Dr. Brad L. Hayman
Podiatrist
Complete Foot & Ankle Care

Dear New Patient,

Welcome to Complete Foot & Ankle Care! We are honored to have you as a new patient! We thank you for choosing us for your foot and ankle care, and we appreciate you placing your trust in our knowledge and expertise. Our commitment is to provide you with the best possible medical care in a compassionate and considerate manner.

Our Mission and Vision Statement
It is our mission to provide the highest possible medical and surgical podiatric care while conducting our practice consistent with Christian values and principles.

Privacy Practices
The law requires us to keep your medical records private. We understand that your medical information is personal and are committed to protecting it. The record we create of your medical care in our office is to provide you with quality care and comply with certain legal requirements. We may disclose this medical information to other healthcare professionals to provide you with the best continuity of care.

Our staff is made up of kind and devoted professionals who work together to give you the highest quality podiatric care.

Again, we would like to thank you for your trust in Complete Foot and Ankle Care and we look forward to serving you.

Sincerely,

Dr. Brad L. Hayman, DPM
And Staff

COMPLETE
Foot & Ankle Care

PATIENT PRIOR AUTHORIZATION POLICY

It is the responsibility of our insured patients to be aware of any restrictions or requirements stated in their insurance policy. These include deductibles, second opinions, policy exclusions or waived benefits, pre-certification requirements, and any other restrictions.

As a COURTESY our office will contact your insurance company for verification on your benefits or pre-authorization requirements. However, a pre-authorization issued by your insurance company is a NOT a guarantee of payment for any services rendered, or products distributed from Complete Foot & Ankle Care. What this means is:

VERIFICATION OF BENEFITS OR PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT FROM YOUR INSURANCE COMPANY. THE PATIENT IS ULTIMATELY RESPONSIBLE FOR PAYMENT.

Your insurance benefits and the payment we receive are determined by the limits set by your insurance company.

IT IS YOUR RESPONSIBILITY TO BE AWARE OF YOUR BENEFITS AND LIMITS.

A deposit may be required, if you have not met your deductible or out-of-pocket expense limit, at the time of service.

By signing below, you, as the patient or responsible party, understand that you are responsible for the charges not covered and paid by your insurance.

Print Patient Name Patient Signature Date

COMPLETE
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Patient Name: _____ Date: _____

Please INITIAL next to each section:

_____ I give permission to Complete Foot & Ankle Care to administer treatment and to perform such procedures deemed necessary in the diagnosis and/or treatment of my foot condition(s).

_____ I authorize Complete Foot & Ankle Care to prescribe and refill medication through a computerized e-prescribing system. I understand that my Physician may be sending my prescriptions electronically, and I have been informed on the e-scribing process. I also give permission for Complete Foot & Ankle Care to obtain my medication history from my pharmacy, my health plans, and other healthcare providers.

_____ I authorize Complete Foot & Ankle Care to release any information acquired in the course of my examination for insurance purposes.

_____ I authorize any Physician, hospital or medical care facility to provide all information on my medical history and treatment to Complete Foot & Ankle Care.

_____ I authorize payment directly to the business office of Complete Foot & Ankle Care on behalf of Dr. Brad Hayman for the surgical and/or medical benefits, if any, otherwise payable to me for the services. I understand I am responsible for charges not covered by my insurance.

_____ I will notify the office immediately with any insurance or demographic changes. Otherwise, I will be held responsible for all actions incurred by inaccurate/outdated information.

_____ If eligibility for insurance cannot be verified, or if deductible, out-of-pocket or co-insurance has not been met, I understand that I will be responsible for the cost of all medical services rendered.

_____ I acknowledge that I was provided a copy of the “Privacy Practices” in the Welcome Letter at the beginning of this packet, and have read and understand it.

_____ I authorize photocopies of this authorization and my signature to be valid as the original.

_____

Signature of Patient or Legal Guardian Date

COMPLETE
Foot & Ankle Care

Patient Name: _____ Date: _____

Financial Agreement

Please carefully read the following statement of our financial policy, prior to treatment. You will be given an opportunity to speak with one of our staff members, if you have any questions.

Our office will charge a $50 no-show fee for any appointment not cancelled within a 24 hour notice.
It is your responsibility to be aware of your insurance benefits. Exclusions, pre-existing conditions, and terminated health benefits may nullify insurance coverage and transfer financial obligation to you. It is the patient or responsible party's duty to know and understand plan specifics, such as deductibles, co-insurances, or non-covered charges. If you are uncertain of your benefits, you will need to contact your insurance carrier for clarification.

If you have an insurance carrier which requires referrals or authorizations for care, it is your responsibility as the patient to obtain any necessary paperwork for your appointment. Please be aware that authorizations and referrals have expiration dates and a certain number of visits allotted per your Primary Care Physician (PCP) or insurance; it is your responsibility to obtain a new referral/authorization upon their expiration. Many PCPs are now requiring up to 14 days notice to issue a referral or authorization.

