Healthy Steps Podiatry Center PLLC
431 E Chocolate Ave
Hershey, PA 17033
717-533-5937

Dear Patient,

We would like to extend a very warm welcome to you! We sincerely appreciate you choosing us for your Podiatry care and we look forward to getting to know you. If there is anything we can ever do to improve your experiences with us, please don't hesitate to ask. This Welcome Packet includes several important documents to read and complete. Please remember to fill out the Patient Information Forms and bring them with you to your first visit. Also, bring any insurance information (member cards) you wish to utilize along with your driver's license or personal identification card. Thank you and we look forward to seeing you soon!

Sincerely,

Diane Bray, DPM

Healthy Steps Podiatry Center, PLLC

Name:_____ Date:_____

Address:_____

Phone:_____ DOB:_____ Age:_____ SSN:_____

Height:_____ Weight:_____ Shoe Size:_____

Chief Complaint (why are you being seen today):_____

_____

Current problem is a result(s) of: **Check all that apply**
Is your injury a result of an automobile accident? Yes_____ No_____
Is your injury job related? Yes_____ No_____
Are you currently involved in a lawsuit as a result of your foot/ankle injury? Yes_____No_____
Do you plan to file a lawsuit because of your foot/ankle injury? Yes_____ No_____
*If you answered yes to any of the previous questions, a **Notice of Injury Form** must be filled out before seeing the physician.*

Circle all that apply: Left Foot Left Ankle Right Foot Right Ankle
Have you seen anyone else for this problem?_____

Primary Care Physician:_____
Date of last visit:_____ Pharmacy:_____

Can you take aspirin? Yes_____ No_____
Do you smoke? Yes_____ No_____ If so, how much?_____
Have you ever smoked? Yes_____ No_____ If so, how long ago and how much?_____
Do you drink? Yes_____ No_____ if so, how much?_____
Do you use recreational drugs? Yes_____ No_____ if so, what?_____

Any problems with local Anesthetic? Yes_____ No_____
If yes: Nausea_____ Vomiting_____ Weakness_____ Other_____

Women: Are you, to your knowledge, Pregnant? Yes_____ No_____
Post-menopausal? Yes_____ No_____
On oral contraceptives? Yes_____ No_____

Medications you are CURRENTLY taking (include dose/strength)_____
_____
_____

Past Surgery?_____

_____

_____

ALLERGIES:

Are you allergic or sensitive to: Penicillin_____ Novacaine_____ Aspirin_____

Sulfa_____ Anesthetic_____ Adhesive tape_____ Iodine_____ Metal_____

Latex_____ Drugs:_____ Other:_____

_____ I am not allergic to anything I know of

GENERAL HEALTH: (if you have or have had, check all that apply)

___Measles
___Mumps
___Chicken Pox
___Bone Fracture
___Lower Back Pain
___Hip Problems
___Ankle Problems
___Skin Problems
___Headaches
___Bruise easily
___Burning or Numbness in Feet
___Burning or Numbness in Legs
___Scarlet Fever
___Pneumonia
___Neck Pain
___Shortness of breath on exertion after being on feet
___HIV
___Hepatitis

Family Health:

Have you or any of your family members ever had any of the following (check all that apply):

You	Family	
___	___	High Cholesterol
___	___	Diabetes, Insulin Dependent Last A1C? _____
___	___	Diabetes, Non-Insulin Dependent Last A1C? _____
___	___	Circulatory Problems
___	___	High Blood Pressure
___	___	Bleeding Problems
___	___	Renal/Kidney Disease
___	___	Liver Problems
___	___	Hepatitis
___	___	Anemia
___	___	Lung Disease/COPD/ Asthma (circle all that apply)
___	___	Blood Disease
___	___	Lymph Disease
___	___	Thyroid Disease
___	___	Epilepsy
___	___	Depression/Anxiety/ Mood Disorder (circle all that apply)
___	___	Muscle Disease _____
___	___	Bone Disease _____
___	___	Varicose Veins
___	___	Osteoarthritis/Rheumatoid Arthritis/Psoriatic Arthritis (circle all that apply)
___	___	Cancer _____
___	___	Rheumatic Fever
___	___	Gout
___	___	Skin Problems

I agree that the above information is accurate and true to the best of my knowledge.

Signature: _____ Date: _____

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431 E. Chocolate Ave.
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Phone: 717.533.5937 Fax: 717.533.5910

Regarding Insurance

INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY

We will inform you if we are a party to your insurance contract and will handle your claims according to our agreement with the Insurance Company. For the insurance plans with which we participate, we will file your claims for you.

