Philly City Foot Doc

29 Bala Avenue, Suite 114
Bala Cynwyd, PA 19004
1311 South Street
Philadelphia, PA 19147

Email: info@phillycityfootdoc.com
Website: www.phillycityfootdoc.com

Telephone: (215) 471-0433
Fax: (215) 471-0430

Patient Information

Name:

_____
Last First Middle

Address:

_____
Street City State Zip

Home#: _____ **Mobile#:** _____

Preferred Contact Phone: □ **Home** □ **Mobile** **Email:** _____

Age: _____ **DOB:** _____/_____/_____ **SS#:** _____-_____-_____ **Sex:** □M □F **Gender:** _____

Primary Physician: _____ **Phone#:** _____

Last Visit: _____ **Under hospice care?** □ Yes □ No **Living Alone?** □Yes □No

Pharmacy: _____ **Phone:** _____ **Fax:** _____

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated **Occupation:** _____

Race: (can check multiple) □ American Indian or Alaska Native □ Asian □ Black or African-American

□ Native Hawaiian or other Pacific Islander □ White □ Unknown □ Other _____

Ethnicity: Hispanic, Latino or Spanish Origin □ Yes _____ □ No

Do you need an interpreter? □ Yes **- Preferred Language:** _____ □ No

Is this related to: Auto Accident □ Yes □ No **Other Accident** □ Yes □ No **Work Related Injury** □ Yes □ No

Is a lawyer involved with your care? □ Yes □ No **Is Another Party Responsible?** □ Yes □ No

Emergency Contact:

_____
Name Phone Relationship

If under age 18, guardian's name: _____ **Relation:** _____

How did you hear about us? _____

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PRIMARY INSURANCE:_____ **Member ID#:**_____

SECONDARY INSURANCE: _____**Member ID #:**_____

Subscriber's Name:_____ **DOB of Insured:** ___ /___ /____

Subscriber's Address:

_____

Street City State Zip

Social History:

Use of Alcohol: □ Never □ Occasional □ Moderate □ Heavy How Long? _____

Use of Tobacco: □ Never □ Quit, date_____ □ Currently, Packs a day?_____Years?_____

Chewing Tobacco: □ Never □ Quit, date_____ □ Currently, Packs a day?_____Years? _____

E-Cigarettes/Vaping: □ Never □ Quit, date_____ □ Currently, Quantity a day? _____ Years?_____

Illicit/Recreational Drug Use: □Yes □ No What kind? _____

Currently Pregnant: □Yes □ No Number of Child Births _____

Medical History

Height: _____ Weight: _____ Shoe Size:_____

Past Medical History: (check all that apply) □ NO TO ALL

AIDS/HIV □ Yes □ No
Anemia □ Yes □ No
Arthritis □ Yes □ No
Artificial Joints □ Yes □ No
Asthma □ Yes □ No
Back Pain □ Yes □ No
Bleeding Disorder □ Yes □ No
Blood Clot □ Yes □ No
Cancer □ Yes □ No
Type_____
Coronary Artery Disease □Yes □No
Deep Vein Thrombosis □ Yes □ No
Diabetes □ Yes□ No
Dialysis □ Yes □ No
Dyslipidemia□ Yes □ No
Edema □ Yes □ No
Fibromyalgia □ Yes □ No
Foot Deformity □ Yes □ No
Frost Bite □ Yes□ No
Gout □ Yes □ No
Headaches □ Yes □ No
Heart Disease □ Yes □ No
Hepatitis □ Yes □ No
Hernia □ Yes □ No
Hypertension □ Yes □ No
Kidney Disease □ Yes □ No
Leg or Foot Ulcers □ Yes □ No
Liver Disease □ Yes □ No
Lung Disease □ Yes □ No
Organ Transplant □ Yes □ No
Osteoporosis □ Yes □ No
Pacemaker □ Yes □ No
Peripheral Vascular Disease □ Yes □ No
Polio □ Yes □ No
Pulmonary Embolism □ Yes □ No
Raynaud's Disease □ Yes □ No
Rheumatoid Arthritis □ Yes □ No
Seizures/Epilepsy □ Yes □ No
Stroke □ Yes □ No
Substance Abuse □ Yes □ No
Thyroid Problems □ Yes □ No
Tuberculosis□ Yes □ No
Varicose Veins□ Yes □ No
Other _____
Other _____

