# NEW PATIENT FORM

DATE: __/__/____

FULL NAME: ________________________________________________________

SSN: ________/_______/________ DOB: ____/____/______ AGE: _______

CURRENT ADDRESS: _________________________________________________

CITY :___________________ STATE: _____________ ZIP: ______________

EMAIL: ______________________________________________________________

Home phone: (____) ______-______ Cell phone: (____)______-_______________

Work Phone:(_____) _______-__________ Preferred contact number: ____________

EMERGENCY CONTACT: ___________________________________________________

CURRENT ADDRESS: _____________________________________________________

CITY: __________________ STATE: __________________ ZIP: _________________

PHONE: (___) ______-_______ RELATIONSHIP: ________________________________

EMPLOYER: _______________________________ TITLE: ____________________

EMPLOYER ADDRESS: _____________________________CITY: ______________

STATE: ______________ ZIP: ________________PHONE:_____________________

PRIMARY CARE DOCTOR: _______________________________________________

PHONE # (_______)-_____________________

LAST DATE SEEN: _______________________ (REQUIRED FOR DIABETICS)

PHARMACY: ______________________________ZIP: _________________________

ADDRESS: ___________________________________________________________

ALLERGIES:

_______________________________________________________________________

MEDICATIONS:

_______________________________________________________________________

_______________________________________________________________________

**DO YOU SMOKE?** (PLEASE CIRCLE ONE)

YES - PACKS: _______ HOW LONG: _____________

NEVER-

FORMER SMOKER YEAR QUIT: ___________

**Diabetic?** (PLEASE CIRCLE ONE)

YES NO If yes, TYPE 1 TYPE 2

Last Blood Sugar: ____________________

FAMILY HISTORY: __________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

*THANK YOU FOR CHOOSING TOTAL FOOT CARE!*

HOW DID YOU HEAR ABOUT OUR PRACTICE? **(CHOOSE ONE)**

- ☐ INTERNET/GOOGLE
- ☐ FRIEND/FAMILY
- ☐ DOCTOR REFERRAL (WHO?) ____________________
- ☐ INSURANCE COMPANY
- ☐ FACEBOOK
- ☐ OTHER_______________________________

***Consent And Understanding***

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

***Consent Related to Privacy Notice:***

I have had a chance to review the Practice Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone, or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

***Consent for Care:***

I, with my signature authorize Total Foot Care LLC, and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but not limited to) preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/ function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

***Consent for Release of Information and Assignment of Benefits:***

I also authorize Total Foot Care LLC to furnish information to the identified insurance carrier(s)for any and all payment activities. I consent to assign all payments for services directly to Total Foot Care LLC. I further consent to the use for any practice operational needs as identified in the Practice Privacy Notice.

***Financial Policy*** :

We appreciate you choosing us for your healthcare. We will adhere to the following financial policy in order to consistently deliver high quality care and services. The patient/Responsible party assumes responsibility to ensure that the financial obligations fulfilled for the health care services received.

- I understand that I am responsible for all co-payments, amounts applied to deductibles, and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulations.
-I understand that if I have an insurance copayment, I am expected to make payment when checking in for my appointment.
-I understand that my contract with my insurance entity may or may not cover some services. All insurance policies are not the same, and they vary by employer group. Consultants in Total Foot Care LLC is not responsible or able to know every policy available. It is my responsibility to verify applicable coverage prior to receiving the services. For example, not all health plans include screenings as a benefit. If I seek care outside of the contract terms, I am aware that I may be responsible for all charges that are incurred.
**-I am aware that if I schedule an appointment, and I do not cancel within 24 hours, or show up I will be charged $25.00.**
**-I am aware that if I am scheduled for surgery, and I do not cancel within 24 hours, or no show I will be charged $300.00.**

***Consultants in Total Foot Care LLC is a physician owned and operated facility.***

Thank you for your understanding and cooperation with this policy. It is our privilege to provide your medical care.
I have read and understand the Consents and Financial Policy stated above and agree to accept full responsibility as described above.

_______________________________________________________ _____________________

**Patient/ Responsible Party** **Date**

**Patient name if different from Responsible Party:** ___________________________________________

**Total Foot Care, LLC**
***Dr. John Harness, DPM***
***1035 Bellevue Ave Ste 315, St. Louis, MO. 63117***
***Phone: 314-473-1296 Fax: 314-442-7766***

---

**Please note that all Patients are responsible for their insurances and insurance benefits so that your claims can be billed properly. Missing or inaccurate information can result in you receiving a bill at your home. **Also note that any missed appointment or cancelled appointments on the day that the appointment was scheduled will result in a* ***$35.00 non-refundable charge****, each time you miss or cancel an appointment.*

***Medication and Consent to treatment***

We have implemented a new Electronic Medical Records (EMR) program that will automatically import your medication history from the third-party sources (i.e. pharmacies). In order to transfer your current and past medications to the new system, we must have your authority to do so.

I____________________ hereby consent and give permission to, Dr. John Harness, DPM and the doctors assistants and /or designated replacements to administer and perform such procedures upon me as the doctor seems necessary. I allow *TOTAL FOOT CARE LLC* to file for insurance benefits to pay for the care I receive. **I understand that: TOTAL FOOT CARE LLC,** will have to send my medical record information to my insurance company. I must pay my share of the costs. I must pay for the cost of these services if any insurance does not pay or I do not have insurance. I understand that I have the right to refuse any procedure or treatment at any time for any reason **_________(Initial)**

***HIPPA AUTHORIZATION***

**Do we have permission to?**

1. **Leave a message on your answering service at your home?** YES/NO
2. **Leave a message on your cell phone?** YES/NO
3. **Leave a message at your place of employment?** YES/NO
4. **Discuss your medical condition with any member of your family?(This also includes the person or persons to call and receive information of your medical condition)** YES/NO

**If you answered yes to the 4th line please list the name, phone# and relationship of the person/persons below**
***** I GIVE PERMISSION TO THE DOCTOR AND STAFF AT TOTAL FOOT CARE LLC, TO RELEASE INFORMATION TO THE PERSON OR PERSONS LISTED BELOW**
**_________(Initial)**

**Name__________________________ Phone# _______-______-_________ Relationship___________________**

**Name__________________________ Phone# _______-______-_________ Relationship___________________**

**If no one is listed in the above area as authorized on your behalf no information will be discussed without your written consent NOTE that we are not able to take verbal consent via phone a new form will need to be submitted to the Total Foot Care LLC, staff.**

**PRINT PATIENT NAME_______________________________________________**

**SIGNATURE:____________________________________ ____________ DATE: ____/____/______**

***FOR PERSONAL REPRESENTATION OF THE PATIENT*** **(if applicable)**

**PRINT NAME OF REP:_________________________________ RELATIONSHIP_______________________**

**SIGNATURE OF REP:_________________________________ DATE____/____/______**