctors, Pllc all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____ _____

Relationship Date

Medicare Authorization

I request that payment of authorized benefits be made to Derby City Foot Doctors, Pllc for any services furnished to me by that physician. I authorize any holder of medical information about me to release the Health Care Financing Administration and its' agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payments be made and authorize release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician supplier agrees to accept the charge determination of the Medicare Carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare Carrier.

_____ _____

Beneficiary Signature Date

SOCIAL HISTORY

Do you smoke cigarettes? Yes / No / In the Past

How many cigarettes do you smoke in a day?_____

How often do you consume alcohol? _____

What type of alcohol? (circle all that apply) Beer Wine Liquor

Are you currently using illicit drugs? Yes / No

If yes, please circle all that apply: Cocaine / Heroin / Marijuana / Pain Pills

Other (Please specify):_____

DERBY CITY FOOT DOCTORS, PLLC

MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

☐Yes	☐No	AIDS/HIV	☐Yes	☐No	Diabetes	☐Yes	☐No	Psychiatric Care
☐Yes	☐No	Allergies to Anesthetics	☐Yes	☐No	Ear Problems	☐Yes	☐No	Radiation Treatment
		Allergies to Medicine or	☐Yes	☐No	Emphysema	☐Yes	☐No	Rash
☐Yes	☐No	Drugs	☐Yes	☐No	Epilepsy	☐Yes	☐No	Respiratory Disease
☐Yes	☐No	Anemia	☐Yes	☐No	Eye Problems	☐Yes	☐No	Rheumatic Fever
☐Yes	☐No	Angina	☐Yes	☐No	Fainting	☐Yes	☐No	Shortness of Breath
☐Yes	☐No	Arthritis	☐Yes	☐No	Foot or Leg Cramps	☐Yes	☐No	Sinus Problems
		Artificial Heart Valves	☐Yes	☐No	Gout	☐Yes	☐No	Special Diet
☐Yes	☐No	or Joints	☐Yes	☐No	Headaches	☐Yes	☐No	Stroke
☐Yes	☐No	Asthma	☐Yes	☐No	Heart Disease	☐Yes	☐No	Swelling in Ankles, Feet
☐Yes	☐No	Back Problems	☐Yes	☐No	Hemophilia	☐Yes	☐No	Swollen Neck Glands
☐Yes	☐No	Bleeding Disorders	☐Yes	☐No	Hepatitis or Jaundice	☐Yes	☐No	Tired Feet
☐Yes	☐No	Bronchial Problems	☐Yes	☐No	High Blood Pressure	☐Yes	☐No	Tuberculosis
☐Yes	☐No	Cancer	☐Yes	☐No	Kidney Problems	☐Yes	☐No	Ulcers
☐Yes	☐No	Chemical Dependency	☐Yes	☐No	Liver Disease	☐Yes	☐No	Varicose Veins
☐Yes	☐No	Chest Pain	☐Yes	☐No	Low Blood Pressure	☐Yes	☐No	Venereal Disease
☐Yes	☐No	Chronic Diarrhea	☐Yes	☐No	Nervous Problems	☐Yes	☐No	Weight Loss,
☐Yes	☐No	Circulatory Problems	☐Yes	☐No	Phlebitis			unexplained

Surgeries you have had _____

_____

_____

Hospitalization other than for the surgeries listed _____

_____

_____

Family physician _____ Last visit date _____

Are you now, or have you been, under any other doctor's care for any reason over the past two years? ☐ Yes ☐ No

If yes, please explain _____

_____

_____

MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins _____

_____

_____

Pharmacy Name(s) _____

Pharmacy Phone(s) _____

Do you take oral contraceptives? ☐ Yes ☐ No

ALLERGIES

☐ Adhesive/Tape
☐ Anticoagulant Therapy
☐ Aspirin
☐ Codeine
☐ Demerol
☐ Iodine
☐ Local Anesthetics
☐ Novocaine
☐ Penicillin
☐ Seafoods
☐ Sulfa

Other _____

CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient's Signature _____ Date _____

REORDER #0008262

Derby City Foot Doctors, PLLC
Rhonda Eichenberger, DPM
9900 Shelbyville Rd Suite 11A
Louisville, KY 40223

I have been given or have had the opportunity to take information pertaining to the practices of using and releasing Personal and Health Information obtained and retained by Derby City Foot Doctors, PLLC.

I give/do not give *(circle one)* permission for the any staff member of Derby City Foot Doctors, PLLC, to leave a message on my answering machine/voice mail/email.

Email Address:_____

I have also been given or have had the opportunity to take information pertaining to the General Office Policies.

I give consent for the patient to be seen by Dr. Rhonda Eichenberger and for her to administer and/or perform such procedures as may be deemed necessary in the diagnosis and/or treatment of the patient's feet.

I give permission for Derby City Foot Doctors, PLLC to bill my insurance including Medicare and any primary or secondary insurance companies. I understand that I am financially responsible for all charges that are not paid by insurance. This includes all services *including but not limited* to surgical procedures, wound care, custom orthotics, diabetic shoes, routine foot care, etc. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Patient Name (Print)

_____ _____
Signature of Patient /Guardian /POA **Date Signed**

Derby City Foot Doctors, Pllc
Rhonda Eichenberger, DPM
Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.

- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check.

- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.

- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible.

- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.

- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

- You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.

- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.

- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.

- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee. 10 days will be given to pay the bad check amount and fee. If not paid, then a civil complaint will be filed.

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party: _____ **Date:** _____