If you are a self-pay or cash-pay patient or wish to submit your own insurance claim, we will require payment in full at the time of service, unless other arrangements are made in advance. For larger balances, we can assist you in obtaining Care Credit assistance. Insurance co-pays are due during the check-in process. Self-pay payments are due at the end of the appointment during the check-out process. You are responsible for any unpaid balance on your account. Our office accepts cash, personal checks, and debit/credit cards with the Visa, MasterCard, Discover, or American Express logo. We also participate with Care Credit services.

In the event that a balance is due on your account after the insurance payment has been made, that balance will be due from you within thirty (30) days. Statements will be sent out on a monthly basis. If your account is not paid in full within sixty (60) days, interest may accrue at a monthly rate of 1.5%. There will be a charge of $25 for any returned checks.

My signature below confirms that I have read the above statement regarding the financial policy and agree to abide by the contents thereof.

_____

Signature of Patient or Legal Guardian Date

Practice: **Today's Date:**

Name: _____ **DOB:** _____ **Chart Number:** _____

Sex: ☐M ☐F **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced **SS#:** _____

E-mail: _____ **Spouse/Partner Name:** _____

E-mail newsletters, reminders, statements, etc. **Emergency Name:** _____ **Phone:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home #: _____ **Cell #:** _____ **Other #:** _____

Employer: _____ **Phone:** _____

Employer Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Primary Insurance: _____ Are you the insured? ☐Yes ☐No

Insured Information

Subscriber Name: _____ Relationship to insured: ☐Spouse ☐ Child ☐Self ☐ other

Phone #: _____ Sex: ☐Male ☐Female DOB: ___/___/___

Address: _____

Policy ID: _____ Group ID: _____ Employer: _____

Secondary Insurance: _____ Are you the insured? ☐Yes ☐No

Insured Information

Subscriber Name: _____ Relationship to insured: ☐Spouse ☐ Child ☐Self ☐ Other

Phone #: _____ Sex: ☐Male ☐Female DOB: ___/___/___

Address: _____

Policy ID: _____ Group ID: _____ Employer: _____

How did you find out about our practice? ☐ Physician ☐ Internet ☐ Telephone book ☐ Family member ☐ Friend ☐ Other: _____

What is the reason for your visit today? _____

_____ **Result of accident or work injury?** ☐Yes ☐No

How long has this bothered you? 1 2 3 4 5 6 7 ☐ days ☐ weeks ☐ months ☐ years

What treatments have you tried & have they been effective? _____

_____

On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain? ___/10

The pain quality is: ☐burning ☐constant ☐dull ☐sharp ☐shooting ☐throbbing ☐tingling Other:_____

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____ Date: _____

History and Physical

Name: _____ DOB: _____ Chart Number: _____

Medical History:
☐ Alcoholism ☐ Blood disorders ☐ Circulation problems ☐ Musculoskeletal ☐ Breathing issues
☐ Liver ☐ Sleep apnea ☐ Gout ☐ Allergies ☐ Heart disease ☐ Asthma
☐ Heart murmur ☐ Stomach/bowel ☐ Depression ☐ Anxiety disorder ☐ Mental illness ☐ Kidney disease
☐ Blood clot ☐ High cholesterol ☐ High blood pressure ☐ Cancer ☐ Hepatitis
☐ Neuropathy *(specify)* _____ ☐ Thyroid disease *(specify)* _____ ☐ Diabetes (type 1, type 2)
☐ Arthritis *(specify)* _____ ☐ other *(specify)* _____ ☐ HIV ☐ CVA
Are you pregnant? ☐ Yes ☐ No **Are you nursing?** ☐ Yes ☐ No ☐ Skin disorders ☐ Stroke

Surgical History ☐ None ☐ Appendectomy ☐ C-Section ☐ Angioplasty ☐ Bypass ☐ Cataracts ☐ Cholecystectomy
Have you ever had any surgical procedures on foot/ankle or anywhere else on your body? ☐ Yes ☐ No
If yes, please describe: _____
Do you have any artificial joints? ☐ Yes (where? _____) ☐ No Do you have an artificial heart valve? ☐ Yes ☐ No

Social History
Do you smoke? ☐ Yes ☐ No If yes how many packs per day? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 For how long?
Do you drink alcohol? ☐ Yes, everyday (5-7 days/week) ☐ Yes, occasionally/socially ☐ No/Rarely
Substance abuse: ☐ Yes, I have a current substance abuse problem. Please specify: _____
☐ Yes, I had a past substance abuse problem. Please specify: _____
☐ No, I have never had a substance abuse problem
What is your occupation? _____ Does it involve mostly ☐ standing or ☐ sitting
Do you exercise regularly? ☐ No, I do not exercise regularly ☐ Yes, I do the following regular exercise: _____
_____

Family History Is there any family history *(blood relative)* of: *(Please indicate family member)*

