OLDHAM COUNTY FOOT & ANKLE

Patient Demographics Form (Please Print)

PATIENT INFORMATION

Name (First, Middle Initial, & Last):

Date of Birth: **Sex:** □ M □ F **Social Security #:**

Address: **Home #:**

City: **State:** **Zip:** **Work #:**

Email: **Cell #:**

Ethnicity: □ Decline Ethnicity & Race □ Not Hispanic or Latino □ Hispanic or Latino

Preferred Language: □ English □ Spanish □ Other,

Preferred Phone (CHOOSE 1): □ Home □ Work □ Cell

Race: □ American Indian or Alaska Native □ Asian □ Black □ Native Hawaiian or Other Pacific Islander □ White □ Other

GUARANTOR/PERSON RESPONSIBLE FOR PAYMENT

Name (First, Middle Initial, & Last): **DOB:**

Address: **SSN:**

City: **State:** **Zip:** **Sex:** □ M □ F

Relationship to Patient: □ Spouse □ Parent □ Legal Guardian **Employer:**

Home #: **Work #:** **Cell #:**

INSURANCE INFORMATION - COMPLETE IF SUBSCRIBER/POLICY HOLDER IS NOT THE PATIENT

Subscriber Info - Primary Insurance	Subscriber Info - Secondary Insurance
Insurance Co:	**Insurance Co:**
Subscriber Name:	**Subscriber Name:**
Subscriber DOB:	**Subscriber DOB:**
Relationship to Patient: □ Spouse □ Parent	**Relationship to Patient:** □ Spouse □ Parent

ADDITIONAL PATIENT INFORMATION

Primary Care Physician (First & Last Name): **Phone:**

Emergency Contact Person: **Phone:**

Pharmacy Name: **Phone:**

Pharmacy Address:

LEGAL INFORMATION

Legal Guardian or Power of Attorney (Name & Phone #):

I hereby certify that the above information is true and correct to the best of my knowledge.

Patient/Guardian Signature **Date**

Revised 01/01/22

OLDHAM COUNTY FOOT & ANKLE

Financial Agreement

Initial here:	Please initial that you have read each of the following (Fees subject to change without notice):
	In outlining this financial agreement, Oldham County Foot & Ankle will be referred to as OCFA.
_____	CLAIMS: I authorize the release of any medical or other information necessary to process my health insurance claim (if applicable). I also request payment to be sent directly to OCFA.
_____	HEALTH INSURANCE: Services rendered will be billed to patient's insurance (unless a known plan exclusion). If any portion of patient's claim has been denied for payment by their insurance company, OCFA reserves the right to bill the patient/guarantor/responsible party for the charges not paid by the patient's insurance company. All charges incurred are the sole responsibility of the patient/guarantor/responsible party regardless of insurance coverage. It is the responsibility of the patient/guarantor/responsible party to know if OCFA provider is participating in their plan and is In-Network, and their copay/deductible/coinsurance information.
_____	DEDUCTIBLES: If a patient has a deductible plan, OCFA requires a minimum payment of $150 for new patients and $75 for established patients at time of service until deductible is met. This may or may not cover the cost of all services rendered. Any additional balance due will be billed to you. Any overpayment will be refunded or applied to future visits.
_____	ACCOUNT BALANCE: All account balances must be paid in full before patient can be seen for an additional scheduled visit. If patient has an account balance due at their next appointment and are unable to pay, patient may be asked to reschedule their visit until balance is paid in full. Any account balances older than 90 days old will be sent to a collection agency.
_____	RETURNED CHECKS: All returned checks will result in a $25.00 returned check fee and patient/guarantor/responsible party will be changed to a "Cash or Credit Card" only status for payments.
_____	CANCELLATION FEE: OCFA reserves the right to charge a fee of $50.00 if patient/responsible party does not contact OCFA at least 24 hours before scheduled appointment.
_____	NO SHOW FEE: OCFA reserves the right to charge a fee of $50.00 if patient fails to show up for their scheduled appointment. After the 3rd No Show, patient may be dismissed as a patient at OCFA.
_____	CREDIT CARD ON FILE: I authorize OCFA to charge my credit card for agreed upon purchases as outlined. I understand that my information will be saved to file for future transactions on my account (see below). I understand that all account balances under the amount of $5.00 will be automatically charged to my card.

