Premiere Pointe Podiatry, PLLC
Angelica Saulabiu, DPM

Medical History

Patient Name: _____ Age: _____ Date of Birth: _____
Height: _____ Weight: _____ Shoe Size: _____
Email: _____
Cell #_____ Home #_____ Work# _____
Home Address:_____ City_____ State_____ Zip Code_____
Notify in case of Emergency_____ Phone# _____

Is this a work-related injury? _____Yes _____No Car Accident? _____Yes _____No
Current Foot or Ankle problem: _____
_____
When did the problem start? _____
What has been done to treat the problem? _____

Primary Physician (first and last name): _____Phone #_____
Date last seen: _____

Other Physician: _____

ALLERGIES and DRUG REACTIONS. (penicillin, novocain, tape, foods, etc.)
1)_____3) _____
2)_____4) _____

MEDICATIONS. (List all medications with dosages)
1)_____5) _____
2)_____6) _____
3)_____7) _____
4)_____8) _____

MEDICAL HISTORY-Please check positive responses to your personal medical history. Examples in ( )

- ☐ Accident/Injuries
- ☐ Arthritis (RA,OA)
- ☐ Blood (sickle cell/anemia)
- ☐ Cancer
- ☐ Diabetes
- ☐ Digestive (reflux, Crohns, etc.)
- ☐ Ears/Nose/Throat
- ☐ Eyes (glaucoma)
- ☐ Gout
- ☐ Heart Disease/Attack/Pacemaker
- ☐ High Blood Pressure
- ☐ Immune Disease (HIV)
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lungs
- ☐ Nerves (neuropathy)
- ☐ OB/GYN
- ☐ Orthopedics (artificial joints)
- ☐ Psych (depression/Alzheimer's)
- ☐ Seizures / Epilepsy
- ☐ Skin (psoriasis,eczema,etc)
- ☐ Stroke
- ☐ Thyroid or other endocrine
- ☐ Vascular / Circulatory
- ☐ Other

Please explain any positive responses above: (ie. hepatitis for liver disease.)
_____
_____
_____
_____

PAST SURGICAL HISTORY (procedure, year and any complications)

1)_____ 5) _____
2)_____ 6) _____
3)_____ 7) _____
4)_____ 8) _____

FAMILY HISTORY (diabetes, heart disease, gout, cancer, foot problems or other):

_____
_____
_____

SOCIAL HISTORY

Occupation: _____ Tobacco: If yes, how much? _____
Alcohol: If yes, how much? _____ Illicit drugs: If yes, how much? _____

IMMUNIZATIONS: Last Tetanus: _____

Whom may we thank for referring you to our office? _____

I hereby give Premiere Pointe Podiatry, PLLC permission to diagnose and administer treatment for my foot or ankle condition and authorize any release of information obtained in the course of my treatment.

Signed: _____ Date: _____

We are dedicated to providing the best possible care and service to you. An essential element of your care and treatment is understanding your financial responsibilities. If you have any questions about the policies, please discuss them with our office manager and/or front office staff.

Health Insurance

We are contracted with most insurance plans to accept assignment of benefits. Our office will file your visit with the insurance company and will only collect your co-pay, deductible, and/or coinsurance when it applies. Please note: Our contract with your insurance carrier requires us to collect your co-pay at each visit.

If you have insurance coverage with a plan that we do not have a prior agreement with, the charge for your care and treatment are due at the time of service. In the event your health plan determines a service to be "non-covered", you will be responsible for the complete charge. Payment is due upon receipt of statement from this office.

Referrals

It is your responsibility to obtain a valid referral from your primary care physician when required by your insurance company.

Disability, Insurance Forms, and Medical Records

There is a $25.00 per form charge to fill out disability and insurance forms. Please mail, email, or leave them at the front desk along with your payment. Forms will not be completed until payment is received. Please allow at least 3-5 working days for processing. We will call you once we have completed your request. There is a $10.00 fee for medical records.

Medication Refills

Refills for medication prescribed by your doctor should be obtained by calling your pharmacy to request the refill. Please do not call the office, as this will only result in additional phone calls for you. Refills are not approved after normal business hours, weekends, or holidays, so please call in your refill request in time for the pharmacy to contact our office.

Cancellation Policy

Our office will make every attempt to confirm your scheduled appointment, but it is ultimately your responsibility to cancel or reschedule when necessary. Our office reserves the right to charge a $25.00 fee for failure to inform our office of appointment cancellation 24 hours prior to the appointment.

I have read and understand the office policies, and I agree to be bound by their terms. I also understand and agree that such terms may be amended from time to time by the practice.

_____ _____

Signature Date

_____

Printed Name

Please read and sign this form. This form will help us receive insurance payment for your visit/services and allow us to communicate with insurance companies:

I assign the right to payment for medical benefits directly to Premiere Pointe Podiatry, PLLC in consideration for medical services and supplies provided to me pursuant to my health insurance plan.

In the event that my health insurance plan refuses to pay for medically reasonable and necessary services provided, I also assign all my ERISA* rights to Premiere Pointe Podiatry, PLLC for a full and fair review of any and all denied claims, including any penalties that may be assessed against the insurance company for claims-processing violations. This ERISA assignment is in consideration for the unpaid services provided, in consideration for my insurance plan's reduced fee schedule, and in consideration for the continued willingness of Premiere Pointe Podiatry, PPLC to see patients, including me, on an insurance assignment basis. I understand that if my treating doctor prevails in any payment dispute, I may be liable for any applicable co-payment for contested services.

I consent to release medical information to Premiere Pointe Podiatry, PLLC. I consent to Premiere Pointe Podiatry, PLLC releasing medical information to other health care providers for the purpose of treatment when necessary for my care. I consent to Premiere Pointe Podiatry, PLLC sending all necessary medical information to my insurance plan.

*ERISA is an acronym for the Employee Retirement Income Security Act, which includes federal laws requiring insurance companies to process submitted insurance claims and appealed (denied) insurance claims according to ERISA regulations. The failure to process submitted insurance claims and appealed (denied) insurance claims according to ERISA regulations may result in fines charged to the insurance company in amounts of up to $110 a day for each infraction.

Patient's Printed Name: _____

Patient's Signature: _____

Date: _____

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE SERVICES THAT I RECEIVE. PAYMENT IS EXPECTED AT THE TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. I UNDERSTAND THAT THERE WILL BE A $30.00 NSF FEE FOR ANY RETURNED CHECKS.

SIGNATURE: _____

DATE: _____

FOR PATIENTS WITH INSURANCE COVERAGE, PLEASE READ AND SIGN:

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION AND REQUEST THAT BENEFITS BE PAID DIRECTLY TO PREMIERE POINTE PODIATRY, PLLC FOR SERVICES RENDERED. I UNDERSTAND THAT PREMIERE POINTE PODIATRY, PPLC IS FILING MY CLAIM AS A COURTESY AND THAT THIS DOES NOT RELIEVE ME OF FINANCIAL RESPONSIBILITY OF NON-COVERED SERVICES OR SUPPLIES.

SIGNATURE: _____

DATE: _____

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I ACKNOWLEDGE THAT THE NOTICE PRIVACY PRACTICES WAS AVAILABLE AND THAT I HAVE READ (OR HAD THE OPPORTUNITY TO READ IF I CHOOSE) AND UNDERSTAND THE NOTICE.

_____ _____

PATIENT NAME (PLEASE PRINT) DATE

_____

PARENT OR AUTHORIZED REPRESENTATIVE (IF APPLICABLE)

_____

SIGNATURE