U.P.G.
Upstate Podiatry Group, PA

# WELCOME

| PATIENT INFORMATION | | INSURANCE INFORMATION |
|---|---|---|
| **Patient Name:**_____ | | **Primary Insurance**:_____ |
| **Date of Birth:** _____**SSN:** _____ | | **Policy Holder's Name**:_____ |
| ❑**Male** ❑**Female** **Optional Pronouns:** _____ | | ❑**Self** ❑**Spouse** ❑**Dependent** |
| ❑**Single** ❑**Married** ❑**Widowed** ❑**Divorced** | | **Policy Holder's Date of Birth**: _____ |
| **Race:** _____ **Ethnicity:** _____ | | Employer: _____ |
| **Address:** _____ | | Secondary Insurance: _____ |
| **City:** _____ **State:** _____ **Zip Code:** _____ | | Policy Holder's Name:_____ |
| **Preferred Telephone Number: (_____)**_____ | | Policy Holder's Date of Birth: _____ |
| Email: _____ | | ❑Self ❑Spouse ❑Dependent |
| When it is available, would you like to receive text reminders for your appointment? ❑Yes ❑No | | **GUARANTOR INFORMATION** |
| **EMERGENCY CONTACT** | | ***only complete this section if the party responsible for payment is different from patient*** |
| **Name:** _____ | | Name: _____ |
| **Phone Number:** _____ | | Date of Birth: _____ Relation: _____ |
| | | Address: _____ |
| **Who may we thank for sending you to our office?** | | City: _____ State: ____ Zip: _____ |
| ❑Doctor: _____ | ❑Insurance Provider List | Telephone: (_____)_____ |
| ❑Patient: _____ | ❑Passed by Location | |
| ❑Social Media: _____ | ❑Health Fair | |
| ❑Other: _____ | ❑Internet Search | |

## PLEASE READ CAREFULLY BEFORE SIGNING BELOW

As part of our office policy, we require that your deductible (if not met), co-payment, and/or co-insurance be paid in full at the time of treatment. You are fully responsible for any amount not paid by insurance. Our office accepts cash, check, Visa, Mastercard, and Discover.

I hereby authorize Upstate Podiatry Group, PA to release my insurance company or other medical professionals any medical information acquired in the course of my examination or treatment. I also authorize payment from my insurance company to Upstate Podiatry Group, PA for any surgical and/or medical benefits due for services rendered.

**By signing below, 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 OR RESPONSIBILE PARTY SIGNATURE** **DATE**

If patient is *under 18 years old* or a *full time student*, please complete the following information:

Mother's Name _____ Phone Number: _____

Father's Name _____ Phone Number: _____

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# PAST MEDICAL HISTORY

**Please check any boxes that may apply to you**

| | | | |
|---|---|---|---|
| ❑ Arthritis | ❑ Coronary Heart Disease | ❑ High Blood Pressure | ❑ Osteoporosis |
| ❑ Anemia | ❑ COPD | ❑ Heart Attacks | ❑ Raynaud's Disease |
| ❑ Asthma | ❑ Diabetes -- ❑ 1 ❑ 2 | ❑ High Cholesterol | ❑ Stroke |
| ❑ Abnormal Bleeding | ❑ Epilepsy/Seizures | ❑ Kidney Disease | ❑ Tuberculosis |
| ❑ Artificial Joints | ❑ Fibromyalgia | ❑ Liver Disease | ❑ HIV/AIDS |
| ❑ Blood Clots | ❑ Gout | ❑ Lung/Respiratory Issues | ❑ Pacemaker |
| ❑ Back Pain | ❑ Heart Disease | ❑ Nerve Disorders | ❑ Phlebitis |
| ❑ Cancer _____ | ❑ Heart Failure | ❑ Organ Transplant | ❑ Ulcers (Type:) _____ |
| ❑ Other: _____ | | | |

| | |
|---|---|
| **Primary Doctor:** _____ _____ **Location:** _____ Last Visit: _____ | **Are you currently pregnant?** ❑ Yes ❑ No |
| **Primary Pharmacy:** _____ **Location:** _____ _____ | **Are you currently breastfeeding?** ❑ Yes ❑ No |