Credit Card on File (Please Read):

It is the policy of OCFA to require a form of payment such as credit, debit, health savings, or flex spending card to be stored on all patient accounts. Cards are stored electronically on our point-of-sale terminal powered by SQUARE, INC (Payment Card Industry (PCI) Compliant & Cyber Security Insured). All precautions have been put in place to protect data stored from a cyber-attack. **The card on file information available to OCFA staff is limited to the last 4 digits of your card number and expiration date.** If your card cannot be saved to your account by swiping it through the Square terminal, an image of your card will be scanned to your payment profile instead. Your card on file can only be used at OCFA, through our secure point-of-sale terminal.

Per your plan contract, all copays are due at the time of service. All additional services rendered will first be billed to your health insurance carrier. After your claim processes, any remaining balance will be billed to you. If payment is not received by the due date, OCFA will charge the balance due to your card on file. **If payment is received by the due date, your card will never be charged.**

You, the Patient/Parent/Guardian, by signing this agreement, agree to allow OCFA to utilize your stored credit card to pay all balances due to OCFA at any time that money is owed AFTER your health insurance carrier has been billed OR for balances not billable/payable by your insurance (i.e. Cancellation/No Show fees). You further agree to allow OCFA to scan and save your payment source to our secured payment terminal powered by Square, Inc.

All account numbers and charges made by OCFA are generally confidential and are protected from disclosure except as provided by law.

Your signature indicates your understanding and compliance with all policies outlined in this financial agreement.

Credit Card Information:

Cardholder Name (as shown on card):_____ **Card Type:** □ VISA □ MC □ DISC □ AMEX

Card Number (Last 4-digits Only): _____ **Expiration Date:** _____ **Billing Zip Code:** _____

Email Address for receipts:

_____ _____

Patient/Parent/Guardian Signature **Date**

_____

Patient Name (Print)

OLDHAM COUNTY FOOT & ANKLE

HIPAA – Patient Consent of Information

Oldham County Foot & Ankle, in order to comply with the HIPAA Privacy Regulation, requires an authorization from the patient before detailed messages are left for the patient. This policy is to protect the privacy of the patient and to protect the physicians and staff of Oldham County Foot & Ankle from violating the patient' s confidentiality. If there is not a signed consent on file, physicians and staff will only leave their name and telephone number on an answering machine, voicemail or with a live person answering the phone requesting the patient to return the call.

By completing the consent below, you are allowing Oldham County Foot & Ankle physicians and its staff to leave a message on a voicemail or with a specified individual. You may specify what information is left and with whom by noting the information on the bottom of this form. By signing, you are also consenting to the mailing or faxing of any results, requested by you, to your primary care physician or another physician involved in your care.

I give my consent to Oldham County Foot & Ankle physicians and staff to leave a message regarding scheduling, treatment, surgery, lab or radiology results, or other information as necessary (check all that apply):

_____ on a voicemail at home or cell phone
_____ on a voicemail at work
_____ with_____relationship_____
_____ with_____relationship_____
_____via email
_____via text (sms) message

_____ I do not consent to messages being left at home, work or with any other person. I wish to be contacted directly

_____ _____
Patient's Name (Please Print) Date of Birth

_____ _____
Patient's Signature Date

HIPAA – Notice of Privacy Practice Acknowledgement

_____I have been provided a copy of Oldham County Foot & Ankle's Notice of Privacy Practice.

_____I have declined a copy of Oldham County Foot & Ankle's Notice of Privacy Practice.

_____ _____
Patient's Signature Date

Revised 11/1/2020

OLDHAM COUNTY FOOT & ANKLE

Patient Medical History (Please Print)

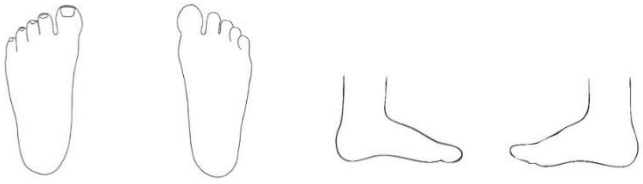
PATIENT NAME:_____ **DOB:**_____

Current Problem

What specific problem brings you to our office today? _____

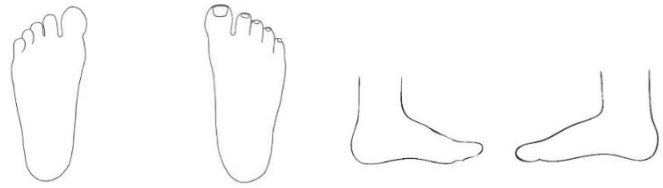
Where is the pain/problem located? (Please mark on the pictures below)