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Previous Surgeries/Hospitalizations: (check all that apply) □ No past surgeries

	Year		Year		Year
Knee Replacement □Yes □No	_____	Back Surgery □Yes □No	_____	Tooth Extraction □Yes □No	_____
C-section □Yes □No	_____	Hip Replacement □Yes □No	_____	Hysterectomy □Yes □No	_____
Cataract Removal □Yes □No	_____	Foot surgery □Yes □No	_____	Hernia repair □Yes □No	_____
Appendectomy □Yes □No	_____	Plastic Surgery□Yes □No	_____	Other Surgeries	_____

Family History (list medical history of immediate family)**: If answer yes, please write relation □ History Unknown**

Diabetes □ Yes □ No _____ Osteoporosis □ Yes □ No _____ Anemia □ Yes □ No _____

Alzheimer's/dementia □ Yes □ No_____ Arthritis □ Yes □ No _____Gout □ Yes □ No_____

Asthma □ Yes □ No_____ Heart Disease □ Yes □ No _____ Stroke □ Yes □ No_____

Bleeding Disorder □ Yes □ No_____ Cancer □ Yes □ No_____ Liver Disease □ Yes □ No_____

High Blood Pressure □Yes □No_____ Sickle Cell Anemia □Yes □No _____

Kidney Disease□ Yes □ No_____ Liver Disease □ Yes □ No_____ Stomach Ulcer □ Yes □ No_____

Low Blood Pressure □ Yes □ No _____ Circulatory Problems □ Yes □ No_____

Medications: (please list all current medications and supplements) if you have a list, please provide a copy □ No Current Medications

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Medication/Substance Allergies (circle all that apply): □ No Known Drug Allergies

Adhesive Tape	□Yes □No	Local Anesthetic	□Yes □No	Sulfa	□Yes □No
Penicillin	□Yes □No	Iodine	□Yes □No	Latex	□Yes □No
Seafood	□Yes □No	Codeine	□Yes □No		

Other allergies not listed_____

Have you ever taken a medication that caused a skin rash, facial swelling, or difficulty breathing?
□ Y / □ N

Have you ever taken a medication that caused vomiting, nausea, dizziness, diarrhea, or headache?
□ Y / □ N

Have you ever had trouble with spinal, general, or local anesthesia?
□ Y / □ N

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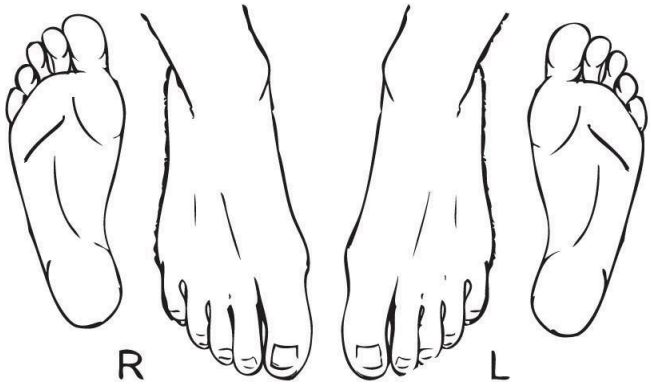
Current Foot problem(s):

_____
_____
_____
_____

PLEASE INDICATE AREA OF CONCERN/ISSUE:

PAIN:
- ☐ DULL ACHE
- ☐ SHOOTING
- ☐ BURNING
- ☐ SHARP
- ☐ THROBBING



PAIN:
- ☐ DULL ACHE
- ☐ SHOOTING
- ☐ BURNING
- ☐ SHARP
- ☐ THROBBING

Where:_____How long?_____□ Days □ Weeks □ Months□ Years

Pain scale (1-10):_____Describe pain: _____

Cause of foot problem: Injury/Deformity/Unknown/Other_____

Aggravated by: □ Walking □ Standing □ Shoes □ Physical Activity

Treatment provided in the past: □PCP □Foot doctor □Chiropractor □ER doctor □Orthopedic Surgeon □Physical Therapist □Dermatologist □Other: _____

