

NEW PATIENT EVALUATION

Patient Name: _____

1. What is the reason for you coming in to our office today?

2. How can you best describe your pain?

<input type="checkbox"/> No Pain	<input type="checkbox"/> Mild	<input type="checkbox"/> Severe
<input type="checkbox"/> Constant	<input type="checkbox"/> Intermittent	<input type="checkbox"/> Radiating
<input type="checkbox"/> Sharp	<input type="checkbox"/> Dull/Aching	<input type="checkbox"/> Numbness
<input type="checkbox"/> Tingling		

3. How long have you had this problem?

4. Do you ever recall injuring this area? When?

5. Do you have any swelling in your ankles/feet?
More in the morning? More in the afternoon?

6. Are there any activities that you cannot do because of your conditions? If so, what are they?

7. Are there shoes that you cannot wear because of this? What type?

8. Employment: Sit at job Stands at job Stands and walks at job Retired

PATIENT HISTORY

1. Have you been treated previously for this or any other foot or ankle problem?
2. What type of treatment did you receive? How long ago?
3. Were you happy with the treatment you received?
4. If not, what would you have liked to have done differently?
5. Have you used any over the counter products for more than 2 months?
6. Is there anything else you would like the doctor to know?

Patient Health History

Patient Name: _____

Height: _____ Weight: _____ Shoe Size & Width: _____

Is your General Health: Good Fair Poor

Do you Smoke?: No Yes ___ packs per day _____ years smoking ___ years stopped smoking

Do you drink Alcohol?: No Yes Amount per day/week/month _____

Are you Allergic or Sensitive to any of the following:

No Known Drug Allergies Anesthetics/Novocain Penicillin Iodine/Betadine

Food(s): _____ Other: _____

Please list any Medications you take now and the dosage (including vitamins, diet pills, aspirin, etc):

Name of Medication	Reason	Dose	Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Who is your Primary Care doctor: _____ Date last seen: _____

Other Physician(s) seen for Feet/Ankles: _____

Fitness Activities you participate in and frequency: _____

Please check if you have or have ever had any of the following and indicate when:

- | | | |
|--|--|---|
| <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Back Problem(s) _____ |
| <input type="checkbox"/> Blood Disease _____ | <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Carpal Tunnel Syndrome _____ |
| <input type="checkbox"/> Circulatory Disease _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Frostbite _____ |
| <input type="checkbox"/> Gout _____ | <input type="checkbox"/> Heart Trouble _____ | <input type="checkbox"/> High Blood Pressure _____ |
| <input type="checkbox"/> Kidney Trouble _____ | <input type="checkbox"/> Liver Trouble _____ | <input type="checkbox"/> Nerve Disorder _____ |
| <input type="checkbox"/> Stomach Ulcers _____ | <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> Thyroid Problems _____ |

Have you ever broken any bones? NO YES

Arm/Wrist/Hand RT LT When? _____ Treatment: _____

Leg/Ankle/Foot RT LT When? _____ Treatment: _____

_____ When? _____ Treatment: _____

_____ When? _____ Treatment: _____

How many pregnancies have you had?: _____ How many live births: _____

Have you ever been Hospitalized? NO YES When? _____ Reason: _____

List any surgeries you have had: surgery: _____ date: _____

surgery: _____ date: _____ surgery: _____ date: _____

Family History, please check if any of your immediate blood relatives have or have had any of the following: (please indicate who, when and if they are deceased)

Cancer _____ Circulation Problems _____ Diabetes _____

Foot Problems _____ Heart Problems _____ Other _____

Financial Policy

Thank you for choosing our office for your foot and ankle health care needs. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. We will require you read and sign this agreement before beginning any treatment. PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECKS AND MOST CREDIT CARDS.

REGARDING INSURANCE:

If we are **participating providers** with your insurance ("contracted insurance") we will collect your co-pays, deductibles and non-covered supplies at time of service. It is your responsibility to make sure your insurance company pays within their contracted period (30 days from date-of-service).

