

PATIENT INFORMATION

Last _____ First _____

Birthdate _____ **Marital Status**

Primary Address _____

_____ Married

City _____ State _____ Zip _____

Gender _____ Single

Home Phone _____

_____ Male _____ Widowed

Cell Phone _____

_____ Female _____ Divorced

Work Phone _____

Social Security Number

Northern Address (if applicable) _____

City _____ State _____ Zip _____

Email: _____

Employer Name _____

Emergency Contact Name _____

Phone _____

PRIMARY INSURANCE

SECONDARY INSURANCE

Insurance Name _____
Please bring insurance cards

Insurance Name _____
Please bring insurance cards

REFERRALS

How did you first hear about Dr. Miller?

PRIMARY CARE PHYSICIAN

Physician's Name _____
Physician's Number _____

NOTICE OF PRIVACY ACT

I have read a copy of Loren J. Miller's Notice of Patient Privacy Practices. _____ (Initials)

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Dr. Loren Miller 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 payment of my benefits. I authorize the use of this signature on all insurance claim submissions. _____ (Initials)

MEDICARE AND INSURANCE AUTHORIZATION

I request that payment of authorized Medicare or insurance benefits be made to me on my behalf to Dr. Loren Miller for any service furnished to me by that physician. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agent's; the information needed to determine these benefits or the benefits payable for any related services. I understand my signature requests that payment be made and authorizes 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 or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductibles, coinsurance, non covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare Carrier. _____ (Initials)

I have read the above policies and I understand and agree to these policies.

Signature _____

Date _____

MEDICAL HISTORY

Please circle "Yes" or "No" if you have had any of the following.

| | | | | | | | | |
|------------------------|-----|----|----------------------|-----|----|---------------------------|-----|----|
| AIDS/HIV | Yes | No | Rheumatoid Arthritis | Yes | No | Varicose Veins | Yes | No |
| Anemia | Yes | No | Arthritis | Yes | No | Claudication | Yes | No |
| Bleeding Disorder | Yes | No | Back Problems | Yes | No | (Leg cramps from walking) | | |
| Cancer | Yes | No | Gout | Yes | No | Hepatitis or Jaundice | Yes | No |
| Hemophilia | Yes | No | Asthma | Yes | No | Liver Disease | Yes | No |
| Swollen Neck Glands | Yes | No | Emphysema | Yes | No | Heart Burn | Yes | No |
| Angina | Yes | No | Respiratory Disease | Yes | No | Ulcers | Yes | No |
| Artificial Heart Valve | Yes | No | Shortness of Breath | Yes | No | Weight Loss-unexplained | Yes | No |
| Chest Pain | Yes | No | Tuberculosis | Yes | No | Numbness or tingling | Yes | No |
| Circulatory Problem | Yes | No | Chemical Dependency | Yes | No | (in feet or legs) | | |
| Heart Disease | Yes | No | Psychiatric Care | Yes | No | Seizures | Yes | No |
| High Blood Pressure | Yes | No | Diabetes | Yes | No | Fainting | Yes | No |
| Low Blood Pressure | Yes | No | Thyroid Disease | Yes | No | Neurological Problems | Yes | No |
| Rheumatic Fever | Yes | No | Eye Problems | Yes | No | Venereal Disease | Yes | No |
| Stroke | Yes | No | Sinus Problems | Yes | No | Kidney Problems | Yes | No |
| Swelling Ankles/Feet | Yes | No | Headaches | Yes | No | Rash | Yes | No |
| Heart Attack | Yes | No | Phlebitis | Yes | No | | | |

ALLERGIES

- Adhesive Tape
- Anticoagulant Therapy
- Aspirin
- Codeine
- Cortisone
- Demerol
- Iodine
- Local Anesthesia
- Novocaine
- Penicillin
- Seafood
- Sulfa
- Other _____

PODIATRIC HISTORY

Describe the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints.)

How long?
 ___ Weeks ___ Months ___ Years

On a scale of 1-10 how bad is pain?
 1 2 3 4 5 6 7 8 9 10
 Minimal Severe

Cigarette/Tobacco use? Yes No
 Years smoked? _____

How much alcohol do you consume?
 ___ Daily ___ Weekly ___ Monthly

FOOT DISORDERS

Please indicate which foot problems you now have or had in the past.

| | | |
|-------------------|-----|----|
| Ankle Pain | Yes | No |
| Athlete's Foot | Yes | No |
| Bunions | Yes | No |
| Corns & Callouses | Yes | No |
| Deformed Toes | Yes | No |
| Fungus Nails | Yes | No |
| Heel Pain | Yes | No |
| Ingrown Toenails | Yes | No |
| Plantar Warts | Yes | No |
| Infection | Yes | No |
| Ulcer/Wound | Yes | No |
| Tired Feet | Yes | No |

SURGERIES

Surgeries I have had _____

MEDICATIONS

Include prescriptions, over the counter medications and vitamins.