Treatment type: □ X-rays □ Taping/Padding □ Injections □ Orthotics □ Wound care □ Foot surgery

Type of foot surgery? _____ □ Medication (what med?): _____

Foot doctors seen in the past and when: _____

Have you ever had (check all that apply):

□ Bunions □ Hammertoes □ Heel spurs □ Corns / Calluses □ Ingrown toenails □ Warts
□ Fungus toenails □ Athlete's Foot □ Flat Feet □ High Arches □ Pinched Nerves

Do you regularly take:

□ Blood Thinners? (e.g. Aspirin, Coumadin, Vitamin E): _____
□ Cortisone or Other Steroids? (What and Dosage?): _____

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PATIENT FINANCIAL POLICY

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED.
Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.
INSURANCE: We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up- to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
MEDICARE: We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. However; that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any copayments, which are usually 20% of the allowed amount for an item or service.
SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company.
COPAYMENTS AND DEDUCTIBLES: All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co- payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
SELF PAY: Payment in full is due at the time of service if you do not have health insurance.
NON-COVERED SERVICES: Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payment of these services.
REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan which mandates that when you visit a specialist such as ours, you must have a referral from your primary care physician prior to seeking specialty care. Therefore, you are financially responsible for the services received, unless your referral is presented at the time of this visit. If you do not have a referral from your primary care physician at the time of a visit, you will be financially responsible for all services received due in full upon completion of the visit. Full credit will be given if a referral is presented to our office within 48 hours of this visit. You will also be given the option to reschedule your appointment.
CLAIM SUBMISSION: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.
PATIENT BILLING: You will be sent up to three notices for your financial responsibility (co-insurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After the third and last notice, your account may be forwarded to collections. Please let the billing office know if you have any difficulties resolving your bill. Payment arrangements can be made on a case by case basis. We accept the following payment methods: Cash, Check or VISA/MasterCard. An additional $35.00 will be added to your statement if the check is returned for insufficient funds. In the event that your insurance company should happen to send payment to you, the patient, we expect that you would forward it to our office to be applied to your balance. A fee may be charged if you fail to cancel your appointment within 24 hours and/or do not show for your appointed time. In addition, all unpaid balances 91 days past due will incur interest of 1.5% per month which will be applied from day 31 from the date of service until the balance is paid in full. All payments are due by the tenth (10^{th}) day of each month. Thank you for your understanding of our Financial Policy.
I have read the above policy regarding my *financial responsibility* to Kimberly Nguyen DPM DBA Philly City Foot Doc for medical services provided. I agree to pay Kimberly Nguyen DPM DBA Philly City Foot Doc any balance unpaid by my insurance carrier for myself or the below named person.

PRIVACY STATEMENT: Any information disclosed in your records will remain confidential and will not be used for any other reason except in providing quality care and treatment as well as to submit your claim to your insurance company and contact you as needed.

PATIENT ACKNOWLEDGE OF NOTICE OF PRIVACY PRACTICES: By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices, and that I have (or had the opportunity to read if I so chose) and understand the Notice and agree to its terms.

Assignment of Benefits
I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to **Kimberly Nguyen DPM PC DBA Philly City Foot Doc** all insurance benefits, payable to me for services

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rendered. I understand that I am responsible for payment of deductibles, co-payments, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information and acknowledge I was provided with a copy of the Notice of Privacy Practices and understand and accept its terms:

PRINT Patient Name:_____ Signature: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(Effective October 12, 2020)

Your health information is confidential and protected by Kimberly Nguyen DPM PC DBA Philly City Foot Doc. We may need to use your protected health information to carry out treatment, payment, healthcare operations and/or other purposes (referrals, continuation of care, etc.). Our Notice of Privacy Practices provides a more complete description of permitted uses and disclosures.

