PATIENT INFORMATION
(Please print)

Chart _______
I.V. _______
Update_______
Update_______

Miss
Mrs
Mr

____
Last name First name M.I. Maiden name

____
Address City State Zip

____
Phone number Cell Phone Number

S
M
D

____
Age Birth date S.S. No. Marital status

____
Email Address

____
Employer Occupation

____
Work phone Ext.

____
Name of spouse Address if different from yours

____
Who is responsible for your bills? Relationship

____
Employer of responsible person if other than yourself

____
Work phone Ext

____
Person to contact in an emergency Phone

____
Who may we thank for referring you to us?

____
Name of nearest relative/friend not living with you Phone

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INSURANCE INFORMATION

Please give the receptionist your insurance card (s) so that they may be copied.

If you are not the subscriber of the insurance card that you are submitting, it is necessary for you to provide the name and birth date of the subscriber.

Subscriber's Name____Birth date________________

ACCIDENT INFORMATION
(if applicable)

____
Where did the accident occur? Work? Home? Auto? Other?

____
Date of accident Time?

____
Who did you report it to? Date reported?

____
Employer (if work related) Phone

____
Employer address

____
Name and address of employer's insurance

WELCOME

Please answer the following questions as completely as possible. We will be happy to assist you if necessary. Thank you.

Have you ever been treated for any of the following conditions? Please check:

Cardiac: High blood pressure___ Angina/Chest Pain___
Rheumatic fever___ MitralValve Prolapse (MVP)___
Myocardial infarction (heart attack)___

Pulmonary: Shortness of breath___ Emphysema___ Asthma____

Kidney : Urinary tract infection ___ Venereal disease___
Blood in the urine___ Kidney stones___

Pulmonary: Hepatitis___ Cirrhosis ___ Jaundice ____ Gall Bladder___

Vascular: Pulmonary emboli (DVT)___ Phlebitis___
Varicose veins___ Cramping: Rt___ Lt___

GI: Ulcers___ Bloody stool___ Colitis____

Endocrine: Diabetes____ Thyroid_____

Other: Gout___ Stroke___ Epilepsy__
Anemia___ Arthritis___

Bone fractures ___ Cancer___(What Type)_______________

Any medical problems with :

Mother: Hypertension___ Heart Attack___ Cancer___ Diabetes_____
Father: Hypertension___ Heart Attack___ Cancer___ Diabetes_____
Siblings: Hypertension___ Heart Attack___ Cancer___ Diabetes_____

What is your alcohol consumption? ___________ Do you use drugs socially?_________
Do you smoke? _____ Quantity______

Any history of TB?
____

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Any surgeries? _______Please identify____

Any complications?____

Are you allergic or have you ever had any reactions to any medications? Please check:

Penicillin___ Sulfa___ Aspirin___ Iodine___ Tape___
Local anesthesia___ Any other? ____________________No drug allergies_____

Primary Physician ___________________________Phone____________________________

Address: __________________________________Date last seen______________________

Pharmacy:_________________________________Phone: _____________________________

Pharmacy Address: ____

Describe your present foot complaint: ____

____

How long have you had this condition? ____

I give my permission to Dr. Thomas A. Hassenfratz/Dr. Jay T. Hassenfratz to administer treatment and to perform such minor operative procedures deemed necessary in the diagnosis/treatment of my foot condition.

I also authorize payment of any such services to be made payable directly to Dr. Hassenfratz. I also understand and agree that regardless of my insurance status I am ultimately responsible for the balance of my account for any professional services rendered. In addition should my account go into default, I will be responsible for any additional attorney or court fees that may be incurred.

I have read all of the information on both sides of this sheet. I have completed the above answers and certify that this information is true and correct to the best of my knowledge. I approve to use of e-mail correspondence, if initiated by me. I will notify you of any changes in my health status or in any of the above information.

Date________Signature____

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MEDICATION HISTORY RECORD

Name **Birthdate** **Chart No.**

Allergies **Medical Alert**

List all medications that you are currently taking, including vitamins and over-the-counter medications.

Date **Medication** **Dosage** **Frequency** **Reason for taking**

Ordered by:

Date **Medication** **Dosage** **Frequency** **Reason for taking**

Ordered by:

Date

Medication **Dosage** **Frequency** **Reason for taking**

Ordered by:

Date **Medication** **Dosage** **Frequency** **Reason for taking**

Ordered by:

Date **Medication** **Dosage** **Frequency** **Reason for taking**

Ordered by:

Date **Medication** **Dosage** **Frequency** **Reason for taking**

Ordered by:

Date **Medication** **Dosage** **Frequency** **Reason for taking**

Ordered by:

Date	Medication	Dosage	Frequency	Reason for taking

Ordered by:

Please use the reverse side if additional space is required. Thank you.

FINANCIAL POLICY

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask any questions that you may have so that you understand your responsibility.

All patients must complete our "Patient Information" form before seeing the doctor.

...If you have no insurance

You will be expected to pay for all charges incurred on the date of service unless a payment arrangement has been made in advance.

...If you have insurance

Please sign the **Insurance Authorization and Assignment** on the reverse side.

Charges for services rendered will be billed to your primary insurance only(except if you have Medicare; then we will bill your secondary insurance as well). If you have more than one insurance, you must submit charges directly to that insurance.

Patients enrolled in an HMO such as Univera or Community Blue are obliged to pay their co-payment at each visit.

Subscribers to other insurances will be expected to pay at least 20% of any covered services incurred for each visit on the day of service.

Full payment is requested for non-covered items.

We will, of course, help you to receive maximum benefits when we submit your insurance claim. You must realize, however, that your insurance is a contract between you, and/or your employer, and the insurance company. We cannot become involved in disputes relating to your deductibles, co-payments, covered charges, secondary insurance, etc. If your insurance company has not paid the full balance within 45 days, you have 15

days to pay the balance. Late payment charges are added to unpaid accounts after 60 days from the date of service. If your insurance company pays more than the balance due, a refund will be issued.

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...Unaccompanied minors

The payment of services rendered to unaccompanied minors are the responsibility of their parents or guardians.

...Patient statements

Patient statements will be mailed monthly. Timely payments on account are necessary to avoid being placed in collection. Payments can be made with cash, check, or credit card. Balances older than 30 days may be subject to additional interest charges of 1 1/2% per month. The fee for returned checks is $25. Charges may also be made for broken appointments and appointments canceled without 24 hour advance notice.

Please remember that it is your responsibility to pay your bill in full when you are billed. We realize that there may be extraordinary circumstances which make it impossible to do so. If you are experiencing such difficulties we may be able to make special arrangements in your case but only if you call the office for assistance.

...Thank you for understanding our financial policy. Please let us know if you have any concerns. We are here to assist you in any way possible.

I certify that I have read the information on both sides of this sheet.

Date______________Signature____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Dr. Thomas A. Hassenfratz or Dr. Jay T. Hassenfratz to furnish information to insurance carriers concerning my illness and treatments, and I do hereby assign to the physician(s) all payments for medical service rendered to me or my dependents. I understand that I am responsible for any amount not covered by insurance.

Date______________Signature____

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ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I Acknowledge that I was provided a copy of the Notice of Privacy Practices and that I read (or had the opportunity to read if I so chose) and understood the Notice.

____ __________________
Patient Name (please print) Date

____
Parent or Authorized Representative (if applicable)

____
Signature