OLDHAM COUNTY FOOT & ANKLE
6400 Westwind Way Ste B, Crestwood, KY 40014 | Phone/Fax (502) 276-9999

Patient Information (Please Print)

(First, Middle Initial, & Last)

Name: Appointment Date:

Sex: ☐ M ☐ F SSN (Medicare Patients): Date of Birth:

Address: Phone (H):

City: State: Zip: Phone (C):

Email: Phone (W):

Preferred Method of Communication: ☐ Home ☐ Cell ☐ Work ☐ Email ☐ Mail

Permission to Send Notification Via: ☐ Text ☐ Voicemail ☐ Email

Primary Care Physician: Phone:

Pharmacy: Phone:

Guarantor/Person Responsible for Payment (If different from Patient)

(First, Middle Initial, & Last)

Name: DOB:

Address: SSN:

City: State: Zip: Sex: ☐ M ☐ F

Relationship to Patient: Phone:

Employer: Work Phone:

Insurance Information (Complete if policy holder is different than patient)

PRIMARY	SECONDARY
Insurance Co:	Insurance Co:
Name of Insured:	Name of Insured:
Insured DOB:	Insured DOB:
Insured ID #: Group #:	Insured ID #: Group #:
Relationship to Patient:	Relationship to Patient:

Patient Name: _____ **DOB:** _____

Legal Information

Emergency Contact Person: Phone:

Relationship to Patient:

Legal Guardian or Healthcare Power of Attorney? ☐ No ☐ Yes If Yes, Name:

Permission to release information to:	Relationship to Patient:
1)	
2)	
3)	

Office Policies Acknowledgements (Please read & sign)

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read and understand the notice.

APPOINTMENT CANCELLATION & NO SHOW POLICY

If it is necessary to cancel my scheduled appointment I must contact the office within 24 hrs of the scheduled time. If I fail to call within the designated time period I will be charged a **$25.00 NO SHOW** fee. After the 3rd No Show, I will be dismissed as a patient at Oldham County Foot & Ankle.

PAYMENT POLICY

INSURANCE: Every attempt will be made to bill your insurance for services rendered. If any portion of your claim has been denied for payment by your insurance company, we reserve 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. Some insurances limit the number of procedures they will pay for in one visit. If your insurance is one of these, the patient/guarantor/responsible party will be billed for the non-covered procedures. If an insurance company has failed to pay a claim within 60 days of filing, the full amount will be charged to the patient/guarantor/responsible party.

ACCOUNT BALANCE: All account balances must be paid in full before patient can be seen for an additional scheduled visit. If you have an account balance due at your next appointment and are unable to pay, you will be asked to reschedule your visit until you can pay your balance in full. Any account balances older than 60 days old will be sent to a collections agency. Exception to this policy would be for those patients in a post-operative global period.

RETURNED CHECKS: All returned checks will result in a $25.00 bounced check fee and patient/guarantor/responsible party will be changed to a "Cash or Credit Card" only status for payments.

REFUNDS: Payments resulting in an account credit are processed as follows. If a patient is still under our treatment the credit will be applied to their future appointments until all claims & treatment have been completed. For patients that have completed treatment refunds are processed on a monthly basis. Credits less than $10.00 will be processed on a quarterly basis.

TREATMENT OF STAFF/NO HARRASSMENT POLICY

Patient care is of the upmost importance to us. So is the treatment of our staff. Any behavior we deem as mistreatment (i.e. condescending remarks, disrespect, impatience, demanding/rude/repeated phone calls) will not be tolerated and may result in a dismissal from our care. If you have an issue with a member of our staff, please contact the office manager.

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

OLDHAM COUNTY FOOT & ANKLE

BILLING AGREEMENT

Patient Name: _____ DOB: _____

Due to the recent increase in high deductible plans, it is now the policy of Oldham County Foot & Ankle, PLLC to require either a Credit/Debit Card or HSA/Flexible Spending Card to be kept on file for all patients. All visits will first be charged to your designated insurance carrier/provider for services rendered by Oldham County Foot & Ankle.

