

## Patient Demographics

Please answer the following questions:

First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_ Sex \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work # \_\_\_\_\_

Cell Phone # \_\_\_\_\_ Can we call your work #? Yes \_\_\_ No \_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Family Physician \_\_\_\_\_

Specialists physician \_\_\_\_\_

How were you referred to our office? \_\_\_\_\_

What foot/ankle problem foot/ankle condition brings you to the office? \_\_\_\_\_

What's your shoe size? \_\_\_\_\_ Do you have Medical insurance? Yes \_\_\_\_\_ No \_\_\_\_\_

Primary Ins. Co. \_\_\_\_\_ Secondary Ins. Co. \_\_\_\_\_

If policy is under your spouse's or parent's name, what is their Social Security number and employer?

Soc. Sec. # \_\_\_\_\_ Employer \_\_\_\_\_

Do you go by a nickname? If so, what do you prefer to be called? \_\_\_\_\_



### Surgical History

Surgeries:	Dates:

Have you ever had any problems with surgery or anesthesia? If so, please describe:

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### Family History

Does your family have a history of any of the following? (If yes please circle)

Arthritis      Cancer      Diabetes      Heart Problems      Foot Problems

### Allergies

Have you ever experienced an allergic reaction to any of the following?

Allergic to:	(circle one)	Reaction: (ex: fever, rash, swelling...)
Adhesive Tape	Yes    No	
Codeine	Yes    No	
Iodine	Yes    No	
Latex	Yes    No	
Morphine	Yes    No	
Penicillin	Yes    No	
Sulfa	Yes    No	
Other:		

**Social History**

Do you drink alcohol? (Please circle one) Yes No

If you answered yes to question #5 how would you describe your drinking habits? (Please circle one)

Less than 2 drinks per week 3-6 drinks per week 7 or more drinks per week

Do you exercise? (Please circle one) Yes No

If yes, how often? : 1-3 times per week 4 or more times per week

Exercise routine? \_\_\_\_\_

Do you use tobacco? (Please circle one) Yes No

If yes what type of tobacco do you use? (Please circle one)

*Cigarettes* *Cigars* *Pipe* *Chewing Tobacco*

How often do you use this tobacco? \_\_\_\_\_

How many years ago did you begin using tobacco? \_\_\_\_\_

## Financial Policy

Thank you for choosing us as your healthcare provider. Our practice firmly believes that a good physician-patient relationship is based upon good communication and a clear understanding of anticipated expenses. It is our intent to provide a Financial Policy that clearly outlines the patient and practice financial responsibilities. We are committed to providing our patients with the best possible medical care. The following is a statement of our Financial Policy which we require you to read and sign before treatment.

- Payment for services is due at the time services are rendered. We accept cash, checks and money orders. Returned checks will be subject to a \$20 charge. *We do not accept credit or debit cards.*
- Our office participates with many insurance companies and managed health care programs. For patients who are members of one of these plans, our billing company will submit a claim for services rendered. You must provide all necessary information and a copy of your insurance card. Any approved outstanding balance will become your responsibility (deductible, co-insurance, non-covered services, etc).
- It is your responsibility to provide us with current insurance information and to bring your current insurance card to each visit.
- It is your responsibility to pay any co-pay, deductible, co-insurance or any portion of the charges as specified by your insurance at the time of service. Any services not covered by your insurance plan are your responsibility and payment in full is due at the time of service.
- If you do not have insurance coverage, payment in full is expected at the time of service. Please let us know that you do not have health insurance, and we will provide you with a *Self Pay Financial Policy* to read and sign. If you are uninsured, we offer a 30% discount on services if paid at the time of service.
- If you have insurance that we do not participate in, payment is expected at the time of service.
- If you have Medicare, and your services are non-covered by Medicare, payment in full is expected on the date of service. If payment is not made on the date of service, we will add 10% to your bill to cover the cost of billing and collection.
- Any billing or financial questions are handled by our billing company, Cardinal Billing Service. We will be happy to provide you with their phone number and address.

If you have any questions regarding these financial matters, or any uncertainty regarding insurance coverage, please do not hesitate to ask. We are here to help.

Please sign that you have read and agree to the Cherry Valley Foot and Ankle Center Financial Policy:

- I authorize Dr. Jeffrey A. Oster to submit an insurance claim to my insurance company for services rendered and to have payment of medical benefits sent directly to Dr. Jeffrey A. Oster. I authorize the release of any medical or other information necessary to process an insurance claim.
- I understand and agree to my financial obligations as described in this Financial Policy.

X \_\_\_\_\_

Signature of Patient or Responsible Party

\_\_\_\_\_

Date

## Consent to Use Personal Health Information

I consent to the use or disclosure of my protected health information by the office of Jeffrey A. Oster, DPM, for the purpose of diagnosing and providing treatment to me or obtaining payment for my health care bills. I understand that diagnosis or treatment may be conditioned upon my consent as evidenced by my signature on this document.

My 'protected health information ' includes my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have the right to revoke this consent, in writing at any time, except to the extent that Jeffrey A. Oster, DPM has taken action in reliance on this consent.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed. Jeffrey A. Oster, DPM is not required to agree to restrictions I may request, but if he agrees to a restriction I have requested, the restriction is binding.

I have been notified of and reviewed Dr. Oster's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices has been provided to me. It describes the types of uses and disclosures of my protected health information that will occur in my treatment and payment of my bills. The Notice of Privacy Practices also describes my rights and the practice's duties with respect to my protected health information.

Jeffrey A. Oster, DPM reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice upon request.

X \_\_\_\_\_  
Signature of Patient or POA                      Print Name of Patient                      Date

The Health Information and Portability Act of 1986 (H.I.P.A.A.) requires that you list anyone you give us permission to talk with regarding your protected health information. Please identify any party to who you would be willing to release health information:

1. \_\_\_\_\_  
Name/ Relationship                                      Phone Number

2. \_\_\_\_\_  
Name/Relationship                                      Phone Number