DR JOEL SCHANCUPP

PODIATRIST—FOOT AND ANKLE SPECIALIST
MEDICINE AND SURGERY OF THE FOOT AND ANKLE

PATIENT INFORMATION

WELCOME TO OUR OFFICE. WE ARE VERY PLEASED TO HAVE YOU WITH US. PLEASE ANSWER THESE QUESTIONS TO HELP US BECOME BETTER ACQUAINTED. IF YOU NEED HELP, PLEASE DO NOT HESITATE TO ASK. THANK YOU.

Name_____ Date of Birth_____ Age_____ M☐ F☐

Address_____ City _____ Zip Code _____

Phone Number Home _____ Work_____ Cell_____

Social Security Number _____

Marital Status: Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐

Name of Spouse, Parent, Guardian_____

Address if different than above _____
Your Occupation_____
Employer_____
Business Address_____
Telephone_____
Person Responsible for Bill _____ CoPay required at time of Service
How Do You Plan to Make Payment Cash☐ Check☐ Visa☐ MasterCard☐

HEALTH INSURANCE
Subscriber's Name _____ Social Security #_____ DOB_____
Insurance Company _____ Policy Number _____
Family Doctor_____ Date of Last Visit _____
Former Podiatrist_____ Date of Last Visit _____
Reason for today's visit?

Please Check answers
1. Are you in good health?.....YES ☐ NO☐
2. Have you ever been treated for heart trouble, stroke, asthma, epilepsy, rheumatic fever, kidney or liver problems? If YES, check the ones.....YES ☐ NO☐
3. Is there any personal or family history of Diabetes?.....YES ☐ NO☐
4. Is there any personal or family history of gout?.....YES ☐ NO☐
5. Do you have any bleeding problems or difficulty healing?.....YES ☐ NO☐
6. Are you presently taking any medications or pills?.....YES ☐ NO☐
7. Have you had any serious illnesses or operations?.....YES ☐ NO☐
8. Are you allergic or have experienced side effects to any of the following?.....YES ☐ NO☐

Penicillin☐ Antibiotics☐ Codeine☐ Demerol☐ Aspirin☐ Iodine☐ Adhesive Tape☐
Novocain or Local Anesthesia☐ Others (Please List) _____
Whom may we thank for referring you to our office? _____

Today's Date _____ Patient/Guardian Signature_____

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Joel Schancupp DPM originates and maintains paper and/or electronic records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for the future care of treatment. I understand that this information serves as:

A basis for planning my care and treatment
A means of communication among the many health professionals who contribute to my care.
A source of information for applying my diagnosis and surgical information to my bill
A means by which a third-party payer can verify that services billed were actually provided, and
A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete descriptions of information uses and disclosures. I understand that I have the following rights and privileges:

The right to review the notice prior to signing this consent,
The right to object to the use of my health information for directory purposes, and
The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Joel Schancupp DPM is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Joel Schancupp DPM reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Joel Schancupp DPM change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclosed my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept/decline the terms of this contract.

Patient's Signature _____

Date _____

FOR OFFICE ONLY

☐ Consent received by _____ on _____
☐ Consent refused by patient, and treatment refused by permitted.
☐ Consent added to the patient's medical record on _____

I hereby give my permission to Dr. Schancupp and staff to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my condition.

Signature _____ Date _____

Please tell us to whom we may disclose your personal health information to. **YOU MAY DISCLOSE INFORMATION TO THE FOLLOWING PEOPLE (INCLUDE THEIR RELATIONSHIP TO YOU)**

Assignment of Benefits

I hereby authorize insurance benefits to be paid directly to the physician, and I acknowledge that **I AM FINANCIALLY RESPONSIBLE FOR ANY UNPAID BALANCE** and any costs incurred in the collection thereof including court costs and attorney fees.

Signature_____ Date _____

Release

I hereby authorize the physician to release any information required to my insurance company

Signature_____ Date _____

MEDICARE patients

I request that payments of authorized medicare benefits be made to my doctor for any services furnished to me by the physician. I authorize any holder of medical information about me to releases to the health care finance administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature_____ Date _____

Additional Information and Explanation of Serious Illness or Operations.