WELCOME

PATIENT INFORMATION

Date _____

Social Security # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____ Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____ SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

PHONE NUMBERS

Home Phone (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to _____
Name of

_____ for any services furnished to me by that provider.
Doctor or Clinic

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____
Signature of Beneficiary, Guardian or Personal Representative

_____
Please print name of Beneficiary, Guardian or Personal Representative

_____ _____
Date Relationship to Beneficiary

PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints.)

_____

_____

_____

Have you ever been to a Podiatrist before? ☐ Yes ☐ No

If yes, please list.

Name _____

Last visit _____

Is there any personal or family history of diabetes? ☐ Yes ☐ No

Your occupation _____

Cigarette/Tobacco use _____

Years smoked _____

Athletic activities in which you participate (please list and indicate frequency)

_____

_____

_____

Please indicate which foot problems you now have or have had in the past.

Ankle Pain	☐ Yes	☐ No
Athlete's Foot	☐ Yes	☐ No
Bunions	☐ Yes	☐ No
Corns and Calluses	☐ Yes	☐ No
Cramps or Numbness in Feet or Legs	☐ Yes	☐ No
Flat Feet	☐ Yes	☐ No
Foot or Leg Cramps	☐ Yes	☐ No
Heel Pain	☐ Yes	☐ No
Ingrown Toenails	☐ Yes	☐ No
Plantar Warts	☐ Yes	☐ No
Swelling in Ankles or Feet	☐ Yes	☐ No
Tired Feet	☐ Yes	☐ No

MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Rash	☐ Yes	☐ No
Allergies to Anesthetics	☐ Yes	☐ No	Eye Problems	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Allergies to Medicine or Drugs	☐ Yes	☐ No	Fainting	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Foot or Leg Cramps	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Sinus Problems	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Artificial Heart Valves or Joints	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Swelling in Ankles, Feet	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hepatitis or Jaundice	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Tired Feet	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Varicose Veins	☐ Yes	☐ No
Chronic Diarrhea	☐ Yes	☐ No	Neuropathy	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Phlebitis	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No			
Ear Problems	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No			

Surgeries you have had _____

_____

_____

Hospitalization other than for the surgeries listed _____

_____

_____

Family physician _____ Last visit date _____

Are you now, or have you been, under any other doctor's care for any reason over the past two years? ☐ Yes ☐ No

If yes, please explain _____

_____

_____

MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins _____

_____

_____

Pharmacy Name(s) _____

Pharmacy Phone(s) (_____) _____

Do you take oral contraceptives? ☐ Yes ☐ No

ALLERGIES

☐ Adhesive/Tape	☐ Local Anesthetics
☐ Anticoagulant Therapy	☐ Novocaine
☐ Aspirin	☐ Penicillin
☐ Codeine	☐ Seafoods
☐ Demerol	☐ Sulfa
☐ Iodine	

Other _____

TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

PAD Patient Intake Decision Tree

Answers to the following questions will help determine if you are at risk for Peripheral Arterial Disease (PAD) and if a vascular examination can help better assess your vascular health status.

1	Do you experience any pain in your legs or feet while at rest?	Yes No
2	Do you have uncomfortable aching, fatigue, tingling, cramping or pain in your feet, calves, buttocks, hip or thigh during walking/exercise?	Yes No
3	If yes to Question 2, does the pain go away when you stop walking/ exercising?	Yes No
4	Do your feet get pale, discolored or bluish at any time during the day?	Yes No
5	Do you have an infection, skin wound or ulcer on your leg or foot that is slow to heal over the past 8-12 weeks?	Yes No
6	Are you over the age of 65	Yes No

1 Yes

ABI

7	Are you over the age of 50	Yes No
8	Do you have high cholesterol or other blood lipid (fat) problems or require cholesterol medication?	Yes No
9	Do you have high blood pressure or take medication to reduce blood pressure?	Yes No
10	Do you have diabetes?	Yes No
11	Do you have a history of chronic kidney disease?	Yes No
12	Do you currently or have you ever smoked?	Yes No
13	Do you have a history of stroke or mini-stroke (TIA)?	Yes No
14	Do you have a history of heart disease (heart attack, MI)?	Yes No
15	Do you have a history of carotid stenosis, AA (abdominal aortic aneurysm), and/ or stent placement?	Yes No

2 Yes

ABI

Greenville Foot Care, LLC

Financial Agreement and Non-covered services policy

Patient/Guarantor's Name:

