Scott L. Shields, DPM - www.TotalFootOk.com
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Email for Correspondence: janell@totalfootok.com or staff@totalfootok.com

NEW PATIENT WELCOME LETTER

Let me be the first to welcome you to our practice! Attached is the paperwork to fill out for your first visit. Fill all the forms out completely. If possible, please fax or email your completed paperwork using the office contact information above. This will help us to better prepare for your evaluation. Please bring your insurance card(s), a picture ID, and a list of medications if any. If you need additional directions, need to reschedule, or have any questions, please do not hesitate to give us a call. We look forward to helping you overcome your podiatric needs!

Thank you for letting us serve you!

Dr. Scott L. Shields and Staff

PATIENT INFORMATION

Circle: ☐Male ☐Female ☐Minor ☐Married ☐Single

Today's
Date: ________________ SSN:______________________ DOB:________________
(Required for Adults)

Name: ____
Last Name First Name Middle Name

Address: ____

City: ____________________________ State: ______________ Zip: ___________

Primary Phone: ________________________ 2nd Phone: ____________________

Email Address: ____

Employer: _____________________________ Occupation: ____________________

Primary Language: ___________________________ Hispanic? Yes / No

How did you learn about our office? ______________________________________

What is your primary concern with your feet today? ________________________

____

____

SPOUSE/PARENT INFORMATION (Parent Info only if minor)

Circle: ☐Male ☐Female ☐Minor ☐Married ☐Single

Spouse / Parent's Name: ____________________________ DOB: _______________

Phone #: _______________________________ SSN: ___________________________
(If different from above)

Address: ____
(If different from above) City State Zip code

Employer: _____________________________ Occupation: ____________________

MEDICAL INFORMATION

Who is your primary care doctor? ____

Pharmacy: ______________________________ Town: __________________________

Medications	Dosage	Medications	Dosage
1		6	
2		7	
3		8	
4		9	
5		10	

(Please attach an additional list of medications)

Current Podiatric Problem (Circle all that apply)

Location: ☐ Right ☐ Left ☐ Both
☐ Achilles ☐ Ankle ☐ Arch ☐ Ball of Foot ☐ Big Toe ☐ Big Toenail ☐ Heel ☐Smaller Toenails ☐ Top of Foot ☐ Other: ____

Nature: ☐ Aching ☐ Bruised ☐ Burning ☐ Cramping ☐ Deep ☐ Dull ☐ Improving ☐ Inflamed ☐ Itchy
☐ Numbness ☐ Pressure ☐ Sharp ☐ Shooting ☐ Sore ☐ Swollen ☐ Tender ☐ Tight ☐ Tingling

Started: ☐ Today ☐ #_____ days
☐ # _____ weeks ☐ # _____ months
☐ # _____ years ago

Timing: ☐ Barefoot ☐ Constant ☐ Evening ☐ In Shoes
☐ Intermittently ☐ Morning ☐ Running ☐ Standing
☐ Walking
Other: ______________________________

Cause: ☐ Unknown ☐ Developed Gradually
☐ Injury: ________________________
____

Treatment: ☐ Compression ☐ Elevation ☐ Heat ☐ Ice ☐ Medication ☐ Rest ☐ Stretching ☐ Shoe Change
Other: ______________________________

Ongoing Medical Conditions/Past Medical History (Circle all that apply)

☐ NONE ☐ Cancer ☐ Gout ☐ Lung Disease ☐ Seizure Disorders ☐ Anxiety ☐ Chemotherapy
☐ Heart Attack ☐ Lupus ☐ Sports Related Injury ☐ Arthritis ☐ Circulation Problems ☐ Heart Disease
☐ Neuropathy ☐ Stomach Ulcers ☐ Asthma ☐ Depression ☐ Hepatitis Type _____ ☐ MRSA Infection
☐ Stroke ☐ Bleeding Disorder ☐ Diabetes (Insulin) ☐ Diabetes (Non-insulin) ☐ High Blood Pressure
☐ Osteoporosis ☐ Swelling in Legs/Feet ☐ Blood Clots ☐ Kidney Disease ☐ Pain in Legs/Feet/Toes
☐ Thyroid Disorders ☐ Callus Formation ☐ Foot Ulcerations ☐ Liver Disease ☐ RSD/CRPS
☐ Other: ____

Previous Surgeries (Circle all that apply)

☐ NONE ☐ Amputation ☐ Angioplasty/Stent ☐ Appendectomy ☐ Back/Spine ☐ Blood Transfusion
☐ Bunion ☐ Carpal Tunnel ☐ Cataracts ☐ Gallbladder ☐ Gastric Bypass ☐ Hammer Toe ☐ Heart Bypass
☐ Heart Valve Replacement ☐ Hysterectomy ☐ Ingrown Nail ☐ Joint Replacement: ________________
☐ Lap Band ☐ Lower Extremity Bypass ☐ Neuroma ☐ Pacemaker ☐ Tonsils
☐ Transplant: __________________ ☐ Other: ______________________________