Patient Name: _____ Date of Birth: ___/___/_____
(please print)

Name and relationship of authorized representative (if applicable):

Name: _____ Relationship: _____
(please print)

I acknowledge I was provided a copy of the Notice of Privacy Practice and I have read (or had the opportunity to read) and I understood the Notice.

I understand this practice serves the right to change the terms of the Notice of Privacy Practices and to make changes regarding all protected health information controlled by this practice. If changes to the policy occur, the practice will provide me with a revised Notice of Privacy Practices upon request.

Signature: _____ Date: _____

Office Policy

(Effective October 12, 2020)

1. To keep medical care and billing costs down, payment for services is required in full at the time services are rendered. This includes co-pays, deductibles, non-covered services, co-insurances, and any services/additional fees deemed not payable by your insurance company. We will bill your insurance company for services performed; you will be responsible for the remaining difference. Payment arrangements are available upon request and with prior approval by our office. The following company will process all insurance claims/billing for Kimberly Nguyen DPM PC DBA Philly City Foot Doc:

   Kimberly Nguyen DPM PC DBA Philly City Foot Doc
   1311 South Street
   Philadelphia, PA 19147
   215-471-0433

2. If it is required by your insurance company to have a referral or authorization to see Kimberly Nguyen DPM PC DBA Philly City Foot Doc you must obtain the referral/authorization prior to the visit or you will be financially responsible for the services provided.
3. For a patient under the age of 18, a parent, guardian or legal representative must accompany the patient during each service and will be responsible for all payments incurred.

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4. Copies of your medical record are available upon request in writing. A minimum of two weeks is required to receive copies of your medical records. A $50.00 fee will be associated with the compiling and copying of your file.
5. If it is determined that you did not present the correct insurance identification card at the time of service, you will be responsible for the charges incurred if denied by your insurance company.
6. If your treatment involves other entities such as hospitals, laboratories, rehabilitation facilities, etc., you will be billed separately by said entity.
7. There will be a $35.00 fee for a returned check issued to Kimberly Nguyen DPM PC.
8. A $100 No Show / Cancellation Fee will be applied for the patient that does not reschedule or cancel the appointment with a 24 hour notice.
9. A $50 fee may be assessed for the completion of any disability forms, personal credit life insurance forms, attending physician statements, letters of medical necessity or other miscellaneous forms. Must allow up to 2 weeks for processing.
10. You may be discharged from the practice after 3 no show/no call or 5 consistent cancellations of scheduled appointments.
11. Opioids/narcotics are only prescribed for a short period of time for patients who have conditions of an acute fracture or post-surgery scheduled from this office. If there is a need for more, you will be referred to pain management. If you are currently being treated by a pain management clinic, this will need to be disclosed to our office and you will need to discuss any further pain management with your pain management team

Patient Authorization
I certify that I have insurance with the company(ies) disclosed and assign directly to Kimberly Nguyen DPM PC DBA Philly City Foot Doc all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all charges whether or not they are paid by my insurance. I authorize the use of my signature on all insurance claims.

Insurance Authorization
I request that payment of authorized insurance benefits be made either to me or my behalf to Kimberly Nguyen DPM PC DBA Philly City Foot Doc for all services.

CONSENT TO TREAT

I authorize Kimberly Nguyen DPM PC DBA Philly City Foot Doc to render services to myself at any of the following locations:
1311 South Street; Philadelphia, PA 19147 / 29 Bala Avenue, Suite 114, Bala Cynwyd, PA 19004 / Dialysis Center / Wound Care Center / Nursing Home / Office or Home. My signature signifies that I have read and fully understand this Financial Policy and agree to abide by all its terms.
_____ **Initials**
I, the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to Kimberly Nguyen DPM PC DBA Philly City Foot Doc all medical and surgical benefits, if any, otherwise payable to me for services rendered. I hereby authorize the release of all medical information necessary for the processing of insurance. I understand that I am financially responsible for all charges whether or not paid by insurance. Copies of this agreement are to be considered valid as an original signature. This policy remains in effect unless revoked by me in writing.
_____ **Initials**
I certify that the information on these forms is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures as deemed necessary in the diagnosis and/or treatments of my podiatric ailments.
_____ **Initials**
I permit Kimberly Nguyen DPM PC DBA Philly City Foot Doc to access any medical records via Electronic Systems to aid in my treatment and processing of my insurance claim/billing.

