Initial Patient Information Sheet

Last Name:________________________ First Name/MI:__________________________

Zip Code:____________ Home Phone: _____________________ SSN:____-____-____

Street:_________________________________ City and State:________________________

Date of Birth (mm/dd/yy):____/____/____Age:____ Marital Status:______ Sex:______

Employer Name:____

Street:_________________________________ City and State:________________________

Zip Code:____________ Work Phone :__________________ Ext:_____________________

Financial Responsible Party (If Other Than Patient)

Last Name:________________________ First Name/MI:___________________________

Street:_________________________________ City and State:________________________

Zip Code:____________ Home Phone:_______________________ SSN:____-____-____

Date of Birth (mm/dd/yy):____/____/____ Age:____ Marital Status:______ Sex:______

Employer Name:____

Street:_________________________________ City and State:________________________

Zip Code:_____________ Work Phone:_________________ Ext:_____________________

Insurance Information

Name of Insurance:____________________________ Policy #________________________

Name of Policy Holder:____

Who can we call in case of an emergency? (friend or relative not living with you)

Name:_________________________________ Phone #:____________________________

I irrevocably authorize that my insurance benefits be payable directly to Thomas W. Madden, DPM. I am responsible for all deductibles, co-insurance, and non-covered charges. I understand that payment is due in full at the time of service, and if not, I am responsible to make appropriate financial arrangements.

Signature:______________________________ Date:_________________________________

I state that I am over 18 years of age, and am responsible for making my own financial commitments and medical decisions.

Signature:______________________________ Date:_________________________________

PATIENT HISTORY

PATIENT NAME ___________________________ DATE _______________

We appreciate your time in filling out the following pages as complete as possible. This will help us to have an accurate account of your medical history. You are responsible for updating us with information regarding medical changes that may occur during your period of treatment with us.

By what name would you prefer we call you (nickname)? _______________________________

Who may we thank for referring you to our office?

Physician____________________________________

Internet/Google ______________________________

Facebook/Twitter _____________________________

Insurance Website ____________________________

Family/Friend ________________________________

What pharmacy do you normally use? ____

Who is your General Physician/Family Doctor?____

And your last visit with them was…____

Please list any medications you are ALLERGIC to: _____________________________________

____

____

Please list any medications you are taking at this time (including over the counter medicine)

____

____

____

Please list any health disorder (diabetes, hearing problems, high blood pressure, cancer, etc)

____

____

____

Please describe your foot problem(s) to the best of your ability:

____

____

____

Is there anything special you should make us aware of that will help us to care for special needs you may have? ____

Patient Name:____

Work Phone:____

Cell Phone:____

Email Address:____

To Whom It May Concern:

I___________________________ DO NOT HAVE, NOR HAVE I HAD ANY OTHER
(PLEASE PRINT)

HEALTH INSURANCE COVERAGE IN THE LAST TWELVE MONTHS.

________________________ ___________________________

SIGNATURE DATE

The Advanced Foot Care Center
4102 S. Clear Creek Road, Ste. 109
Killeen, Texas 76549
(254) 634-3668

It is your responsibility to notify the office in a timely manner when refills are necessary. Approval of your refill may take up to 3 business days so please be courteous and do not wait to call. If you use a mail order pharmacy, please contact us fourteen (14) days before your medication is due to run out.

Medication refills will only be addressed during regular office hours (Monday – Thursday, 8am-4pm and on Friday 8am-12pm). Please notify our office on the next business day if you find yourself out of medication after hours. No prescriptions will be refilled on Saturday, Sunday or Holidays.

Refills can only be authorized on medication prescribed by our office. We WILL NOT refill medications prescribed by other providers.

Some medications require prior authorization. Depending on your insurance this process may involve several steps by both your pharmacy and your provider. The providers and pharmacies are familiar with this process and will handle the prior authorization as quickly as possible. Only your pharmacy is notified of the approval status. Neither the pharmacy nor the provider can guarantee that your insurance company will approve the medication. Please check with your pharmacy or your insurance company for updates.

It is important to keep your scheduled appointment to ensure that you receive timely refills. Repeated no shows or cancellations will result in a denial of refills. All prescriptions require a follow up appointment every 3 to 6 months.

If you have any questions regarding medications, please discuss these during your appointment. If for any reason you feel your medication needs to be adjusted or changed, please contact us immediately.

New symptoms or events require a clinic appointment. Dr. Madden will not diagnose or treat over the phone

____
PRINT - PATIENTS NAME/DOB

____ ______________________
PATIENT SIGNATURE DATE

MISSED APPOINTMENTS

Your appointment is a SCHEDULED APPOINTMENT. We have many patients waiting to be seen and would like to accommodate them. In order to help them, we need your cooperation.

Due to the increase of patients not showing for their scheduled appointment, we are obligated to charge $50 for any missed appointments or $50 for those who do not notify our office at least 24 hours before their appointment date.

I hereby understand and agree to pay a fee of $50 for appointments missed or without a 24 hour notice.