Family Medical History (Circle all that apply)

Biological Family				
Mother	Cancer	Diabetes	Hypertension	None
Father	Cancer	Diabetes	Hypertension	None
Sibling	Cancer	Diabetes	Hypertension	None
Grandparent	Cancer	Diabetes	Hypertension	None

Social History (Circle all that apply)

Alcohol Consumption	Smoking	
☐ None	☐ Never	☐Vaping
☐ Occasional	☐ Former	
☐ Daily	☐ Daily	
	☐ Social	

Review of Systems (Circle all that apply)

Psychiatrics: ☐ Dementia ☐ Schizophrenia ☐ Anxiety ☐ Bipolar ☐ ADD ☐ Mental Retardation
Head & Eyes: ☐ Dizziness ☐ Fainting ☐ Headaches ☐ Double Vision ☐ Infection
Ear, Nose & Throat: ☐ Pain in Ears ☐ Sores ☐ Infection ☐ Pain Swallowing ☐ Hoarseness ☐ Ringing Ears
☐ Nosebleed (within 7 days)
Respiratory: ☐ Bronchitis ☐ Painful Breathing ☐ Coughing Blood ☐ Emphysema
☐ Difficulty Breathing (unless sitting up)
Cardiovascular: ☐Phlebitis ☐ Hypertension ☐ Heart Murmur ☐ Shortness of Breath ☐ Chest Pain
☐ Edema ☐ SOB with Exertion ☐ Palpitations ☐ Claudicating ☐ Atrial Fib ☐ Ulceration
☐ Congestive Heart Failure
Endocrine: ☐ Diabetic ☐ Borderline Diabetic ☐ Hypothyroid ☐ Addison's Disease ☐ Cushing Syndrome
Other: ____
Gastrointestinal: ☐ Jaundice ☐ Cirrhosis ☐ Abnormal Stools ☐ GI Ulcers ☐ Nausea ☐ Vomiting
Genitourinary: ☐ Frequent Urination ☐ Incontinence ☐ Frequent UTI's ☐ Renal Dialysis
Musculoskeletal: ☐ Joint Pain ☐ Joint Swelling ☐ Muscle Pain ☐ Heel with Standing After Rest
☐ Joint Disability ☐ Weakness ☐ Back Pain ☐ Osteoarthritis
Dermatologic: ☐ Skin Infection ☐ Psoriasis ☐ Spider Veins ☐ Blisters ☐ Athletes Foot
☐ Macerated Webspace ☐ Rash ☐ Bleeding ☐ Bruising ☐ Itching ☐ Excessively Thick Nails
☐ Foot Ulcer ☐ Keloid: ______________________
Neurologic: ☐ Loss of Muscle Function ☐ Tics ☐ Tremors ☐ Seizures ☐ Foot Numbness
☐ Tingling Hands or Feet
Allergic Immunologic: ☐ Seasonal Allergies ☐ Anaphylactic Reaction: ___________________________
☐ HIV ☐ Immune System Suppression ☐ Recurring Infection ☐ Rheumatoid Arthritis ☐ Fibromyalgia
Hematology/Oncology: ☐ Sickle Cell Anemia ☐ Anemia ☐ Leukemia ☐ Current Chemotherapy

Allergies (Circle all that apply)

☐ NONE ☐ Adhesive/Tape ☐ Local Anesthetics ☐ Aspirin ☐ Blood Thinners ☐ Codeine ☐ Demerol
☐ Iodine ☐ Sulfa ☐ IV Contrast Dye ☐ Latex ☐ Penicillin ☐ Shellfish ☐ Other: ________________________
____

Height: ___________________ Weight: ___________________ Shoes Size: _________

The above information is completed correctly to the best of my knowledge, I also understand it is my responsibility to inform this office of any changes associated with this form.

Signature of Responsible Party: ______________________________ Date: ______________

PRIMARY INSURANCE

Insurance Company: ____

Subscriber ID# ______________________________Group# ____________________

Fill the following section out if insured is someone other than patient

Primary Member's Name: ____

Last Name First Name Middle

Relationship to Patient: ________________________DOB: ________________

SECONDARY INSURANCE

Insurance Company: ____

Subscriber ID# ______________________________Group# ____________________

Fill the following section out if insured is someone other than patient

Primary Member's Name: ____

Last Name First Name Middle

Relationship to Patient: ________________________DOB: ________________

ADDITIONAL INSURANCE

Insurance Company: ____

Subscriber ID# ______________________________Group# ____________________

Fill the following section out if insured is someone other than patient

Primary Member's Name: ____

Last Name First Name Middle

Relationship to Patient: ________________________DOB: ________________

EMERGENCY CONTACT

Who should we contact? ____

Primary phone: ____________________ Secondary phone: ____________________

PRIVACY RIGHTS

I acknowledge that Total Foot and Ankle is compliant with the Federal Privacy laws. I understand this Privacy Notice, and I had the opportunity to read the Federal Privacy Act or keep a copy of it if I so chose.