_____ **Initials**

MEDICAL HISTORY ATTESTATION

To the best of my knowledge, my medical history on this form is complete and the questions have been accurately answered. It is my responsibility to inform the doctor's office of any changes in my medical history, including but not limited to allergies, past medical history, medications, etc.

Signature of Patient / Parent or Guardian Date

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PATIENT CONSENT FOR MEDICAL PHOTOGRAPHY

Patient Name:_____ Date: _____

I consent for medical photographs to be made of me or my child (or a person for whom I am legal guardian). I understand that the information may be used in my medical record, for purposes of medical teaching. By consenting to these medical photographs, I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future, I may contact the office via phone call and/or via email at info@phillycityfootdoc.com

By signing this form below, I confirm that this consent form has been explained to me in terms which I understand.

- I consent for these photographs to be used and shown for teaching purposes and to be used for my medical record.

_____(Signature) _____(Witness)

☐ Check here if minor or unable to provide consent

- For patients between ages 7 and 18 years, a signature below indicates that the information in this consent form has been explained to me, and I assent to use of my images as outlined above:

_____ _____
(Signature of Patient) (Witness)

Medical Information Release Form (HIPAA Release Form)

Release of Information: (please check below)

[ ] I authorize the release of information including the diagnosis, records;
Examination rendered to me and claims information. This information may be released to:
[ ] Spouse_____
[ ] Child(ren) _____
[ ] Other_____
[ ] Information is **not** to be released to anyone.
This **Release of Information** will remain in effect until terminated by me in writing.
Please call [ ] my home [ ] my work [ ] my cell number: _____
If unable to reach me:
[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call

Signature: _____ Date: ____/____/_____

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CONSENT TO USE
AND
DISCLOSE PROTECTED HEALTH INFORMATION

Your protected health information will be used by this practice, known as Kimberly Nguyen DPM PC dba Philly City Foot Doc, or disclosed to others for the purposes of treatment, obtaining payments or supporting the day-to-day healthcare operations of this practice.
You may request a restriction on the use or disclosure of your protected health information. If you wish to restrict your disclosure, you should make the request in writing.
This practice, however, may or may not agree to restrict the disclosure of your protected health information.
You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date of your revocation of consent is received and will not be affected.
This practice reserves the right to modify the privacy practices outlines in this notice.
I have reviewed this consent form and have reviewed the Notice of Privacy Practices. I give my permission to this practice to use and disclose my health information in accordance with it.

Patient Signature: _____ Date: _____

Personal Representative: _____ Relationship: _____

CONSENT TO OBTAIN PATIENT MEDICATION HISTORY

The purpose of this consent is for permission to obtain your medication history. Patient medication history is a list of prescription medicines that our providers or other providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribution to the collection of this history. The collected information is stored in the practice electronic medical record system (EHR/EMR) and becomes part of your personal medical record. Medication history is very important in helping healthcare providers treat your symptoms and/or illnesses properly and in avoiding potentially dangerous drug interactions. It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make drug history information available, and your drug history may not include drugs purchased without using your health insurance. Also, over-the-counter drugs, supplements and/or herbal remedies that patients take on their own may not be included. By signing this consent form you are giving your healthcare provider permission to collect and giving your pharmacy and your health insurer permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. I certify that I have read and fully understand the above statements and consent fully and voluntarily to allow Kimberly Nguyen DPM PC dba Philly City Foot Doc and associated entities to obtain my medication history.

Patient Signature: _____ Date: _____

Personal Representative: _____ Relationship: _____