- As my patient, I want to provide you the best care possible. Please remember that insurance is considered a method of reimbursing the PATIENT for the fee paid to the doctor and is NOT a substitute for payment. Some companies pay fixed allowances for certain procedures, and others only pay a percentage of the charge. Some medical devices and testing procedures are not always reimbursed. We will do our best to inform you ahead of time if a procedure is not covered. However, do to updates with insurance policies that may not always be possible as a previously covered procedure may not be covered now. We will bill your insurance company for you as a courtesy. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance. Any known non-covered charges are due in full at the time of service. _____**(initial)**
- **MISSED APPOINTMENTS AND APPOINTMENTS NO CANCELLED/MOVED/CHANGED 24 HOURS PRIOR TO THE SCHEDULED TIME WILL RESULT IN A $50.00 FEE.** We do try to give our patients reminder calls as a courtesy. However, these courtesy calls are NOT to be relied on as the only source to remember an appointment. It is the patient's responsibility to make/cancel their appointments in a timely fashion. Of course, extenuating circumstances may make this impossible, and if so, know that it is at the discretion of Brian Kille D.P.M or La'Shonda Moore D.P.M to assess or not assess this fee. _____**(initial)**
- **MISSED SURGERIES AND SURGERIES NOT CANCELLED/MOVED/CHANGED 48 HOURS PRIOR TO THE SCHEDULED TIME WILL RESULT IN A $250.00 FEE.** _____**(initial)**
- **If two or more appointments are missed without proper notice, it is within the rights of this office to refuse further services and terminate you from the practice.** _____**(initial)**
- You must notify our office of the following: name change, address change, phone number change, and/or change in insurance. If you fail to notify this office, please note that you will still be held financially responsible for all fees incurred. _____**(initial)**
- I understand and agree to the terms outlined in the aforementioned articles. I agree to pay all professional fees for services rendered. I understand that all fees are payable upon receipt of services. I agree to be responsible for all fees as well as any interest, attorney fees, collection fees and costs, and all other costs associated with the collection of fees. I waive all rights and exemptions under the laws of the State of Alabama concerning collection of fees. _____**(initial)**

_____ _____

Signature Date

_____ _____

Printed Name Relationship to patient

GREENVILLE FOOT CARE, LLC

BRIAN KILLE, DPM
6916 WINTON BLOUNT BLVD.
MONTGOMERY, AL 36117
(334) 265-7585

LA'SHONDA MOORE, DPM
220 FT. DALE ST
GREENVILLE, AL 36037
(334) 382-1400

NOTICE OF PRIVACY PRACTICES SUMMARY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE PLEASE CONTACT OUR PRIVACY OFFICER.

THIS SUMMARY OF OUR NOTICE OF PRIVACY PRACTICE WHICH DESCRIBES HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS AND FOR OTHER PURPOSES THAT ARE PERMITTED OR REQUIRED BY LAW. IT ALSO DESCRIBES YOUR RIGHTS TO ACCESS AND CONTROL YOUR PROTECTED HEALTH INFORMATION AND TO PROVIDE YOU WITH A NOTICE OF OUR LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT TO PROTECTED HEALTH INFORMATION.

WE ARE REQUIRED TO ABIDE BY THE TERMS OF THE NOTICE OF PRIVACY PRACTICES. WE MAY CHANGE THE TERMS OF OUR NOTICE AT ANY TIME, AND RESERVE THE RIGHT TO DO SO. THE NEW NOTICE WILL BE EFFECTIVE FOR ALL PROTECTED HEALTH INFORMATION THAT WE MAINTAIN AT THAT TIME. WE WILL USE YOUR PROTECTED HEALTH INFORMATION AS PART OF RENDERING PATIENT CARE, INCLUDING TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS.

OTHER USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION WILL BE MADE ONLY WITH YOUR WRITTEN AUTHORIZATION, UNLESS OTHERWISE PERMITTED OR REQUIRED BY LAW. YOU MAY REVOKE THIS AUTHORIZATION AT ANY TIME, IN WRITING, EXCEPT TO THE EXTENT THAT YOUR PHYSICIAN'S PRACTICE HAS TAKEN AN ACTION IN RELIANCE ON THE USE OR DISCLOSURE INDICATED IN THE AUTHORIZATION. WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION IN CERTAIN SITUATIONS WITHOUT YOUR AUTHORIZATION OR OPPORTUNITY TO AGREE OR OBJECT.

YOU HAVE THE RIGHT TO REQUEST A RESTRICTION OF YOUR PROTECTED HEALTH INFORMATION. YOU HAVE THE RIGHT TO RECEIVE AN ACCOUNTING OF CERTAIN DISCLOSURES WE HAVE MADE IF ANY, OF YOUR PROTECTED HEALTH INFORMATION. YOU HAVE THE RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE FROM US.

YOU MAY COMPLAIN TO US OR THE SECRETARY OF HEALTH AND HUMAN SERVICES IF YOU BELIEVE YOUR PRIVACY RIGHTS HAVE BEEN VIOLATED BY US. YOU MAY FILE A COMPLAINT WITH US BY NOTIFYING OUR PRIVACY CONTACT OF YOUR COMPLAINT. WE WILL NOT RETALIATE AGAINST YOU FOR FILING A COMPLAINT.

PATIENT SIGNATURE _____ DATE _____

WITNESS _____ DATE _____

Greenville Foot Care, LLC

Patient Questionnaire

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and diagnosis:

   _____

   _____

2. Please list family members or any other persons, if any, whom we may inform about your medical condition ONLY IN AN EMERGENGY:

   _____

   _____

3. Please check off the number you prefer we contact you on regarding appointments, labs, x-rays or other health care information: _____Home _____Cell _____Work _____Other (please list number) _____

4. Can confidential messages be left on voicemail at the number checked above.

   _____yes _____no

Patient Name (please print):_____

Patient Signature:_____

Date:_____