Creswell Foot & Ankle Surgery

Dr. Joseph A. Creswell DPM

PATIENT INFORMATION PHARMACY:_____TODAYS DATE:_____

FIRST:_____M.I. _____LAST:_____MALE ___ FEMALE_____

DATE OF BIRTH:_____AGE:_____PHONE #:_____

MATIRIAL SATUS: (CIRCLE ONE) N/A SINGLE WIDOWED MARRIED spouse name:_____

ADDRESS:_____CITY:_____STATE:_____ZIPCODE_____

EMPLOYER:_____ OCCUPATION:_____

CITY/STATE/ZIP:_____ EMAIL:_____

PARENT/GUARDIAN/EMERGENCY CONTACT/ P.O. BOX/ ETC:

NAME:_____PHONE:_____D.O.B._____

ADDRESS:_____CITY/STATE/ZIP_____

Responsible Party? (circle one) Yes No Employer:_____Occ:_____

EMAIL:_____Relationship to patient:_____

INSURANCE INFORMATION: (SKIP IF CARD HAS BEEN PROVIDED) *PATIENTS SSN_____(TRICARE)

IS PATIENT COVERED BY INSURANCE? (circle one) YES NO CO-PAY AMOUNT: $_____

PRIMARY INSURANCE:_____ID#:_____GROUP#_____

SECONDARY INSURANCE:_____ID#:_____GROUP#_____

Worker Comp Claim? (circle one) YES NO IF YES, Date of Injury:_____State Injury Occurred:_____

Claim#_____ Adjuster Name_____ P#_____ F#_____

REQUIRED SECTION PLEASE ANSWER EACH REQUEST

MEDICAL INFORMATION:

PRIMARY CARE DOCTOR:_____PHONE:_____

LIST ALL CURRENT MEDICATIONS:

_____

_____

ALLERGIES/SENSITIVITIES? YES NO PLEASE LIST ALLERGY(S) AND REACTION:

_____

REASON FOR BEING SEEN/ FOOT PAIN/ PROBLEMS:_____

HAVE YOU HAD RECENT X-RAYS OF YOUR FEET/ANKLES? YES NO IF yes WHERE?_____

Any recent hospitalizations? YES NO If yes, please note name of hospital and reason for admission:

_____

HOSPITAL PREFERENCE:_____

HEALTH HISTORY, FAMILY HISTORY & MEDICAL CONDITIONS ✔ ALL THAT APPLY

ALCOHOL: Do you drink alcohol? YES ☐ NO ☐ If yes, what kind?_____ How many drinks per week?_____

TOBACCO: Do you use tobacco? YES ☐ NO ☐ cigarettes ☐ Chew ☐ Pipe ☐ Vape ☐ #packs/day:_____

DRUGS: Do you currently use recreational or street drugs?_____ YES ☐ NO ☐ If yes, what?_____

ACTIVITY LEVEL: VERY ACTIVE ☐ MODERATE ☐ SEDENTARY ☐ /TYPES OF ACTIVITY _____

FAMILY HISTORY : CIRCLE ALL THAT APPLY

FOOT ISSUES DIABETES HIGH BLOOD PRESSURE STROKE CANCER VASCULAR DISEASE

YOUR MEDICAL CONDITIONS: ✔ ALL THAT APPLY

HEAD & NECK: Glaucoma ☐ Hearing Loss ☐ Visual Problems ☐ Concussion ☐ Headache ☐

CARDIOVASCULAR: Hypertension ☐ Heart Attack ☐ Coronary Disease ☐ Poor Circulation ☐ High Cholesterol ☐

RESPIRATORY: Asthma ☐ Emphysema ☐ Pneumonia ☐ Breathing Problems ☐ Oxygen required ☐

GASTROINTESTINAL: Reflux ☐ Hepatitis ☐ Colitis ☐ Vomiting ☐ Nausea ☐ Cirrhosis ☐ Ulcers ☐

ENDOCRINE: Diabetes type 1 ☐ Diabetes type 2 ☐ Thyroid Disease ☐ Chronic Fatigue ☐

