Alabama South Family Podiatry
204 Luds Way, Dothan AL 36303
Phone (334) 678-7036 Fax (334) 702-4208

M. Diane Collier, D.P.M.

Patient Information

Date _____
Patient Name _____
SSN _____-_____-_____ Date of Birth ____/____/____
Sex □ M □ F Martial Status □ M □ S □ D □ W
Address _____
City _____State ____ Zip Code _____
Home Phone _____ Cell _____
Preferred Phone _____

Height _____ Weight_____ Shoe Size _____
Employer _____
Work Phone _____
Full or Part Time _____ Student Full Time □ Yes □ No
Primary Care Physician _____
Date of Last Visit _____

Race □ American Indian or Alaska Native □ Asian
□ Black or African American □ White □ Declined

Ethnicity □ Hispanic or Latino □ Not Hispanic or Latino

In Case of Emergency Contact:
Name _____
Relationship to Patient _____
Home Phone _____Work Phone _____
Referred By _____
Complete if 65 years old and older:
Do you have a living will? □ Yes □ No
If no, why? _____
Do you have a decision maker? □ Yes □ No
If yes, who? _____

Insurance

Insurance Company _____
Policy # _____
Group # _____
Subscriber's Name _____
Date of Birth _____/_____/_____ SSN_____-_____-_____
Relationship to Patient _____

Is patient covered by additional insurance? □ Yes □ No

Insurance Company _____
Policy # _____
Group # _____
Subscriber's Name _____
Date of Birth _____/_____/_____ SSN_____-_____-_____
Relationship to Patient _____

Consent to Treatment

I certify that my information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Signature _____
Relationship _____ Date _____

Consent for Contact

I hereby consent to provide my telephone number(s), including my wireless telephone number(s), so that representatives from the Physician Clinic, its successors or assigns can contact me in any manner including but not limited to by manually placing a call, by using an automatic telephone dialing system or an artificial or prerecorded voice, by texting, or by e-mailing, regarding any matter, including but not limited to my medical treatment, prescriptions, insurance eligibility, insurance coverage, scheduling, billing, or collection matters. This consent includes any updated or additional contact information I may provide. I understand that I will be able to change my preference at any time.

Signature _____ Date _____

Contact Preferences

I would prefer to be contacted in the following manner. I understand some of these options may not be available at this time but will be implemented once they become available. I understand I will be able to change my preferences at any time.

□ Home Phone □ Cell Phone □ Work Phone: _____
□ Text Message: _____
□ E-Mail: _____

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Allergies

□ None □ Adhesive Tape □ Anesthetics □ Anticoagulants □ Aspirin □ Codeine □ Iodine □ Latex
□ Penicillin □ Seafood □ Sulfa □ Other _____
Additional Allergies _____

Medications

Drug	Dosage/Frequency	Doctor	Drug	Dosage/Frequency	Doctor

Medical History

□ AIDS/HIV	□ Cancer	□ Fibromyalgia	□ Kidney Problems	□ Sinus Problems
□ Allergies	□ Chemical Dependency	□ Flat Feet	□ Liver Disease	□ Special Diet
□ Anemia	□ Chest Pain	□ Foot or Leg Cramps	□ Mitral Valve Prolapse	□ Stomach Ulcers
□ Angina	□ Circulatory Problems	□ Frequent Infections	□ Neurological Disorders	□ Stroke
□ Arthritis	□ Cirrhosis	□ Gout	□ Plantar's Wart	□ Swelling of Ankles/Feet
□ Artificial Joints	□ Diabetes	□ Headaches	□ Phlebitis	□ Thyroid Problems
□ Asthma	□ Drug Addiction	□ Heart Disease	□ Psychiatric Disorders	□ Ulcers
□ Athlete's Foot	□ Ear Problems	□ Heel Pain	□ Radiation Treatment	□ Varicose Veins
□ Back Problems	□ Emphysema	□ Hepatitis	□ Rash	□ Other _____
□ Bleeding Disorders	□ Epilepsy	□ Hernia	□ Respiratory Disorders	_____
□ Blood Clots	□ Eye Problems	□ High Blood Pressure	□ Rheumatic Fever	
□ Bunions, Corns, Calluses	□ Fainting or Dizziness	□ High Cholesterol	□ Short of Breath	□ **NONE**
	□ Feet Ulcerations	□ Ingrown Toenails	□ Sickle Cell Trait	