**Tobacco/E-cigarettes:** ❑ Never a Smoker ❑ Former Smoker ❑ Current Daily Smoker ❑ Current Occasional Smoker

If current, how many packs per day? _____

**Alcohol:** ❑ No ❑ Occasional ❑ Moderate ❑ Heavy

**Your main reason for today's visit:**

_____

**Surgical History: Have you had surgery before? ❑ Yes ❑ No If so, please list below.**

| | | | |
|---|---|---|---|
| 1)_____ | Year: _____ | 4)_____ | Year: _____ |
| 2)_____ | Year: _____ | 5)_____ | Year: _____ |
| 3)_____ | Year: _____ | 6)_____ | Year: _____ |

## PLEASE LIST ALL CURRENT MEDICATIONS:

| | | | |
|---|---|---|---|
| 1)_____ | Dose: _____ | 6)_____ | Dose: _____ |
| 2)_____ | Dose: _____ | 7)_____ | Dose: _____ |
| 3)_____ | Dose: _____ | 8)_____ | Dose: _____ |
| 4)_____ | Dose: _____ | 9)_____ | Dose: _____ |
| 5)_____ | Dose: _____ | 10)_____ | Dose: _____ |

## PLEASE MARK ALL ALLERGIES THAT APPLY AND LIST YOUR REACTION:

| | | |
|---|---|---|
| ❑ Cortisone _____ | ❑ Aspirin _____ | ❑ Shellfish _____ |
| ❑ Sulfa _____ | ❑ Latex _____ | ❑ Nickel/Metal _____ |
| ❑ Adhesive Tape _____ | ❑ Codeine _____ | ❑ NSAIDS _____ |
| ❑ Local Anesthetic _____ | ❑ Penicillin _____ | ❑ No Known Allergies |
| ❑ Other: _____ | | |

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# Narcotics Policy

**Our office policy on the use and prescription of narcotics is as follows:**

No new narcotic or refill narcotic prescriptions will be issued after 5:00PM Monday through Thursday, after 12:00PM on Friday, or on weekends- **no exceptions**. If you feel that you are going to run out of your prescription, please call us at least one business day prior to needing the refill so your physician may review the request before you run out. Prescriptions will not be filled if you have not been seen within 1 month. Narcotic prescriptions may not be called in to your pharmacy. A physical prescription is needed.

**Office Visits**:

✳ No narcotics will be prescribed for chronic pain. However, narcotics may be prescribed for acute injuries when they are less than one week old. The narcotic prescription will not exceed 5 days of treatment.

✳ If you are under the supervision of a pain management physician, we expect you to disclose this information to us on your first visit. Failure to do so would be fraud and would violate your contract with your pain management physician. Further, if you have been receiving narcotics from your primary care physician or any other physician, we expect you to disclose this information.

**Post-Operative:**

✳ Narcotics will only be prescribed for period of two weeks after a surgical procedure. Under extreme circumstances, a patient may receive narcotic medications for up to three months post-surgery. If the pain continues after this time, a pain management consult will be issued. There are occasional exceptions to this rule, but your physician may need to see you to reevaluate your condition prior to renewing your prescription.

✳ If you are on chronic narcotics from a pain management physician, you will need to receive your post-operative pain medicine from that physician, unless pre-arranged with us *prior* to your surgery.

**As part of keeping our patients informed, we want to make you aware of the reasons we limit the use of narcotics.**

✳ Severe postoperative/post injury pain that would require narcotics will usually reduce significantly by 2-3 days after surgery or injury and is usually gone by 10-14 days. Postoperative needs for narcotics longer than this period may signal complications that potentially require a more direct or specific treatment plan instead of covering up the problem. Often, a need for narcotics longer term indicates the patient may be overdoing things and compensating with narcotics. Although you may desire to be active, it is possible to be too active. It is important to listen to your body and respond to the cues it gives. A quicker recovery is more likely with reduced activities so that pain is controllable without narcotics. The goal is to make the best recovery from surgery or injury as possible.

