TUSCANY PODIATRY, PC – NEW PATIENT INFORMATION

Name: (Last)_____ (First)_____ (MI)_____

Mailing Address:_____

City, State, Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

SSN:_____ Age:_____ Date of Birth:_____ Sex: M / F

Employer:_____ Occupation:_____

FT / PT / RETIRED / NA Student: FT / PT / NA Marital Status: S / M / D / W

Spouse Name:_____ Spouse Date of Birth:_____

Spouse SSN:_____ Email:_____

Shoe Size:_____ Height:_____ Weight:_____

Emergency Contact: Name:_____ Phone:_____

Relationship to Patient:_____ Referred By:_____

PRIMARY INSURANCE:_____

Subscriber:_____ Subscriber DOB:_____

Relationship to Patient:_____

SECONDARY INSURANCE:_____

Subscriber:_____ Subscriber DOB:_____

Relationship to Patient:_____ Workers Comp? Y / N Auto Accident? Y / N

CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment. I hereby authorize medical information to be sent to my primary physician.

Signature:_____ Date:_____

AUTHORIZATION FOR TREATMENT/PAYMENT: I authorize Tuscany Podiatry, PC to provide medical treatment and hereby agree to pay any outstanding balance whether paid for or denied by my insurance company or third-party payer.

AUTHORIZATION TO RELEASE INFORMATION: I authorize the physician to release any information required, in the course of my exam or treatment, to my insurance company or third-party with whom I have coverage. Furthermore, I authorize any holder of medical information about me to release said information to a physician or other medical professional who may be a part of my care.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: If I have insurance, I authorize payment directly to the physician for medical services rendered. I understand that Tuscany Podiatry, PC will file insurance claims to my primary and/or secondary insurance carrier. Tuscany Podiatry, PC does not currently file with a third-party payer.

COPAYS, DEDUCTIBLES AND NON-COVERED CHARGES: I understand that I am responsible for any unpaid balance, co-pays, deductibles and non-covered services rendered. I understand that Tuscany Podiatry, PC will file insurance claims on my behalf to any carrier other than a third-party payer. I understand that any amount that is my responsibility will be due at time of service. I further acknowledge that any copays, deductibles or balances must be paid before any procedure can be scheduled. Accounts having a balance over 30 days old are considered delinquent. I understand if my account goes to collections that I will be responsible for collection fees, court costs and/or attorney fees involved in collecting the delinquent bill.

PATIENT or RESPONSIBLE PARTY SIGNATURE: _____ **DATE:**_____

REV. 12/29/2020

TUSCANY PODIATRY PC MEDICAL HISTORY FORM

Patient Name _____ **DOB** _____ **Date** _____

Who is your primary care doctor? _____ Phone number _____
When were you last seen by this doctor? _____

If you are under the regular care of any other doctors, or see an endocrinologist or vascular surgeon, please list their names: _____

MEDICAL HISTORY (Check all that apply)

AIDS/HIV	___	Diabetes	___	High Blood Pressure	___	Stomach ulcers	___
Anemia	___	Epilepsy	___	High Cholesterol	___	Thyroid problems	___
Arthritis	___	GERD	___	Kidney Disease	___	Tuberculosis	___
Asthma	___	Gout	___	Liver Disease	___	Valve/Joint replacement	___
Bleeding problem	___	Heart Disease	___	Phlebitis	___	Varicose veins	
Cancer	___	Hepatitis	___	Sickle Cell Disease	___	Other _____	
				Stroke	___		

CURRENT MEDICATIONS:

_____ _____ _____
_____ _____ _____
_____ _____ _____

HAVE YOU EXPERIENCED...	**YES**	**NO**		**YES**	**NO**
Back problems	___	___	Falls	___	___
Burning, tingling or numbness in toes	___	___	Fatigue	___	___
Blood Clots	___	___	Headaches	___	___
Dryness of skin	___	___	Itchy skin on feet	___	___
Episodes of Fainting	___	___	Reaction to local anesthetic	___	___
Foot/leg cramps while sleeping	___	___	Shortness of breath	___	___
Foot/Leg cramps while walking	___	___	Swelling of Feet/Ankles	___	___
			Keloid or thick scars	___	___
			Painful contact with socks	___	___
			Painful contact with bed sheets	___	___

ALLERGIES: List allergies below **-OR-** _____ Check if you have NO known drug allergies