Date of Last Flu Shot _____/_____/_____

Date of Last Pneumonia Shot _____/_____/_____

Women Only: Are you pregnant or breastfeeding? □ **Yes** □ **No**

Past Surgical History

Surgery	Year

□ **NONE**

Family History

If yes, list which family member associated with each.
□ Cancer □ Circulatory Problems □ Diabetes □ Gout
□ Heart Disease □ Thyroid Problems □ Other □ **None**

_____

Social History

Check which one you use and how much/how often.
□ Alcohol _____
□ Tobacco _____
□ Never Smoked □ Former Smoker
□ Illegal Drug Use _____
□ Exercise _____

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1. Assignment of Insurance Benefits/Promise to Pay

I certify that I (or my dependent) have insurance cover with _____ and I hereby assign and authorize payment directly to the Physician Clinic all insurance benefits, sick benefits, injury benefits due because of liability of a third-party, or proceeds of all claims resulting from the liability of a third party, payable by any party, organization, et cetera, to or for the patient unless the account for this Physician Clinic, outpatient visit, or series of outpatient visits is paid in full upon discharge or upon completion of outpatient series. If eligible for Medicare, I request Medicare services and benefits. I further agree that this assignment will not be withdrawn or voided at any time until the account is paid on full. I understand that I am responsible for any charges not covered by my insurance company. I authorize the use of my signature on all insurance submissions. I hereby authorize the Physician Clinic to release all information necessary to secure the payment or benefits.

I understand that I am obligated to pay the account of the Physician Clinic in accordance with the regular rates and terms of the Physician Clinic. If I fail to make payment when due and the account becomes delinquent or is turned over to a collection agency or an attorney for collection, I agree to pay all collection agency fees, court costs, and attorney's fees. I also agree that any patient or guarantor overpayments on the above Physician Clinic visit may be applied directly to any delinquent account for which I or my guarantor is legally responsible at the time of the collection of the overpayment. I consent for the Physician Clinic to work with my insurance company/companies on my behalf on authorization, appeal on my behalf any denial for reimbursement, coverage, or payment for services or care provided to me.

Relationship to Patient _____ Date _____

Responsible Party's Signature _____

2. Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Alabama South Family Podiatry for any services rendered to me. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim if "other insurance" is indicated on item 9 of the HCFA 1500 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, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full deductible are based upon the charge determination of the Medicare carrier.

Beneficiary's Signature _____ Date _____

3. Notice of Privacy Practices

Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I have received or been offered the opportunity to review a copy of the Physician's Clinic's Notice of Privacy Practices. I hereby consent to the use and disclosure of my protected health information as described in the Notice of Privacy Practices. This will included all of my protected health information generated during hospitalization and outpatient treatment at the Physician Clinic, including but not limited to treatment for mental health, drug and alcohol abuse, communicable diseases such as HIV/AIDS, developmental disabilities, genetic testing, and other types of treatment received.

Signature _____ Date _____

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4. Patient Consent for E-Prescribing (Electronic Prescribing)

I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information. I have been provided the Electronic Prescribing Notice.

Signature _____ Date _____

5. Patient Questionnaire

Please list the family members or other persons, if any, and their relationship to you whom we may inform about your general medical condition and your diagnosis (including treatment, payment, and healthcare operations). Please include their phone number as well.

1. _____ Relationship: _____ Phone Number: _____

2. _____ Relationship: _____ Phone Number: _____

3. _____ Relationship: _____ Phone Number: _____

6. E-Mail

I hereby consent to provide my e-mail address, so that representatives from the Physician Clinic can e-mail information to me about health education or disease prevention and up-to-date information about the Physician Clinic, its affiliated physicians, and our services. I understand I will be able to change my preferences at any time. For Medicare patients, we must have either your e-mail address or a family/friend who can receive your personal medical information. Please include the name of the person whose e-mail you list in the above questionnaire.

7. Videotaping/Recording

I understand and agree not to photograph, videotape, audiotape, record, or otherwise capture imaging or sound on any device. I also understand it is my responsibility to assure those accompanying me comply with this requirement.

Signature _____ Date _____

8. Appointment Cancellation Policy

Because of the limited appointment slots along with the negative financial impact missed appointments have on our practice, we have put the following appointment cancellation policy in place.

A $40.00 charge will now be assessed for each appointment missed or rescheduled without the required 24 hour advance notice. Patients with 2 unpaid missed appointment charges will not be rescheduled.

I have read and understand the Appointment Cancellation Policy and agree to be bound by its terms.

Signature _____ Date _____