____________________________________ ____________________________

PRINT NAME DATE

____

SIGNATURE

____

RELATIONSHIP TO PATIENT

OFFICE POLICIES AND PROCEDURES

1. There will be a $50.00 fee charged to the patient for appointments not cancelled 24 hours before the appointment. You can call after hours and our answering service will advise us of your cancellation.
2. If you do not show for your appointment on three consecutive occasions, you will be notified by registered mail of your discharge as a patient and will be given 30 days to find another provider
3. There will be a $150.00 fee charged to the patient for any SURGERY APPOINTMENTS cancelled after it has been arranged with the hospital. It takes the time of several people to set up a surgery
4. There is a $25.00 cash fee for release of medical records for personal use. However, if your records are requested by a physician involved in your care, no fee will be applied. Records requested by your primary care will be accommodated. These records will be mailed or faxed directly to the requesting physicians.
5. There is a $25.00 cash fee for any letters, paperwork or documents that need to be filled out by our office and signed by the physician based on appointment type and physicians' discretion. **There is a one week turn around period for these to be picked up.**
6. There is a **24-48 hour turn around period for all prescriptions to be picked up or called into the pharmacy of your choice**
7. Co-payments and deductibles are due upon signing in before being seen by the doctor. Any other fees are also due upon signing in.
8. Payments for services are due at the time of service for non-insured patients.
9. Any returned checks will result in a $50.00 return check fee. You will also be required to pay cash for any future appointments.
10. **IT IS THE RESPONSIBILITY OF THE PATIENT TO ENSURE THAT THEIR REFERRAL HAS SUFFICIENT VISITS AND IS CURRENT. IT IS NOT OUR RESPONSIBILITY TO OBTAIN A NEW REFERRAL FOR A PATIENT**.

I HAVE READ AND UNDERSTAND THE ABOVE POLICIES AND PROCEDURES FOR THE OFFICE OF DR. THOMAS MADDEN.

______________________________ ____________________________

PATIENT NAME OR PARENT SIGNATURE AND DATE

PLEASE READ CAREFULLY

Payment Policy

1. All office visit charges are due at time of service.
2. It is your responsibility to make sure Dr. Madden is in your HMO or PPO Insurance network.
3. All HMO/PPO co-payments are due at the time of service.
4. Your insurance is responsible and you are responsible to the doctor for payment of your charges. We will bill your insurance company as a courtesy to you.
5. All co-payments, deductibles, and amount over "usual and customary" are due by you. WE DO NOT ACCEPT what insurance companies' state as "usual and customary". We strive to notify in advance if this might occur.
6. If your insurance has not paid within 30 days, you will be required to start paying on your account. When the insurance company pays and you have been credited, you will be refunded.

Elective Surgery

1. All co-payments and deductibles are due BEFORE SURGERY.

Pre- Certification

1. We will try to fulfill all the requirements your insurance has for pre-certification, but we will not be responsible for any reductions in benefits if this is not done.
2. Be sure and tell us if pre-certification is necessary BEFORE we schedule any procedures.

Medicare

1. If you are on Medicare, we accept assignment and bill Medicare for you. You are responsible for the 20% co-payment and any part of the $150 annual deductible that has not been met.

Authorization

I authorize the release of medical records to determine liability for payment and to obtain reimbursement. I assign all medical and/or surgical benefits, including Medicare, private insurance, and other health plans to Thomas W. Madden, DPM, FACFS.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY MY INSURANCE COMPANY.

Signature________________________________ Date______________

ACKNOWLEDGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

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

______________________________ __________________

Patient Name (please print) Date

____

Parent or Authorized Representative (if applicable)

____

Signature

COVID-19 SCREENING QUESTION

PLEASE READ ALL THE QUESTIONS CAREFULLY AND ANSWER TRUTHFULLY.

1. Do you currently have a cough, fever, shortness of breath or difficulty breathing?	Yes	No
2. Have you traveled outside of the United States within the last 14 days?	Yes	No
3. Have you be on a cruise within the past 14 days?	Yes	No
4. Have you had contact with someone with known or suspected COVID-19 in the past 14 days?	Yes	No
5. Have you had COVID-19 in the past 14 days?	Yes	No
6. Have you tested negative in the past 14 days?	Yes	No

Printed Name:____________________________

Signature:______________________________

Date: ________________________________

this page is front + back :)

Diet, Sleep and Exercise Questionnaire

Circle all that apply:

Type of Diet: Regular Diabetic Gluten Free High Calories High Carbohydrates
High Fat High Fiber High Sugar Kosher Lactose Free Liquid Low Calorie
Low Carbohydrates Low Fat Low Fiber Vegan Vegetarian DASH

Purpose of Special Diet: Is there a reason for your particular diet?
Maintain Health Health Condition Personal Beliefs Weight Gain Weight Loss

Dieting: Did you partake in any fad or crash diets? Yes or No

Exercise: None Flexibility Aerobic Anaerobic

Intensity: None Light Moderate Vigorous

Duration: 0-30 Min 31-60 Min 1-1.5 hour 1.5-2 hour More than 2 hours

Frequency: None 2-3 times a week 4-6 times a week 2-3 times a month a few times a year

Sleep: How many hours do you sleep at night?
2 hours or less 3-5 hours 6-7 hours 8-9 hours 10-12 hours 12 or more hours

Naps: If you nap, how many minutes or hours do you nap in total?
0-15 Min 15-30 Min 31-60 Min 1-3 hours 3-5 hours More than 5 hours

Signature: ____________________________ Date: ______________________________