

Practice:

Today's Date:

Name: _____ DOB: _____ Chart Number: _____
 Sex: M F Marital Status: Single Married Widowed Divorced SS#: _____
 E-mail: _____ Spouse/Partner Name: _____
E-mail newsletters, reminders, statements, etc. Emergency Name: _____ Phone: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home #: _____ Cell #: _____ Other #: _____
 Employer: _____ Phone: _____
 Employer Address: _____ City: _____ State: _____ Zip: _____

Primary Insurance: _____ Are you the insured? Yes No
Insured Information
 Subscriber Name: _____ Relationship to insured: Spouse Child Self other
 Phone #: _____ Sex: Male Female DOB: ___/___/___
 Address: _____
 Policy ID: _____ Group ID: _____ Employer: _____
 Secondary Insurance: _____ Are you the insured? Yes No
Insured Information
 Subscriber Name: _____ Relationship to insured: Spouse Child Self Other
 Phone #: _____ Sex: Male Female DOB: ___/___/___
 Address: _____
 Policy ID: _____ Group ID: _____ Employer: _____

How did you find out about our practice? Physician Internet Telephone book Family member Friend
 Other: _____
 What is the reason for your visit today? _____
 _____ Result of accident or work injury? Yes No
 How long has this bothered you? 1 2 3 4 5 6 7 days weeks months years
 What treatments have you tried & have they been effective? _____

 On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain? ___/10
 The pain quality is: burning constant dull sharp shooting throbbing tingling Other: _____

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____

Date: _____

History and Physical

Name: _____ DOB: _____ Chart Number: _____

Medical History:

| | | | | |
|---|--|--|---|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Circulation problems | <input type="checkbox"/> Musculoskeletal | <input type="checkbox"/> Breathing issues |
| <input type="checkbox"/> Liver | <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Gout | <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Stomach/bowel | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety disorder | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Blood clot | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Neuropathy (specify) _____ | <input type="checkbox"/> Thyroid disease (specify) _____ | <input type="checkbox"/> Diabetes (type 1, type 2) | <input type="checkbox"/> HIV | <input type="checkbox"/> CVA |
| <input type="checkbox"/> Arthritis (specify) _____ | <input type="checkbox"/> other (specify) _____ | <input type="checkbox"/> Skin disorders | <input type="checkbox"/> Stroke | |

Are you pregnant? Yes No **Are you nursing?** Yes No

Surgical History None Appendectomy C-Section Angioplasty Bypass Cataracts Cholecystectomy

Have you ever had any surgical procedures on foot/ankle or anywhere else on your body? Yes No

If yes, please describe: _____

Do you have any artificial joints? Yes (where? _____) No Do you have an artificial heart valve? Yes No

Social History

Do you smoke? Yes No If yes how many packs per day? 1 2 3 4 5 For how long? _____

Do you drink alcohol? Yes, everyday (5-7 days/week) Yes, occasionally/socially No/Rarely

Substance abuse: Yes, I have a current substance abuse problem. Please specify: _____

Yes, I had a past substance abuse problem. Please specify: _____

No, I have never had a substance abuse problem

What is your occupation? _____ Does it involve mostly standing or sitting

Do you exercise regularly? No, I do not exercise regularly Yes, I do the following regular exercise: _____

Family History Is there any family history (blood relative) of: (Please indicate family member)

| | |
|---|--|
| <input type="checkbox"/> Alzheimer's _____ | <input type="checkbox"/> Depression _____ |
| <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Bleeding disorders _____ | <input type="checkbox"/> Emphysema _____ |
| <input type="checkbox"/> Blood clot _____ | <input type="checkbox"/> Heart disease _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> High Blood Pressure _____ |
| <input type="checkbox"/> Cataracts _____ | <input type="checkbox"/> Neurological _____ |
| <input type="checkbox"/> Circulation problems _____ | <input type="checkbox"/> Strokes _____ |
| <input type="checkbox"/> Other (specify): _____ | |