___ Listed additional meds on back.

Pharmacy Name _____

Pharmacy Phone _____

CONSENT

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

Signature _____ Date _____

FAMILY HISTORY

MOTHER: LIVING ____ / DECEASED ____ / AGE ____ / CAUSE OF DEATH _____

FATHER: LIVING ____ / DECEASED ____ / AGE ____ / CAUSE OF DEATH _____

BROTHERS OR SISTER: YES ____ / NO ____ / HOW MANY BROTHERS ____ / SISTERS ____

STILL ALIVE: YES ____ / NO ____ / IF DECEASED – AT WHAT AGE AND FROM WHAT

HOW MANY CHILDREN DO YOU HAVE ____ BOYS / ____ GIRLS / COMMENTS:

ANY FAMILY HISTORY OF DIABETIES: YES ____ / NO ____ / IF YES THEN WHO

ANY FAMILY HISTORY OF FOOT PROBLEMS (BUNIONS, HAMMERTOES, ETC.)
YES ____ / NO ____ / IF YES WHO AND WHAT TYPE OF FOOT PROBLEMS

LOREN J. MILLER D.P.M., F.A.C.A.S., PLC
BOARD CERTIFIED IN FOOT SURGERY
DIPLOMATE AMERICAN BOARD OF PODIATRIC SURGERY
4167 5TH Ave. N. St. Petersburg, FL 33713 (727)-321-3100 Fax (727)-327-6800

Failure to keep scheduled appointments

If you are unable to keep your scheduled appointment, we ask that you please notify our office, at least 24 hours prior to your appointment time. Should you fail to provide proper notice, you will be charged \$25.00 for the time that was allotted to you.

By not contacting our office to cancel or reschedule your appointment, those in need of a time slot are unfortunately unable to see us.

Thank you for your cooperation.

Patients Signature

Date

OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy which we require you to read and sign prior to any treatment.

All patients must complete our information packet and produce insurance cards to be copied before seeing the doctor.

CUSTOM MADE PRODUCTS (SHOES, INSERTS, ORTHOTICS, ETC.) ARE NON-REFUNDABLE.

NON-INSURANCE PATIENTS (SELF PAY):

FULL PAYMENT IS DUE AT THE TIME OF SERVICE.
WE ACCEPT CASH, CHECKS, OR CREDIT CARDS.

INSURANCE COVERAGE:

Regarding Insurance Plans where we are NOT providers:

We may accept assignment of insurance benefits after your second visit. However we do require 30% of the bill to be paid at the time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information and the original claim form if required. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits we require that you be pre-approved on our extended payment plan, and pay 20% of the charges at the time of service or provide a credit card with authorization to bill the account for the balance. If your insurance company has not paid your account in 30 days we will, on your behalf file a complaint with the Insurance Commissioner. If after the complaint has been filed, the account is not paid in full by 45 days (from the date of service), the balance will automatically be transferred to your credit card or the extended payment plan. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other Medical Insurance.

Regarding Insurance Plans where we ARE participating providers, all co-pays and deductibles are due at the time of treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph.

USUAL AND CUSTOMARY RATES:

Our practice is committed to providing the best treatment to our patients and we charge what is usual and customary for our area. You are responsible for the payment regardless of any insurance company's arbitrary determination of usual and customary rates.

ADULT PATIENTS:

Adult patients are responsible for their portion of payment at the time of service depending on Self-pay or insurance coverage.

MINOR PATIENTS:

The adult accompanying a minor and the parents or guardians of the minor are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, credit card, or payment by cash or check at the time of service.

UNPAID BALANCES:

All accounts with unpaid balances at the end of each month will be charged an interest charge of 18%, and will continue each month until balance is paid in full.

ANY AND ALL RETURNED CHECKS WILL HAVE A \$25.00 PROCESSING FEE APPLIED TO THE ACCOUNT

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy:

Signature of patient or responsible party

Date