✳ After 3-7 days, your brain wants to, and is supposed to manage the pain naturally. This is the best way to manage medium and long-term soreness and mild pain. Narcotics are known to block these normal processes, inhibiting the body's own pain control. Narcotics are proven to be habit forming. Dependency on pain medication can start in as little as 2 weeks after beginning use. We cannot tolerate allowing this to happen.

The South Carolina Podiatric Medical Association and the Drug Enforcement Administration track physicians and their prescribing of narcotics. Podiatric surgeons are not expected to prescribe narcotics for long-term use. We agree with this policy set forth by our state. Therefore, if you are receiving narcotics from your previous physician or primary care physician, you will need to continue to see them for prescriptions.

We do not deny that you may often have pain. However, it is necessary to be aware of your body's own ability to tolerate pain and the need to rely on this process in a timely manner. We have created this policy to assist in assuring that our patients receive the best possible care and appreciate your assistance in enforcing it.

If you have any questions regarding our office policy on the use of narcotics, feel free to contact us so we can discuss it further. If you feel you need assistance with long-term (chronic) pain control, we will be happy to guide you to a pain management specialist.

**By signing the line below, I acknowledge that I have read, understand, and agree to the above policy.**

_____

**Print Name** **Signature** **Date**

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# HIPAA FORM

## Consent to Leave Message and Discuss Medical Records

**Please read this form carefully prior to signing**

**Patient Name:** _____ Record Number: _____

I wish to be contacted at the following number(s) regarding my care and follow-up, including appointment reminders. The best telephone number(s) to reach me are:

❑ Cell Phone (_____) _____ ❑ Home Phone (_____) _____

**PLEASE CHECK BELOW THE BOXES BELOW THAT BEST APPLY TO YOU**

❑ I give my permission to leave relevant medical information on my answering machine or voicemail.

**OR** ❑ I do not give my permission to leave relevant medical information on my answering machine or voicemail.

❑ There is no one other than myself that may receive or discuss my medical information with.

**OR** ❑ Other than myself, I would like to list the following individuals on my HIPAA release, allowing them to receive and discuss my pertinent medical information:

_____

_____

**PATIENT SIGNATURE: _____ DATE: _____**

## OFFICE POLICIES AND PROCEDURES

- Payment is due when services are rendered. Payment due is based upon individual insurance benefits. If you carry a balance higher than $100 you may be asked to pay towards that balance prior to making future appointments.
- *New **self-pay*** patients are asked for a $75 *non-refundable* payment at the time of scheduling their first appointment. This $75 goes towards the full payment due on the day of your first appointment. You may reschedule your appointment *within 24 hours of scheduling* in order to retain your $75 deposit, however any cancellations will result in the loss of your down payment.
- Trimming of corns and calluses is considered a routine procedure by *most* insurance companies (with the exception of Medicare). You will be required to pay for this service as an out-of-pocket expense. Medicare will only allow these services every 61 days.
- Kindly give us **24-hour notice** if you need to cancel an appointment. Appointments ***not*** cancelled within the 24 hours and/or appointments broken without notification ***will be charged a $35 fee.***
  ***Cancelled or broken surgical appointments will be charged a $50 fee.***
- Prescriptions called in or picked up will have a charge of $10 per prescription. Please ask for any prescriptions you may need during your office visit to avoid this charge.
- There will be a $250 charge for any letters provided by physicians.
- There will be a charge of $10 minimum to fill out **Disability/FMLA** forms. This amount is subject to change. Payment is due before the completed paperwork can be faxed.
- There will be a minimum $25 charge for providing **medical records** in any format. The charge will increase accordingly for lengthier/involved charts. This charge also applies for requests from a patient's attorney. The charge will be applied to your account once the records have been prepared, even if you fail to pick them up.
- **Please silence your cell phone while in the treatment room.**

**By signing the line below, I acknowledge that I have read, understand, and agree to following the above policies.**

_____

**PATIENT SIGNATURE** **DATE**