Healthy Steps Podiatry Center, PLLC must be able to establish eligibility with your insurance company for you within 60 days of the first date of service. If eligibility can not be verified by 60 days, the visit charges will become your personal responsibility.

YOU ARE RESPONSIBLE FOR RESPONDING TO ANY CLAIM REQUESTS SENT TO YOU BY YOUR INSURANCE COMPANY. FAILURE TO RESPOND TO THESE INQUIRIES WILL RESULT IN THE FEES CHARGED BY OUR OFFICE TO BECOME YOUR PERSONAL RESPONSIBILITY.

We will not become involved in the disputes between you and your insurance company regarding deductibles, co-payments, and covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply information as necessary.

YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT.
All patients will pay co-pays, deductibles, co-insurance or amounts not covered by insurance AT THE TIME OF THE VISIT. Any outstanding balances after insurance has paid on a bill is due with the first billing to you. Failure to do so will result in the unpaid bill being sent to our collection agency.

BY SIGNING BELOW, I ACKNOWLEDGE MY UNDERSTANDING AND WILL ABIDE BY THE FINANCIAL POLICY OF HEALTHY STEPS PODIATRY CENTER, PLLC.

Patient Signature_____ Date:_____
Parent/Guardian Signature_____ Date:_____

NO SHOW POLICY

In the event you are unable to keep your appointment with this office, it is imperative that you call to cancel and/or reschedule your appointment. Any patient that does not keep an appointment and has not called to cancel, will be charged a $25.00 fee. You will not be permitted to schedule an appointment until this fee is paid. This policy is necessary to ensure

that patients needing appointments can get them in a timely manner. Healthy Steps Podiatry Center, PLLC reserves the right to waive the fee on a case by case basis.
We thank you for your cooperation.

Patient Signature:_____ Date:_____

CONSENT FOR TREATMENT, AUTHORIZATION TO RELEASE INFORMATION, AND ALLOW PAYMENTS OF INSURANCE BENEFITS

Patient Name_____ Date:_____

I acknowledge and authorize Healthy Steps Podiatry Center, PLLC to deliver, teach, administer, or perform as necessary, the product and treatment prescribed by my physician.
I authorize Healthy Steps Podiatry Center, PLLC to submit a claim(s) for services to my insurer on my behalf and I authorize my physician and Healthy Steps Podiatry Center, PLLC to release any of my medical information required by my insurance to process the claim(s).
I understand that I am responsible for, and I agree to pay any portion of the amount due for such services not paid by my insurance carrier when resulting from deductibles, co-pays, coinsurance or amount due as patient responsibility.

Patient or Guarantor Signature_____
Relationship to Patient_____

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ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY AND PRACTICES

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

I also give permission to the following:

	Leave appointment message on:		**Leave other medical information on:**	
Home answering machine	Y	N	Y	N
Office voice mail	Y	N	Y	N
With another person	Y	N	Y	N
Send through mail	Y	N	Y	N
Send via email	Y	N	Y	N
Cell phone #____-____-____	Y	N	Y	N
Test messaging	Y	N	Y	N
Patient portal	Y	N	Y	N

Please list person(s), and their relationship to your, authorized to communicate with. We will communicate with any and all doctors, hospitals, and facilities unless you specify otherwise:

_____

_____

PATIENT SIGNATURE_____

DATE_____

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MEDICARE EXTENDED AUTHORIZATION
SIGNATURE ON FILE

BENEFICIARY NAME_____ MEDICARE HIC#_____

I request that payment of authorized Medicare Benefits be made either to me or on my behalf to HEALTHY STEPS PODIATRY CENTER, PLLC for any services furnished to me by the physician. I authorize any holder of medical information about me to release to the CMS and its agents, any information needed to determine these benefits or benefits payable for related services.

X_____
Patient Signature

_____
Date

MEDIGAP ASSIGNMENT OF BENEFITS
SIGNATURE ON FILE

I request that payment of authorized Medigap benefits be made either to me or on my behalf to HEALTHY STEPS PODIATRY CENTER, PLLC for any services furnished me by the listed physician/supplier.
I authorized any holder of medical information about me to release to my Medigap insurer any information needed to determine these benefits for related services.
This assignment shall remain in effect until revoked by me in writing. A copy of this assignment is considered as valid as an original.

Patient's name printed_____

X_____
Patient's Signature

Provider's Name, Address, Zip Code
Healthy Steps Podiatry Center, PLLC
431 E Chocolate Ave
Hershey, PA 17033

Medicare Number _____ Medigap Insurer_____

Medigap Number_____