A = True allergy **S** = Sensitivity

Adhesive Tape	____	Local Anesthetics	____	Sulfa Drugs	____
	____	Shellfish	____	Penicillin	____
Aspirin	____	Iodine	____	Codeine	____
Demerol	____	Other _____			
Latex					

SURGICAL HISTORY (Procedure and year) _____

SOCIAL HISTORY Nicotine use YES NO Alcohol abuse YES NO Drug abuse YES NO
Previous/current
If yes to nicotine use, for how long? _____ When did you quit? _____

FAMILY HISTORY **(M) MOM (D) DAD (S) SIBLING (G) GRANDPARENTS**
Diabetes ____ Heart Disease ____ Cancer ____ Keloid scars ____ Sickle cell disease ____ Blood Clots ____
Arthritis ____ Hypertension ____ Other _____

What is your chief complaint today? _____
How long has it been bothering you? _____ If applicable, what was the date of injury? _____
Previous treatments? _____ Pain Level: 1 2 3 4 5 6 7 8 9 10

TUSCANY PODIATRY 215 HARGROVE ROAD EAST TUSCALOOSA, AL 35401
Telephone (205) 758-8870 Fax (205) 758-8870

Medical Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth: ____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

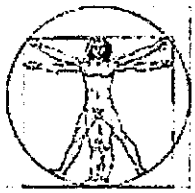
[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/____/_____



Tuscany Podiatry, P.C.

Tuscany Podiatry, P.C.
Patricia Antero, DPM
215 Hargrove Road East Tuscaloosa, AL 35401
Phone: 205-758-8809 **Fax:** 205-758-8877

FINANCIAL POLICIES
(initial each line)

_____ All copays, deductibles and non-covered charges are due at the time of service, regardless of who brings the patient in for his/her visit. We accept cash, check, Visa, MasterCard, American Express and Discover for your convenience.

_____ It is the patient's responsibility to know your insurance benefits and whether or not the physician you see here is a preferred provider. If your insurance requires a referral to see a specialist, it is your responsibility to obtain the referral.

_____ In order to release medical records, we MUST have a release form signed by the patient. There will be a fee for copies of medical records unless they are sent directly to another physician. Any balance due must be paid in full prior to the release of medical records.

_____ A minimum fee of $25 is required for completion of medical forms. Please allow up to 30 days for completion of forms. See office staff in advance to determine individual cost for form completion.

_____ If your balance is over 60 days old, you may incur finance charges of up to 33% of the balance.

_____ There is a $50 no show fee for appointments missed and not canceled 24 hours prior to appointment time.

_____ There is a $30 returned check fee.

Agreement to Accept Financial Responsibility, Insurance Authorization and Assignment of Benefits

I acknowledge that, at my request, Tuscany Podiatry, PC has provided or will provide me or my dependent with professional services, and I agree to the above financial policy. I also understand that if I fail to comply with this agreement and if my account becomes more that 90 days past due, it may be turned over to a collection agency, an attorney or small claims court for collection. I understand that any expenses incurred by Tuscany Podiatry, PC in its effort to collect claims will be added to my bill and become my responsibility.

I hereby authorize Tuscany Podiatry, PC to furnish medical information to my insurance carriers for payment of claims. I hereby assign to the physician all payments for medical services rendered to me or my dependents. I understand that I am responsible for any amount not covered by insurance.

_____ _____ _____
Printed Name Relationship to Patient Date

_____
Signature

*REV. 9/10/2020

COVID-19 POLICY CHANGES

Have you had a fever?	YES	NO
Have you traveled outside the US in the past month?	YES	NO
Has your doctor advised you to self-quarantine?	YES	NO
Do you have flu like symptoms (cough, chills, etc.)?	YES	NO
Does anyone in your family have the flu?	YES	NO

Please note:

-If you are here for routine nail care, you are welcome to reschedule WITHOUT penalty or charge.

-You will be expected to wait in your car, so please list a cell phone number and we will call or text you when it's time for you to go into an exam room. Cell #_____

-Only patients, not family members, will be brought into the exam room unless necessary (children or patients that need assistance).

-We will be taking your temperature prior to seeing the doctor. Rescheduling may be recommended.

Please be respectful of your neighbor's personal space. If you need hand sanitizer, it is available at the front desk. Thank you for your patience and understanding.

Sincerely,
Tuscany Podiatry

NAME:_____ DATE:_____

SIGNATURE:_____