Foot Care Solutions, LLC
3184 West Broad Street, Suite C
Columbus, OH 43204
Phone: 614-274-7448 Fax: 614-274-4498

Welcome,

Thank you for choosing Foot Care Solutions. As a new patient we would like to insure that your first visit will be as beneficial as possible and all of your questions and concerns are addressed. In an effort to provide the best care to all of our patients in an efficient manor we ask that you **complete the enclosed/attached forms, prior to your visit, and bring them with you.**

In an effort to protect your identity and to provide the best care**, please present the following upon arrival**: (Without this information you may be asked to reschedule your appointment.)

1. **Government Issued Photo ID** (Drivers License, Passport, or State Issued ID).
2. **Health Insurance Card(s)**
3. **Co-Pay** (if required by you insurance). We accept Cash, Check, Visa, Mastercard, Discover and American Express.
4. Any pertinent testing/records completed prior to your visit (lab work, X-rays, CT Scans, MRI, films and reports)

Should you need to cancel your appointment we ask that you contact our office at least 24 hours in advance.

We are located at 3184 West Broad Street, in Suite C. We are in the Athens Professional Building, a brown brick building, on the North side of the street. Parking is available on the East side of the building.

If you have any questions, please feel free to contact our office at 614-274-7448.

We appreciate you business.

Sincerely,

Foot Care Solutions, LLC

Foot Care Solutions Patient Registration

PATIENT INFORMATION: **TODAY'S DATE: _____**
Full Legal Name: _____ DOB: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
May we leave a message on your voicemail/answering machine? _____
SS#: _____ Sex: _____ Marital Status: _____

Responsible Party/Guardian Information: (if other than patient)
Name: _____ Relation: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency Contact Information:
Name: _____ Relation: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

Referring Physician: _____
Address: _____
Office Phone: _____ Office Fax: _____

Primary Care Physician: _____
Address: _____
Office Phone: _____ Office Fax: _____

INSURANCE INFORMATION:
Primary Insurance Carrier: _____ Phone: _____
ID#: _____ Group#: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Name of Insured: _____ Relation: _____
SS# of Insured: _____ DOB of Insured: _____

Secondary Insurance Carrier: _____ Phone: _____
ID#: _____ Group#: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Name of Insured: _____ Relation: _____
SS# of Insured: _____ DOB of Insured: _____

It is the your responsibility to verify our participation with your insurance plan prior to your visit. For those patients required to pay a co-pay, payment is required at the time of the visit. We accept payments in the form of cash, check, and/or credit card. In the event that your check is returned to us unpaid you will be charged a $30 returned check fee.

I attest that the above information is correct and I understand that I am responsible for any charges not covered by my insurance plan including any applicable co-pays, deductibles, and co-insurance.

Patient/Responsible Party Signature: _____ Date: _____

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Consent to Treatment:

I consent to allow the Physicians and employees of Foot Care Solutions, LLC to perform examination and provide treatment of myself or my dependent as may be deemed necessary in the care of various diagnoses and conditions affecting the lower extremities.

Patient/Responsible Party Signature: _____
Date: _____

Assignment of Benefits:

I, the undersigned, certify that I (or my dependent) have insurance coverage as indicated and assign all medical benefits payable to Foot Care Solutions, LLC. I further authorize the practice to release to my insurance carrier(s) any and all information necessary to secure payment of benefits to cover the medical services provided.

I understand that I am personally financially responsible for any services provided and not covered by my insurance carrier, as well as any applicable co-pays, deductibles, and co-insurance.

Patient/Responsible Party Signature: _____
Date: _____

Medicare Recipients:

I request that payment of authorized Medicare services be made to Foot Care Solutions, LLC. I authorize release to the Health Care Financing Administration and its agents any medical information required to determine benefits payable for services rendered. I understand that I am personally responsible for any balances not covered under this plan.

Patient/Responsible Party Signature: _____
Date: _____

Foot Care Solutions Patient Medical Questionnaire

Patient Name: _____ DOB: _____

What is the primary complaint for which you are seeking treatment today?
_____
_____

Past Medical History: Please check any present or past medical problems listed below.

Diabetes	___	Heart Disease	___	Lung Disease	___
Poor Circulation	___	Kidney Disease	___	Depression/Anxiety	___
Neuropathy	___	High Cholesterol	___	Gout	___
Multiple Sclerosis	___	Liver Disease	___	Ulcers	___
Bleeding Disorder	___	Thyroid Problems	___	AIDS/HIV	___
High Blood Pressure	___	Cancer	___	Tuberculosis	___
Stroke	___	Arthritis	___	Blood Clots	___

Any other medical problems? _____
_____
_____

Surgical History: Please list procedures and dates.
_____
_____
_____

Medications:
_____
_____
_____
_____
_____
_____
_____
_____
_____

Allergies: Please list allergy and reaction.
_____
_____

Social History:
Tobacco: Yes ___ No ___ Alcohol: Yes ___ No ___ Substance Abuse: Yes ___ No ___

By signing below, I attest that the information above is complete, accurate, and answered to the best of my knowledge.

Patient/Responsible Party Signature: _____ Date: _____

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Authorization for Release of Medical Records

Patient Name: _____ DOB: _____

Street Address: _____
City: _____ State: _____ Zip: _____

I hereby authorize Foot Care Solutions, LLC to (circle one) **obtain records from/release records to**:

Name: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

This authorization applies to:

___ All healthcare information
___ Only healthcare information relating to the following conditions, treatments, or specified dates: _____
_____

I release Foot Care Solutions, LLC from any liability for breach of confidentiality, misdirection of transmission, or failure to receive transmission if my records are transmitted by fax.

I understand these records may contain information from other healthcare providers as well as information that may be administrative in nature. I specifically consent to the release of any information contained in the medical record which may relate to HIV, AIDS or related conditions.

I release Foot Care Solutions, LLC from all liability which may arise from compliance with this request to release medical records.

I understand that this is an optional form and that my refusal to sign will not affect my ability to obtain treatment and that I am entitled to a photocopy of this form upon request. This release is effective for one year from the date of execution; however, it may be revoked by me at any time by providing written notice to the above named party. A facsimile or photocopy of this document will be accepted in lieu of the original.

Patient/Responsible Party Signature: _____ Date: _____
Witness to Signature: _____ Date: _____

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Receipt of Privacy Notice

Patient Name: _____ DOB: _____

My signature on this form acknowledges that I have read a copy of this practice's privacy notice. I have also received a copy of the Privacy Notice if I requested it. I understand that this document provides an explanation of the ways in which my health information may be utilized or disclosed by this practice and of my rights with respect to the information.

I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.

Patient/Responsible Party Signature: _____ Date: _____

I permit this practice to provide my personal health information to the person(s) listed below:
_____
_____
_____
_____