THOMAS F. VAIL, DPM

1725 Western Ave. Suite C., Findlay OH 45840

WELCOME TO OUR OFFICE

DATE_____________ ***CONFIDENTIAL PATIENT INFORMATION*** ACCT. NO_________

LEGAL NAME **BIRTHDATE** **SEX** **AGE** **SOCIAL SECURITY #**

- - **M** ☐ **F** ☐

LAST FIRST MI MM DD YYYY

☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ STUDENT SPOUSE NAME ________________________

Primary Language: ☐English☐Spanish☐Other_______**Race:** ☐White ☐ Black/African American☐Asian☐ Other________**Ethnicity**:___________

PATIENT ADDRESS

STREET CITY STATE ZIP HOME PHONE

PATIENT OCCUPATION:__________________________ CELL PHONE NUMBER

EMPLOYER EMPLOYER ADDRESS EMPLOYER PHONE

E-MAIL ADDRESS ________________________________ **REFFERED BY**________________________________

PERSON RESPONSIBLE FOR PAYMENT (IF NOT PATIENT)

LAST FIRST MI ADDRESS PHONE

EMPLOYER EMPLOYER ADDRESS EMPLOYER PHONE

FAMILY PHYSICIAN

NAME ADDRESS CITY DATE OF LAST VISIT

INSURANCE

PRIMARY INSURANCE *PATIENT'S RELATIONSHIP TO INSURED:* SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

INSURANCE INSURED'S NAME INSURED'S SS# INSURED'S D.O.B.

SECONDARY INSURANCE *PATIENT'S RELATIONSHIP TO INSURED:* SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

INSURANCE INSURED'S NAME INSURED'S SS# INSURED'S D.O.B.

TERTIARY INSURANCE *PATIENT'S RELATIONSHIP TO INSURED:* SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

INSURANCE INSURED'S NAME INSURED'S SS# INSURED'S D.O.B.

LOCAL PHARMACY: Name ________________________**Address** _____________________ **Phone #**_________________________

Mail Order Pharmacy: Yes ☐ No ☐ **Name**_____________________ **Phone #**______________________

CONTACT PERSON OTHER THAN YOURSELF **Use only in:** Emergency ☐ Always ☐

NAME PHONE #

HEIGHT___________ WEIGHT___________

PREVIOUS FOOTCARE: YES ____ NO ____ IF YES, BY WHOM ________________________________

NATURE & LOCATION OF TODAY'S FOOT PROBLEM:

Signature of Patient or Responsible Party Date

Advanced Footcare Clinic, Dr. Thomas F. Vail
Payment & Office Policy

Thank you for choosing Advanced Footcare Clinic as your foot care provider. We are committed to providing you with quality and affordable health care.

Please read the following office payment policy and feel free to ask us any questions that you may have. Once you accept this policy, kindly sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. 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. Each policy has different deductibles, co-pays, and co-insurance responsibility of the participant. Therefore, we encourage you to check your policy's specific requirements for pre-certification for various treatments that may be planned for specific care. This may include, but not be limited to, MRI, bone scans, and physical therapy. We will continue to pre-certify surgeries and pre-certify as well as check into orthotics coverage as needed. However, a quote of benefit coverage is not a guarantee of payment. This office is not responsible for services rendered and not covered. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-Payments and Deductibles. All co-payments 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 from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. Deductibles are due immediately when insurance deems patient responsible. We reserve the right to ask for payment on deductibles not met before certain treatments and surgeries.

3. Non-Covered Services. Please be aware that some – and perhaps all – of the services you receive may be uncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit. Medicare does not cover routine foot care; this includes the trimming of nails and cutting of calluses. If you are a diabetic or have peripheral vascular disease or painful nails, Medicare may pay for cutting of fungus nails. Medicare has other requirements such as timely appointment with your primary care physician or your specialist who manages your diabetes or peripheral vascular disease in order for these services to be covered. This would be your responsibility to supply those dates of service at your visit for your foot care. You also must be seen within the past 6 months by your primary care physician.

4. Proof of Insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. If required, obtaining the proper referral form from your Primary Care Physician is your responsibility. Patients presenting to our office without a valid referral will be asked to pay in full. This payment will be held for 48 hours and will become non refundable if the proper referral is not obtained by then.