- **HMO PATIENTS:** It is your responsibility to obtain the appropriate referral(s) prior to your visit, or we will have to collect payment at the time of service.
- **ASSIGNMENT OF BENEFITS:** In the event we are participating providers with your insurance we will accept payment from your

Insurance. Your signature below authorizes this action; you will be billed once your insurance has responded. If we are not contracted with your insurance ("**non-participating**"), we expect payment at the time of service. We can usually offer a discount for full payment at time of service as well. We also offer as an added service to you, one free electronic billing of the charges to your insurance for your convenience.

- **MEDICARE PATIENTS:** We do not accept assignment from Medicare. Therefore you are expected to pay in full at time of service. We will only charge you Medicare allowed fees and submit to Medicare on your behalf. Medicare will reimburse you for allowed charges, if you have met your deductible and submit to your secondary insurance.
- **MINOR PATIENTS:** The adult accompanying a minor is responsible for full payment at time of service. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to a credit card or cash/check is send with the patient.
- **ADULT PATIENT:** Adult patients are responsible for full payment at time of service.
- **ASSIGNMENT OF BENEFITS:** In the event we do agree to accept payment from your non-contracted insurance, we require a credit card authorization and/or written payment plan for any balance due. Should your insurance not pay within 45 days, the entire balance will be transferred to the credit card number on file. We are not a party to this type of insurance contract. What they deem "medically necessary" or "reasonable and customary" is an issue between you and your insurance company.

USUAL AND CUSTOMARY RATES:

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

PATIENT RESPONSIBILITY:

Patients are responsible for their insurance CO-PAYS, DEDUCTIBLES, CO-INSURANCE and all NON-COVERED ITEMS.

MISSED APPOINTMENTS:

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of normal office visit. Please help us serve you better by keeping scheduled appointments.

COLLECTION OF AN OUTSTANDING BALANCE:

PAYMENT IS DUE AT THE TIME OF SERVICE, OR WITH IN THIRTY DA YS OF BEING BILLED

If we need to send more than one (1) statement, an eight-dollar (\$8.00) billing fee will be added to your account.

If your account should become past due, and every reasonable attempt has been made on our part to collect the debt, your account may be sent to Collections. Reasonable collection costs will be added to each account. You may also be responsible for legal and attorney's fees.

RELEASE OF INFORMATION:

Please refer to the "Summary of Notice of Privacy Practices" in the office waiting room.

I have read the financial policy above and understand and agree to these arrangements.

Patient Name (printed)

Signature of Responsible Party

Date

IMPROVING YOUR OFFICE VISIT

Our goal is to provide the best care and treatment and to make the most of your office visit today. Optimal results can only occur when you, the patient, become a partner in your healthcare by asking questions, ensuring your understanding of your care and treatment, and agreeing with treatment plans offered by Dr. Stilwell.

Before you are seen:

- Think about what you want to tell Dr. Stilwell
- If this is a follow-up visit for the same medical condition, are you better? Worse? What works best? What doesn't work?
- What are your symptoms?
- What makes your symptoms better or worse?
- What questions do you have?
- What medications are you on?

During your visit:

- Tell Dr. Stilwell what you want to tell.
 - What have you learned about your condition from other sources?
 - What do you think the problem is?
 - What concerns you most?
- Answer the doctor's questions.
- What questions do you have? (There are no "stupid" questions, please ask.)
 - Have the doctor explain things you don't understand.
 - Do I need to tell my other doctors about this visit and care?
 - Are there other options for treatment? What's good and bad about each option?
 - How long will it take to get better or heal?
- Have you had any tests or x-rays? What are the results?
- What medications do I need?
- Tell the doctor if you have any important health condition you haven't discussed or been asked about.
- Tell the doctor if you can't follow the treatment plan.
- If you are considering surgery, ask the doctor to explain the procedure, the costs, and alternatives to surgery