



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

Emergency Contact:

Name Phone Relationship

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

How did you hear about us?

- Family/Friend (Who?):
- Search Engine (Google, Yahoo, Bing):
- Newspaper/Magazine (which?):
- Physician Referral (Dr?):
- Patient (Who?):
- Insurance company:
- Employer/other:
- Our Website:



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

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

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

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



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

Knee Replacement <input type="checkbox"/> Yes <input type="checkbox"/> No _____	Back Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No _____	Tooth Extraction <input type="checkbox"/> Yes <input type="checkbox"/> No _____
C-section <input type="checkbox"/> Yes <input type="checkbox"/> No _____	Hip Replacement <input type="checkbox"/> Yes <input type="checkbox"/> No _____	Hysterectomy <input type="checkbox"/> Yes <input type="checkbox"/> No _____
Cataract Removal <input type="checkbox"/> Yes <input type="checkbox"/> No _____	Foot surgery <input type="checkbox"/> Yes <input type="checkbox"/> No _____	Hernia repair <input type="checkbox"/> Yes <input type="checkbox"/> No _____
Appendectomy <input type="checkbox"/> Yes <input type="checkbox"/> No _____	Plastic Surgery <input type="checkbox"/> Yes <input type="checkbox"/> 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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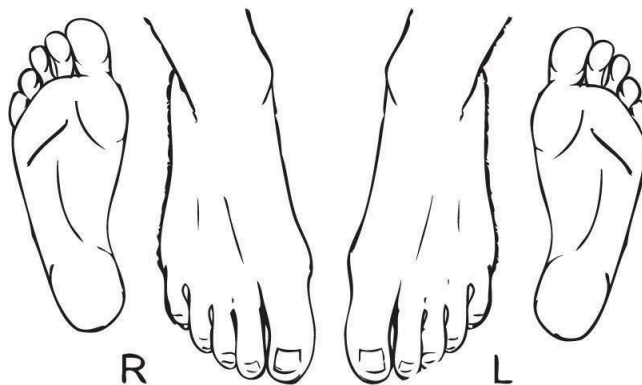
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Current Foot problem(s):

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 (10th) 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