SKIN: Psoriasis ☐ Dermatitis ☐ Moles ☐ In growing Toenails ☐ Lesions ☐ Open Ulcer/Wound ☐ Cellulitis ☐

MUSCULOSKELETAL: Arthritis ☐ Joint Replacement ☐ Clubfoot ☐ Multiple Sclerosis ☐ Osteomyelitis ☐

MENTAL HEALTH: Depression ☐ Bipolar ☐ Schizophrenia ☐ Alzheimer's ☐ Dementia ☐

HEMATOLOGIC: Hemophilia ☐ HIV ☐ Blood Clots ☐ Gout ☐

ONCOLOGY: Cancer ☐ WHAT TYPE?_____

IMPLANTABLE DEVICES: Pacemaker ☐ IUD ☐ Stent ☐ Other Implant:_____

Height:_____ **Weight:**_____

LIST ANY OTHER MEIDCAL CONDIDITONS:

_____

_____

PROCEDURES/SURGERIES:

PLEASE READ THE FOLLOWING:

WITH MY SIGNATURE ON THIS DOCUMENT, I acknowledge that all the above is true and accurate. I authorize the release of any information to all claims for benefits submitted on my behalf and/or dependents, FOR TODAY & FUTURE VISITS. I understand that I am financially responsible for ALL charges incurred. I understand it is my/patients responsibility to know and understand insurance coverage and I further acknowledge that any insurance benefits will be credited to my account. I acknowledge that I am responsible for my/patients' compliance and understand that it directly affects the outcome of my treatment. Permission is given to Dr. Creswell to render the proposed podiatric examination and treatment.

X_____ DATE:_____

(SIGNATURE OF PATIENT OR GUARDIAN REQUIRED)

PLEASE NOTE: Payments and copays are required at time of service unless current insurance has been provided.

TREATMENT, KNOWLEDGE OF INSURANCE, AUTHORIZATION AND ASSIGNMENT

I understand and acknowledge that I am responsible for my/patients' compliance, that compliance of patient directly effects the outcome of treatment. Permission is given to Dr. Joseph A. Creswell to render the proposed examination and treatment (s). I authorize Joseph A. Creswell, DPM to provide information to my insurance carriers concerning illness, diagnoses, injuries, and treatments. I further assign to Dr. Creswell all insurance payments for medical services rendered to my dependents of myself. I UNDERSTAND THAT IS MY RESPONSIBILITY TO OBTAIN KNOWLEDGE AND UNDERSTANDING OF MY SPECIFIC INSURANCE POLICY AND WHAT AY OR MAY OT BE COVERED DURING EACH VISIT AND TREATMENT. I ALSO UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE. Dr. Creswell's office is not required to know what may or may not be covered or applied to the deductible of the insured/parent/guardian's policy that is the PATIENTS responsibility.

****NOTE******

ONLY TWO (2) STATEMENTS WILL BE SENT FOR A SINGLE DATE OF SERVICE. AFTER WHICH YOUR ACCOUNT WILL BE CHARGED INTEREST WITH EACH STATEMENT PERIOD THEREAFTER. ACCOUNT MAY BE TURNED OVER TO OUR COLLECTIONS AGENCY AFTER 3RD STATEMENT SENT. ALL ACCOUNTS ARE DUE WITHIN 60 DAYS OF SERVICE OR INSURANCE EOB RECEIVED UNLESS WRITTEN SIGNED, ARRANGEMENTS HAVE BEEN MADE CO-PAYS ARE DUE AT THE TIME OF SERVICE. CO-PAYS NOT MADE AT TIME OF SERVICE ARE SUBJECT TO $15 FEE ADDED TO CO-PAY AMOUNT. MINIMUM MONTHLY PAYMENTS OF $50 IS REQUIRED ON BALANCES OF $100.00 OR MORE.