LEFT FOOT



Top of Foot | Bottom of Foot | Inside of Foot | Outside of Foot

RIGHT FOOT



Bottom of Foot | Top of Foot | Outside of Foot | Inside of Foot

How long ago did this problem first start? _____ Days / Weeks / Months / Years

Did your pain or problem: ☐ Begin All of a Sudden ☐ Gradually Develop Over Time

Since the time your pain or problem began, has it: ☐ Stayed the Same ☐ Become Worse ☐ Improved

How would you describe your pain?
☐ No pain ☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Radiating ☐ Itching ☐ Stabbing ☐ Other _____

How would you rate your pain on a scale from 0 to 10? (Please Circle)
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 *(Worst Pain Possible)*

What makes your pain or problem feel worse? ☐ Walking ☐ Standing ☐ Daily activities ☐ Resting ☐ Dress shoes
☐ High heels ☐ Flat shoes ☐ Any closed toe shoe ☐ Running ☐ Other_____

What makes your pain feel better? _____

What treatments have you had for this problem? _____

How has this problem affected your lifestyle or ability to work? _____

Was this problem cause by an injury?
☐ No ☐ Yes (Describe) _____, If YES, was it a work-related injury? ☐ Yes ☐ No

Have you previously been a patient of Dr. Pedersen in the last 3 years? ☐ Yes ☐ No

How did you hear about us? ☐ Facebook ☐ Internet Search ☐ Newspaper Ad ☐ Other_____

☐ Dr. Referral _____ ☐ Friend/Family Member _____

Height: _____ **Foot** _____ **Inches** **Weight:** _____lbs **Shoe Size**: _____

Employer: _____ **Occupation:** _____

How much are you on your feet at work? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

Do others depend upon you for their care? ☐ Children ☐ Pet(s) ☐ Elderly or Disabled Family Member

Exercise: ☐ Never ☐ Rare ☐ Weekly ☐ Daily Type: _____

Social History (Please ✓ All That Apply)

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Use of Alcohol: ☐ Never ☐ No Longer Use ☐ History of Alcohol Abuse ☐ Current __Rare __Occasional __Moderate __ Daily

Use of Tobacco: ☐ Never ☐ Smoke, ____packs/day, for _____ years ☐ Quit, How long ago? _____

Revised 11/1/2020

Please List All Prior Surgeries and/or Hospitalizations:

Surgeries	Date	Hospitalization	Date
1)		1)	
2)		2)	
3)		3)	
4)		4)	
5)		5)	

Have You Ever Had Any of the Following? (Please ✓ All That Apply)

□ Diabetes Type 1	□ Liver Disease	□ Open Sores	□ Fibromyalgia
□ Diabetes Type 2	□ Hepatitis A	□ Cancer	□ Migraine Headaches
□ Neuropathy	□ Hepatitis B	□ Anemia	□ Thyroid Disease
□ Kidney Disease	□ HIV+/AIDS	□ Asthma	□ Skin Disorder
□ Abnormal Bleeding	□ Stomach Ulcers	□ Bronchitis/Emphysema	□ Bladder Infections
□ Stroke	□ Acid Reflux	□ Sleep Apnea	□ Polio
□ Heart Attack	□ Arthritis	□ Pneumonia	□ Rheumatic Fever
□ Heart Disease/Failure	□ Gout	□ Tuberculosis	□ Sickle Cell Disease
□ High Blood Pressure	□ Mitral Valve Prolapse	□ Blood Transfusion	□ Other Conditions:
□ Low Blood Pressure	□ Blood Clots	□ Back Trouble	_____

Allergies?

□ None Known □ Iodine □ Latex □ Shellfish □ Tape

□ Anesthesia _____ □ Foods _____

□ Medications _____ □ Other _____

Please List All Medications You Are Currently Taking (Include Prescriptions, Over-the-Counter Medicine, & Herbal Supp.)

Name	Dose	How often do you take?
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		
9)		
10)		

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

Patient/Legal Guardian/Authorized Representative Signature **Date**

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