☐ Alzheimer's	_____	☐ Depression	_____
☐ Arthritis	_____	☐ Diabetes	_____
☐ Bleeding disorders	_____	☐ Emphysema	_____
☐ Blood clot	_____	☐ Heart disease	_____
☐ Cancer	_____	☐ High Blood Pressure	_____
☐ Cataracts	_____	☐ Neurological	_____
☐ Circulation problems	_____	☐ Strokes	_____
☐ Other (specify):	_____		

Review of Systems *(Please check the box if you currently have any of these symptoms or check "NONE")*

Cardiovascular	☐ leg pain when walking	☐ fever	☐ chest pain/pressure	☐ leg swelling	☐ cold hands/feet
	☐ fainting	☐ palpitations	☐ vascular disease	☐ valve problems	☐ **NONE**
Genitourinary	☐ blood in urine	☐ hesitancy	☐ incontinence	☐ increased urgency	
	☐ decreased frequency	☐ excessive urination	☐ kidney disease	☐ kidney stones	☐ **NONE**
Gastrointestinal	☐ abdominal pain	☐ heartburn	☐ blood in stool	☐ vomiting	☐ ulcers
	☐ diarrhea	☐ trouble swallowing	☐ decrease appetite	☐ increase appetite	☐ constipation ☐ **NONE**
Integumentary	☐ athletes foot	☐ nail abnormalities	☐ keloids	☐ itchiness	☐ dry, scaly skin ☐ **NONE**
Hematologic	☐ lower leg ulcers	☐ sickle cell disease	☐ anemia	☐ blood thinners	☐ clotting disorders ☐ **NONE**
Neurological	☐ tingling	☐ weakness	☐ seizures	☐ numbness	☐ headaches
	☐ tremors	☐ paralysis			☐ **NONE**
Musculoskeletal	☐ back pain	☐ joint swelling	☐ muscle weakness	☐ muscle pain	☐ neck pain
	☐ sciatica	☐ joint stiffness	☐ joint pain	☐ joint instability	☐ arthritis ☐ **NONE**
Respiratory	☐ chest pain	☐ wheezing	☐ COPD	☐ coughing	☐ snoring
	☐ shortness of breath	☐ emphysema			☐ **NONE**

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____ Date: _____

Practice: **Today's Date:**

Name: _____ **Chart #:** _____ **Date of birth:** _____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Declined to specify

Race: ☐Asian ☐American Indian or Alaska Native ☐Black or African American

☐White ☐Native Hawaiian or other Pacific Islander ☐Declined to specify

Preferred Language: _____ ☐Declined to specify

Pharmacy Name: _____ **Pharmacy Phone:** _____

Pharmacy Address: _____ City, State, Zip: _____

Primary Care Physician: _____ Phone: _____ Date Last Seen: _____

Address: _____

Referring Physician: _____ Phone: _____ Date Last Seen: _____

Address: _____

Privacy Information Preferences

Do you want to be exempt from public reporting? ☐Yes ☐No Can we send mail to the address on file? ☐Yes ☐No

Can we call the phone number on file? ☐Yes ☐No Can we leave voicemail on machine? ☐Yes ☐No

Will you allow us to send internet based (e-mail) delivery of reminders and newsletters? ☐Yes ☐No

If yes, please provide your e-mail address: _____

Who can we leave messages with? ☐Wife ☐Husband ☐Daughter ☐Son ☐Other: _____

Name(s): _____

Smoking Status

☐Current Every Day ☐Smoker, Current Status Unknown

☐Current Some Day ☐Heavy Tobacco ☐Unknown If Ever

☐Former ☐Never ☐Light Tobacco ☐I decline to answer

Vital Signs

Blood Pressure: _____ / _____

Height: _____ Weight: _____

Current Medications

☐No Known Medications ☐I take the following medications:

Name / Dose: _____

Name / Dose: _____

Name / Dose: _____

Name / Dose: _____

Name / Dose: _____

Name / Dose: _____

Name / Dose: _____

Name / Dose: _____

Use the back of this form if more room is needed

Allergies

☐No Known Allergies ☐No Known Drug Allergies

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Last Flu Shot Date: _____ **Did you get a pneumococcal vaccination?** ☐Yes ☐No

Have you fallen in the last 12 months? ☐Yes ☐No **Were you injured from the fall?** ☐Yes ☐No

Advanced Directives: ☐Living Will ☐DNR ☐Durable Power of Attorney ☐Surrogate Appointed ☐None

PLEASE READ AND SIGN: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. *(Assignment of Benefits)*: I authorize payment of medical benefits to the practice named above. *(Release of Information)*: I authorize the release of any medical information necessary to process this claim. *(HIPAA Privacy)*: I acknowledge that I received my HIPAA Privacy Practices Notice. *(Medication History)*: I authorize the Doctor's office to retrieve my medication history.

Patient Signature: _____ Date: _____