Review of Systems (Please check the box if you currently have any of these symptoms or check "NONE")

| | | | | | |
|-------------------------|--|--|--|--|--|
| Cardiovascular | <input type="checkbox"/> leg pain when walking | <input type="checkbox"/> fever | <input type="checkbox"/> chest pain/pressure | <input type="checkbox"/> leg swelling | <input type="checkbox"/> cold hands/feet |
| | <input type="checkbox"/> fainting | <input type="checkbox"/> palpitations | <input type="checkbox"/> vascular disease | <input type="checkbox"/> valve problems | <input type="checkbox"/> NONE |
| Genitourinary | <input type="checkbox"/> blood in urine | <input type="checkbox"/> hesitancy | <input type="checkbox"/> incontinence | <input type="checkbox"/> increased urgency | |
| | <input type="checkbox"/> decreased frequency | <input type="checkbox"/> excessive urination | <input type="checkbox"/> kidney disease | <input type="checkbox"/> kidney stones | <input type="checkbox"/> NONE |
| Gastrointestinal | <input type="checkbox"/> abdominal pain | <input type="checkbox"/> heartburn | <input type="checkbox"/> blood in stool | <input type="checkbox"/> vomiting | <input type="checkbox"/> ulcers |
| | <input type="checkbox"/> diarrhea | <input type="checkbox"/> trouble swallowing | <input type="checkbox"/> decrease appetite | <input type="checkbox"/> increase appetite | <input type="checkbox"/> constipation |
| Integumentary | <input type="checkbox"/> athletes foot | <input type="checkbox"/> nail abnormalities | <input type="checkbox"/> keloids | <input type="checkbox"/> itchiness | <input type="checkbox"/> dry, scaly skin |
| | | | | | <input type="checkbox"/> NONE |
| Hematologic | <input type="checkbox"/> lower leg ulcers | <input type="checkbox"/> sickle cell disease | <input type="checkbox"/> anemia | <input type="checkbox"/> blood thinners | <input type="checkbox"/> clotting disorder |
| | | | | | <input type="checkbox"/> NONE |
| Neurological | <input type="checkbox"/> tingling | <input type="checkbox"/> weakness | <input type="checkbox"/> seizures | <input type="checkbox"/> numbness | <input type="checkbox"/> headaches |
| | <input type="checkbox"/> tremors | <input type="checkbox"/> paralysis | | | <input type="checkbox"/> NONE |
| Musculoskeletal | <input type="checkbox"/> back pain | <input type="checkbox"/> joint swelling | <input type="checkbox"/> muscle weakness | <input type="checkbox"/> muscle pain | <input type="checkbox"/> neck pain |
| | <input type="checkbox"/> sciatica | <input type="checkbox"/> joint stiffness | <input type="checkbox"/> joint pain | <input type="checkbox"/> joint instability | <input type="checkbox"/> arthritis |
| | | | | | <input type="checkbox"/> NONE |
| Respiratory | <input type="checkbox"/> chest pain | <input type="checkbox"/> wheezing | <input type="checkbox"/> COPD | <input type="checkbox"/> coughing | <input type="checkbox"/> snoring |
| | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> emphysema | | | <input type="checkbox"/> NONE |

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____ Date: _____

Practice:

Today's Date:

Name: _____ **Chart #:** _____ **Date of birth:** _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino Declined to specify

Race: Asian American Indian or Alaska Native Black or African American
 White Native Hawaiian or other Pacific Islander Declined to specify

Preferred Language: _____ Declined to specify

Pharmacy Name: _____ **Pharmacy Phone:** _____

Pharmacy Address: _____ **City, State, Zip:** _____

Primary Care Physician: _____ **Phone:** _____ **Date Last Seen:** _____

Address: _____

Referring Physician: _____ **Phone:** _____ **Date Last Seen:** _____

Address: _____

Privacy Information Preferences

Do you want to be exempt from public reporting? Yes No Can we send mail to the address on file? Yes No

Can we call the phone number on file? Yes No Can we leave voicemail on machine? Yes No