Patient Signature (or guardian if minor): ______________________Date: ____________

Print Patient Name (or guardian if minor): ______________________

Total Foot and Ankle Financial Policy Effective 8-8-22

As a provider participating in certain insurance plans, we have certain contractual obligations. However your insurance policy is a contract that exists between you and your insurance company. And ultimately, you as the patient or responsible are accountable for services provided. If you have questions about your policy, please call the phone number provided on your insurance card. We are fully aware of and acknowledge the "No Suprises Act" Sections 2799B-1 and 2799B-2 (requirements for providers). Even so, this financial policy shall serve as an agreement, that if the insurance does not pay for claims submitted on your behalf, the billed or insurance allowable for these charges will be owed by the patient or responsible. Furthermore, please inform us on every visit of any changes to your insurance coverage. **(**Please thoroughly read through the next sections. Although some of the following sections may not directly apply to you as the patient or responsible, this is a standard policy that ALL patients or responsible MUST sign**)**

- COPAYMENTS: It is a requirement of your insurance company that we collect your co-pay. Payment is required before meeting with the doctor.
- DEDUCTIBLES & CO-INSURANCE: If you have a high deductible plan, you are responsible at time of service to pay for services/products in full up to your deductible and coinsurance. Any remaining balance after submission to your insurance company is your responsibility.
- SELF-PAY: Full payment is due at time of service. A down-payment will be required before seeing the doctor. At a minimum, an evaluation and management fee will be charged. The doctor may recommend additional procedures/services. You will be informed of these charges before proceeding with treatment.
- REFERRAL: If your insurance plan requires a referral from your primary care doctor, this will be required at the time of your visit. Without a referral available, we can see you as a self-pay at our soonest opening or reschedule your appointment until you get a referral.
- NO SHOW: 24-hour notice is required for cancellation of your appointment and failure to do so will incur a $50 fee. Failure to provide 24-hour notice of a procedure visit will incur a $100 fee. This is a courtesy to us and our other patients. Work with us and we will work with you.
- SURGERY CANCELLATION: Failure to provide 5 business days' notice before surgery will incur a $500 fee.
- Qualifying forgiveness is "Only" acceptable if a cancellation is beyond your normal control i.e., Sickness or Car Accident, Hospital Admittance etc. To qualify for forgiveness requires physical documented proof being submitted to our Patient Account Specialist before removal of fee is possible.
- BALANCES/COLLECTION FEES: If balance is not collected within 30 days from the postmark date of the mailed statement, a $15 re-billing fee will be added to each additional statement due to an unpaid balance. Accounts due more than 90 days will be turned over to our collection agency and a $100 administrative fee will be added along with modification to your balance due to cover collection services fees.
- FMLA/DISABILITY/MEDICAL RECORDS: There is a $25 charge for having the doctor complete these forms. There is a $10 fee to obtain a copy of your medical records.
- RETURNED ITEMS: Must be returned in "LIKE NEW" condition. Items acceptable for return should show **no wear and have not been soiled**. The return will be subject to a 15% restocking fee (this percentage will be based on the purchase or billed price of the item.)

I have read, understand, and agree to the terms of this financial policy.

Patient Name (print): ____

Patient/Responsible Party Signature: ________________________________ **Date:** ___________________

ASSIGNMENT & RELEASE

I hereby give permission to Total Foot and Ankle and staff to perform any necessary diagnostic treatment as may be deemed necessary to diagnose and/or treat the patients' foot/ankle condition. I authorize the release of any medical information necessary to process this claim and request payment of benefits either to myself or to the party who accepts assignment. I authorize Total Foot and Ankle, staff, and/or any provider, supplier of services, or third-party billing entity to release the information to secure payment of benefits. I further authorize Total Foot and Ankle and staff to act on my behalf concerning all claims connected to Total Foot and Ankle. I authorize the use of this signature on all submissions.

Signature of Responsible Party ______________________________ Date: ______________

MEDICAL RECORDS RELEASE (OPTIONAL)

I give Total Foot and Ankle permission to share my medical records with the following person(s). I will not hold Total Foot and Ankle Responsible for any misuse of this information.

Name: ______________________________________ DOB: ____________________
Relation to Patient: ___________________________
Patient Signature: ____________________________ Date: ____________________

Name: ______________________________________ DOB: ____________________
Relation to Patient: ___________________________
Patient Signature: ____________________________ Date: ____________________

Name: ______________________________________ DOB: ____________________
Relation to Patient: ___________________________
Patient Signature: ____________________________ Date: ____________________

(PLEASE ADD A LIST OF ANY ADDITIONAL AUTHORIZED PERSONS)