If your claim comes back with a patient responsibility balance such as co-pays/coinsurance/deductibles you will receive a statement. You will have 15 days from the statement date to pay your balance in full. Any remaining balances will then be charged to the card kept on file. All cards will be stored electronically in our Payment Card Industry (PCI) Compliant & Cyber Security Insured system to protect and alleviate any worries you may have of a cyber-attack.

It is YOUR responsibility to notify us of any change to your insurance so that we can determine if there is any change in your benefits.

You, the Patient, by signing this agreement, agree to allow Oldham County Foot & Ankle, PLLC to utilize your Credit/Debit Card or HSA/Flexible Spending Card to pay all fees and costs due to Oldham County Foot & Ankle, PLLC at any time that money is owed after your primary insurance carrier has been billed or from amounts excluded from your insurance (i.e. NO SHOW fees). You further agree to allow Oldham County Foot & Ankle, PLLC to scan the Credit/Debit Card or HSA/Flexible Spending Card kept on file.

All account numbers and charges made by Oldham County Foot & Ankle, PLLC are generally confidential and are protected from disclosure except as provided by law.

Your signature indicates your understanding and compliance with this policy.

_____ _____

PATIENT NAME (Print) **PATIENT SIGNATURE**

_____ _____

GUARDIAN NAME **GUARDIAN SIGNATURE**
(If patient is under 18 years of age) (If patient is under 18 years of age)

Date: _____

Name on Card: _____ **Type of Card (VISA/MC/DISC/AMEX):** _____

Last Four Digits on Card: _____ **Card Expiration Date:** _____

PATIENT MEDICAL HISTORY

Patient Name: _____ **DOB:** ____/____/_____ **Appointment Date:** _____

Please List All Prior Surgeries and/or Hospitalizations:

Surgeries	Date	Hospitalization	Date
1)		1)	
2)		2)	
3)		3)	
4)		4)	
5)		5)	
6)		6)	
7)		7)	
8)		8)	

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

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

Other Conditions: _____

Family History (Please ✓ All That Apply)

□ Diabetes	□ Coronary Artery Disease	□ High Blood Pressure	□ Stroke
□ Cancer	□ Heart Disease	□ Rheumatoid Arthritis	□ Thyroid Disease

Other Conditions: _____

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 use–type:

- □ Rare
- □ Occasional
- □ Moderate
- □ Daily

Use of Tobacco

- □ Never
- □ Smoke
  - How many packs/day? ____
  - For how many years? _____
- □ Quit
  - How long ago? _____

Use of Recreational Drugs

- □ Never
- □ Quit
  - How long ago? _____

Current use-type:

- □ Rare
- □ Occasional
- □ Moderate
- □ Daily

Height: _____ Foot _____ Inches Weight: _____ lbs

Employer: _____ Occupation: _____

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

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

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

PATIENT MEDICAL HISTORY

Patient Name: _____ DOB: ____/____/_____ Appointment Date: _____

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

Shoe Size: _____ Width: _____ How long ago did this problem first start? _____ Days/Wks/Mos/Yrs

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

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)*

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

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? ☐ Yes (Describe) _____ ☐ No

If YES, was it a work-related injury? ☐ Yes ☐ No

PATIENT MEDICAL HISTORY

Patient Name: _____ **DOB:** ____/____/_____ **Appointment Date:** _____

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, and Herbal Supplements)

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

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 _____

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**

NOTICE OF PRIVACY PRACTICES

(PATIENT COPY)

USES AND DISCLOSURES OF HEALTH INFORMATION:
We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

USES AND DISCLOSURES BASED ON YOUR AUTHORIZATION:
We will not use or disclose your health information without your written authorization.

USES AND DISCLOSURES NOT REQUIRING YOUR AUTHORIZATION:
In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas or as otherwise required by law.

PATIENT RIGHTS. AS OUR PATIENT, YOU HAVE THE FOLLOWING RIGHTS:

- To have access or and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made on your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

OFFICE POLICIES

(PATIENT COPY)

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