5. Claims 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 claims. Your insurance benefit is a contract between you and your insurance company.

6. Coverage Changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

7. In-Office Supplies. Our office supplies as a convenience to our patients over-the-counter supplies. This is an effort to eliminate going to the store to pick these items up. In order to stock these supplies, we require payment at the time of service. Insurance companies do not cover the cost of these supplies; therefore you are responsible. The office assistant will discuss a fee for the item prior to your departure. If you are unable to pay for the item at the time of service, then we kindly request you return to pick up the item when you are able to afford it.

8. Nonpayment. Invoices are sent out every 30 days. Your prompt payment will assist us in keeping the cost of healthcare down. A re-billing charge of $10.00 per month will accrue on all accounts 60 days past due and over. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to collection with an additional charge added to cover the cost of the collection agency service fee. If this occurs you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative podiatric care. During that 30-day period, our physician will only be able to treat you on an emergency basis. ***Any checks returned with insufficient funds will be charged a $25.00 processing fee.***

9. Missed Appointments. Our policy is to charge $30.00 for missed appointments not canceled at least 24 hours prior to appointment or for an understandable reason. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our fees are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I hereby give my permission for Dr. T.F. Vail, DPM to examine my feet medically or orthopedically. I authorize release of any information pertaining to my medical treatment
The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependants, and that I will be bound by this signature as though the undersigned had personally signed the particular claims.

I ____ hereby authorize ______________________________________ to pay and hereby assign
(Name of Insured) (Name of Insurance Company)
directly to Dr. Thomas F. Vail all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I understand I am
(Name of Provider)
financially responsible for all charges incurred. I further acknowledge that any insurance benefits when received by and paid to Dr. Thomas F. Vail
will be credited to my account, in accordance with the above said assignment. (Name of Provider)

I have read and understand the payment policy and agree to abide by its guidelines:

_______________________________________ ___________________________

Authorized Signature of Subscriber Date

THOMAS F. VAIL, DPM

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MEDICATION ALLERGIES

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

___ADHESIVE TAPE ___ASPIRIN ___CODEINE ___IODINE ___NOVOCAINE

___PENICILLIN ___SULFA ___OTHERS ______________

LIST CURRENT MEDICATIONS AND DOSAGE

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

MEDICAL HISTORY

MEDCIAL HISTORY - CHECK *YES* TO ALL THAT APPLY. PLEASE COMMENT ON ANY SPECIAL CONDITIONS.

Yes	Nature of Problem	Comments	Yes	Nature of Problem	Comments
	Allergic Rhinitis			Hypoglycemia	
	Allergies/Hayfever			Hypothyroidism	
	Amputation			Influenza	
	Anemia or Abnormal Bleeding			Jaundice	
	Arthritis			Joint Pain or Stiffness	
	Asthma			Keloid	
	Autism			Keratosis	
	Bladder Dysfunction			Kidney Disease or Stones	
	Blood Disease			Leukemia	
	Broken Bones in Feet or Legs			Liver Conditions	
	Cancer			Low Back Pain	
	Candidiasis (Yeast Infection)			Lungs (Pneumonia, TB etc)	
	Cellulitis			Lymphoma	
	Chest Pain			Measles	
	Chickenpox			Menopause	
	Circulation			Mumps	
	Colitis			Heart Murmur	
	Congestive Heart Failure			Muscular Dystrophy	
	Cramps in Feet or Legs			Nasal Condition	
	Crohn's			Neoplasm	
	Cystic Fibrosis			Nervous Disorder	
	Deep Vein Thrombosis			Numbness in Feet or Legs	
	Dentures/Partials			Neuropathy	
	Depression			Obesity	
	Diabetes			Osteomyelitis	
	Dialysis			Osteoporosis	
	Diverticulitis			Other Problems	
	Double Jointed			Phlebitis	
	Ear Conditions			Psoriasis	
	Eye Conditions			Psychiatric	
	Fainting or Convulsions			Raynaud's Disease	
	Fungal Infections			Recent Weight Loss	
	Gallbladder			Rheumatic Fever	
	Ganglion			Shortness of Breath	
	Gastritis			Sickle Cell Anemia	
	Cardiovascular Problems			Skin Problems	
	GERD			Slow Healing	
	GI Bleed			STD (VD/HIV +)	
	Gout			Stomach or Bowel Problems	
	Hardening of Arteries			Stroke	
	Headaches			Swelling in Feet or Ankles	
	Heart Trouble			Throat Conditions	
	Hemophilia			Thyroid	
	High or Low Blood Pressure			Varicose Veins	
	HIV+ (please list symptoms)			Warts	