Will you allow us to send internet based (e-mail) delivery of reminders and newsletters? Yes No

If yes, please provide your e-mail address: _____

Who can we leave messages with? Wife Husband Daughter Son Other: _____

Name(s): _____

Smoking Status

Current Every Day Smoker, Current Status Unknown
 Current Some Day Heavy Tobacco Unknown If Ever
 Former Never Light Tobacco decline to answer

Vital Signs

Blood Pressure: _____ / _____

Height: _____ Weight: _____

Current Medications

No Known Medications I take the following medications:

Name / Dose: _____

Name / Dose: _____

Name / Dose: _____

Name / Dose: _____

Name / Dose: _____

Name / Dose: _____

Name / Dose: _____

Name / Dose: _____

Use the back of this form if more room is needed

Allergies

No Known Allergies No Known Drug Allergies

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Last Flu Shot Date: _____ **Did you get a pneumococcal vaccination?** Yes No

Have you fallen in the last 12 months? Yes No **Were you injured from the fall?** Yes No

Advanced Directives: Living Will DNR Durable Power of Attorney Surrogate Appointed None

PLEASE READ AND SIGN: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. (Assignment of Benefits): I authorize payment of medical benefits to the practice named above. (Release of Information): I authorize the release of any medical information necessary to process this claim. (HIPAA Privacy): I acknowledge that I received my HIPAA Privacy Practices Notice. (Medication History): I authorize the Doctor's office to retrieve my medication history.

Patient Signature: _____ Date: _____

Christopher L Hendrix, DPM, PC- Notification of Office Policies and Procedures

Emergency/After Hours: During a medical emergency, patients should call 911 or proceed to the nearest emergency room. The facility will contact our physician for post-operative complications and other urgent situations.

Refills and Medication: Refills and Medication will be completed on the same day if received/requested Monday through Thursday before 3:00 p.m. and all others will be handled the next business day except on Fridays. Narcotics are no longer allowed to be e-prescribed or phoned in. If the physician approves a narcotic, the prescription will have to be picked up in the office during the hours of Monday through Friday from 8:00 a.m. to 4:00 p.m.

Payment: Our office accepts Visa, MasterCard, Discover, Cash or Checks.

Returned Checks: A \$35 fee will be charged to the patient on all returned checks. Any NSF or Closed Account will result in future services on a pre-pay cash or credit basis.

Delinquent Accounts: In the event that your account is placed with a Collection Agency, a collection-fee in the amount of 33 1/3% of the then outstanding balance may be added to your account and shall become a part of the Total Amount Due. You will be responsible for any and all cost of collection including attorney fees and court cost. You agree, that in order for us to service your account or to collect any amounts you may owe, we and our collection agencies may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We and our collection agencies may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

“No Show” Appointments: A \$25 fee will be charged to the patient for any “No Show” appointments.

Appointment Hold: Repetitive broken appointments, non-compliance, hostile behavior, and/or financially deficient accounts will result in appointment hold and/or the termination of the Doctor/patient relationship. A 30 day notice will be given should the situation result in a transfer of the patient’s care.

Over the Counter Convenience Items (OTC): Our office will not submit claims for OTC items (eg. Shoe inserts, Surgical shoe(s), Nail polish, Formula 3, Toe pads/Correctors/Caps, etc...)

Returns: Only unworn and non-custom items are returnable within 14 days of receipt, if no visible signs of wear, tear or odor. Custom items are tailored to meet individual needs; custom items are non-returnable, non-refundable.

Medical Records/FMLA or Short Term Disability Forms: Copies of the patient’s medical records will be given to the patient at no charge. A \$5 fee will be charged to the patient if the patient requests copies of their x-rays on a disk. A \$10 fee will be charged to the patient for completing FMLA or Short Term Disability Forms.

Non-Covered Services: I have been informed that the services listed may be denied by any insurance as services not covered by my plan. I agree to be fully responsible for payment of any services provided that are non-covered or excluded from my insurance policy. Examples- Debridement or cutting of nails (routine care), Paring or a lesion (Corns & calluses), Custom orthotics, etc.