REFERRALS

It is the responsibility of me, the patient or guardian to obtain a current referral from the primary are physician, IF REQUIRED by insurance before services are renered in our office. If I do not have a current referral, I will be fully responsible for payment in full in the event my insurance company denies payment due to no referral.

ASSIGNMENT OF PROCEEDS

I grant and assign Dr. Creswell any & all proceeds form any settlement or court determination related to injuries for which Dr. Creswell has treated me. In consideration for the physician's examination and treatment I agree to all promises set forth above and further agree to pay Dr. Creswell at the time of billing for all services rendered and for all costs and losses caused by any failure by me to pay this commercial transaction in a timely manner I further agree that all information and promises stated above are freely given with the knowledge that I am granting Dr. Creswell substantial rights in the event that I fail to pay for his services in a timely manner.

NO-SHOW/CANCELLATION POLICY

(Please read this policy as provided with paperwork)

My signature acknowledges that I have read the office policy regarding the no-show, rescheduling and cancellation fees. My signature states that I have read and understand the above policies regarding treatment knowledge of insurance, authorization assignment referrals and have been given the opportunity to ask any question regarding these policies.

Patient Name:_____

PARENT/GUARDIAN/POA NAME:_____

SIGNATURE:_____ **DATE:**_____

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MEDICARE SIGNATURE ON FILE

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE ON MY BEHALF TO JOSEPH A. CRESWELL, D.P.M. (THE PROVIDER) FOR ANY SERVICES FURNISHED TO ME BY JOSEPH A. CRESWELL, D.P.M. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO BE RELEASED TO THE HEALTH CARE FINANCING ADMINISTRATION AND IT'S AGENCIES ALONG WITH ANY INFORMATION NEEDED TO DETERMINE BENEFITS PAYABLE TO RELATED SERVICES.

I UNDERSTAND MY SIGNATURE BELOW REQUESTS THAT PAYMENT BE MADE AND AUTHORIZES RELEASE OF MEDICAL INFORMATION NECESSARY TO PAY THE CLAIM. IF "OTHER HEALTH INSURANCE" IS INDICATED IN ITEM 9 OF THE HCFA -1500 CMS FORM OR ELSEWHERE ON OTHER APPROVED CLAIM FORMS OR ELECTRONICALLY SUBMITTED CLAIMS, MY SIGNATURE AUTHORIZES RELEASING OF THE INFORMATION TO THE INSURER OR AGENCY SHOWN. IN MEDICARE ASSIGNED CASES, DR. CRESWELL AGREES TO ACCEPT THE ALLOWED AMOUNT SET BY MEDICARE AS THE FULL ALLOWED AMOUNT AND THE PATIENT IS RESPONSIBLE ONLY FOR THE DEDUCTIBLE, CO-INSURANCE, ITEMS LISTED ON AN ABN AND WHAT MEDICARE DEEMS AS PATIENT RESPONSIBILITY.

MY SIGNATURE TODAY IS VALID FOR TEN YEARS FROM TODAY'S DATE UNLESS I SPECIFY DIFFERENTLY IN WRITING ADDRESSED TO DR. CRESWELL.

_____ _____

PATIENT NAME TODAYS DATE

_____ _____

SIGNATURE OF PATIENT/POA/GUARDIAN PATIENT'S MEDICARE # (IF CARD NOT AVAILABLE)

PROVIDED A COPY OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notices of Privacy Practices of Joseph A. Creswell, DPM and that I have been given the opportunity to read it if I so choose and understand the notices.

_____

PATIENT NAME (PLEASE PRINT)

_____

PARENT/GUARDIAN/POA NAME (PLEASE PRINT)

_____ _____

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE TODAYS DATE

FOR OFFICE USE ONLY

PATIENT NAME:_____ DATE_____ The patient presented for his/her appointment on this and was provided a copy of the practice's privacy notice. A good faith effort was made to obtain a written acknowledgement of the receipt of Privacy Notice. However, an acknowledgement was not obtained because:

( ) Patient refused to sign
( ) patient was unable to sign or initial because_____

_____

_____

Employee completing this form_____