Patient Name: ______________________**Patient Initials** ________ **Date** ________

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SURGICAL HISTORY

PLEASE LIST & DATE ANY PREVIOUS SURGERIES

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

FAMILY HISTORY

FAMILY HISTORY - Please check all that apply.

___Alcoholism ___Cancer ___Seizures ___Heart Problems

___Anesthesia Problems ___Cystic Fibroses ___Respiratory

___Arthritis ___Diabetes ___Neurological Disorder

CURRENT SHOE SIZE ________ **WIDTH**______

SOCIAL HISTORY

SOCIAL HISTORY

Do you Drink Coffee? ____ How much? ___________

Do you Drink Alcohol? ____ How much? ____________

Do you Smoke? ____ How much? ____________

REVIEW OF SYSTEMS

REVIEW OF SYSTEMS – Please check all that apply.

1. Constitutional Symptoms:
- ☐ Dizziness
- ☐ Faintness
- ☐ Fever
- ☐ Headache
- ☐ Sleep Problems

2. Eyes:
- ☐ Dry Eyes
- ☐ Excess Tearing
- ☐ Itchy Eyes
- ☐ Glaucoma
- ☐ Macular Degeneration

3. Ear, Nose, Mouth, Throat:
- ☐ Hearing Loss
- ☐ Sore Throat
- ☐ Blisters in Mouth
- ☐ Sinus Problem

4. Cardiovascular:
- ☐ Arm Pain
- ☐ Chest Pain
- ☐ Cold Hands
- ☐ Calf Cramping
- ☐ High Blood Pressure
- ☐ Cold Feet
- ☐ Chest Pressure

5. Respiratory:
- ☐ Difficulty Breathing
- ☐ Chest Tightness
- ☐ Snoring
- ☐ Shortness of Breath

6. Gastrointestinal:
- ☐ Abdominal Pain
- ☐ Blood in Stool
- ☐ Heartburn

7. Genitourinary:
- ☐ Kidney disease
- ☐ on Dialysis
- ☐ Currently Pregnant
- ☐ Painful Urination

8. Musculoskeletal:
- ☐ Back Pain
- ☐ Heel Pain
- ☐ Hip Pain
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Muscle Pain
- ☐ Neck Pain
- ☐ Stiffness

9. Integumentary:
- ☐ Athletes Foot
- ☐ Cyst
- ☐ Dry, Scaly Skin
- ☐ Discoloration
- ☐ Leg Swelling
- ☐ Lower Leg Ulcers

10. Neurological:
- ☐ Dizziness
- ☐ Confusion/Dementia
- ☐ Forgetfulness/Alzheimer's
- ☐ Headache
- ☐ Migraines
- ☐ Seizures
- ☐ Tingling-Numbness in feet/toes
- ☐ Tremors

11. Psychiatric:
- ☐ Alcoholism
- ☐ Dementia
- ☐ Depression
- ☐ Drug Abuse

12. Endocrine:
- ☐ Diabetes I (insulin)
- ☐ Diabetes II (non-insulin)
- ☐ Hypothyroid (underactive)
- ☐ Hyperthyroid (overactive)

13. Hematologic/Lymphatic:
- ☐ Ankle/Foot Edema
- ☐ Bruise Easily
- ☐ Bleeding Problems
- ☐ Calf Pain/Phlebitis

14. Allergic/Immunologic:
- ☐ Coughing
- ☐ Seasonal Allergies
- ☐ Sensitivity to Dust

Patient Name: ______________________________**Patient Initials** ________ **Date** ________

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1998 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment r health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name ____

Relationship to Patient____

Signature ____

Date ____

OFFICE USE ONLY

I attempted to obtain the patient’s signature in acknowledgment on the Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date:________ Initials:______Reason:______________________________