Referral: If my insurance plan requires a referral in order to be treated, it is my responsibility to obtain the referral prior to being treated. If a referral is required and I fail to obtain one, I will be financially responsible for any services rendered.

The undersigned certifies that he/she has read and understands the foregoing statements, and is either the patient, or is duly authorized by the patient as the patient’s general agent or the guarantor of the patient to execute the above and accepts its terms.

Print Name of Patient or Legal
Representative

Signature

Relationship
to Patient

Date

Christopher L Hendrix, DPM, PC
Authorization from Patient or Legal Representative

Consent to Treat: The undersigned consents to any initial or follow-up evaluations, examinations, x-rays, laboratory procedures, other tests, medications, medical treatment, surgery, home instructions, orthotics, other durable medical equipment, photographing and/or videotaping and/or other services rendered to the patient. The undersigned agrees that it is their responsibility to contact and/or schedule with our office any follow up visits, other services, prescriptions and items ordered for the patient.

Assignment of Benefits: I hereby irrevocably assign, transfer and convey to Christopher L Hendrix, DPM, PC, any and all benefits and all interest and rights (including causes of action, the right to enforce payment and the right to appeal an adverse benefit determination) to which I'm entitled under an employee benefit plan sponsored by my employer, all insurance policies, benefits, any third-party reimbursement, or prepaid health care plan for services rendered or products I received from Christopher L Hendrix, DPM, PC.

Medicare Assignment: I certify that the information given by me in applying for payment under XVIII of the Social Security Act is correct. I authorize the release of information concerning me to the Social Security Administration or its intermediaries as well as any information needed for filing a Medicare claim; I request that payment and authorized benefits be made on my behalf. I assign benefits payable for services to Christopher L Hendrix, DPM, PC.

Authorization to Release Information: I consent and authorize Christopher L Hendrix, DPM, PC and its agents to release my health information for the purpose of payment, treatment, and healthcare operations to any of the following: insurance company and its affiliates, any practitioner, support staff or facility involved in my plan of care or transfer of care. In addition I understand that the potential uses and disclosures of my Health Information are detailed in the Privacy notice. The HIPAA Notice of Privacy Practices is available in the office. I have read/had the opportunity to read my HIPAA rights.

Designation of Authorized Representative: I designate and appoint Christopher L Hendrix, DPM, PC (and its agents) as my authorized representative and authorize it to act on my behalf to 1) request and receive a copy of the summary plan description, 2) pursue a benefit claim, 3) appeal an adverse benefit determination, and/or 4) file a legal/equitable action to recover benefits from my employee benefit plan, insurance policy, and any third-party reimbursement or prepaid health care plan. I understand and agree that my authorized representative shall have full authority to act, and receive notices, on my behalf with respect to an initial determination of the claim for health benefits relating to treatment and health care services received by me/my child, any requests for documents relating to this claim and appeal of an adverse determination of the claim.

Financial Agreement: I hereby promise to pay for all products received or services rendered to me/my child to the extent I am legally responsible for such payment. According to the language of the physician's insurance contract, I understand that I am responsible for all health insurance copayments, deductibles, coinsurances, OTC- over the counter convenience items and NCS- non-covered services and any other amounts that apply at the time of service or at the preoperative appointment. Regardless of the assignment of benefits, should the insurance misrepresent their coverage or delay payment of a claim greater than 60 days, as the designated responsible party, I am responsible for all the monies owed to Christopher L Hendrix, DPM, PC. I also understand that the insurance policy is a contract between me and the insurance company; therefore the policy holder should contact the insurance carrier first when there are questions regarding explanation of benefits.

The undersigned certifies that he/she has read and understands the foregoing statements, and is either the patient, or is duly authorized by the patient as the patient's general agent or the guarantor of the patient to execute the above and accepts its terms. This document shall remain in force until a written revocation by me is delivered to Christopher L Hendrix, DPM, PC.

Print Name of Patient or
Legal Authorized Representative

Signature

Relationship to
Patient

Date