ASSOCIATED PODIATRISTS, PA.

8919 Parallel Parkway, Suite 550,
Kansas City, KS 66112
p: (913) 321-0522
f: (913) 334-9422

Today's Date:

patient information

Name ______ Preferred Name/Nickname ______

Date of Birth ___/___/___ Age: ______ Marital Status: ○ Single ○ Married ○ Other

Address ______ City ______ State ______ Zip ______

Primary Contact Phone ( ) - ○ Home ○ Cell ○ Work

Secondary Contact ( ) - ○ Home ○ Cell ○ Work

Other Contact ( ) - ○ Home ○ Cell ○ Work

E-mail ______ APPA may send me secure email / text messages ○ Yes ○ No

○ Male ○ Female SS# ___ - __ - ____

Primary Care Doctor ______ Last Seen Date: ______

Were you referred by a physician/ therapist for this visit? ○ No ○ Yes ○ ER / Urgent Care

If yes, Provider's Name: ______ or ER / Urgent Care Facility ______

Preferred Language: ○ English ○ Other: ______

Race: ○ American Indian / Alaska Native ○ Black or African American ○ Asian ○ White ○ Native Hawaiian / Other Pacific Islander

Ethnicity: ○ Hispanic / Latino ○ Not Hispanic / Latino ○ Other: ______

Emergency Contacts / Release of Medical & Appointment Information

Name ______ Number ( ) -

Relationship ______

Permission to share: ○ All info ○ Emergency only ○ Discuss appointment ○ Medical Information

Name ______ Number ( ) -

Relationship ______

Permission to share: ○ All info ○ Emergency only ○ Discuss appointment ○ Medical Information

---

Did you schedule today's appointment as a result of an injury? ○ Yes ○ No

If YES: Did this injury occur at work: ○ Yes ○ No Did this injury occur in an automobile: ○ Yes ○ No

Date of injury: ______ State where injury occurred: ○ KS ○ MO ○ Other: ______

How did injury occur: (see list below)

○ Altercation	○ Fell	○ Injury at Home	○ MVA	○ Straining Injury
○ ATV Injury	○ Fell at Home	○ Injury at School	○ Running	○ Tripped
○ Bike Injury	○ Fell on Ice	○ Lifting	○ Soccer	○ Twisting
○ Exercising	○ Fell at Work	○ Motorcycle Injury	○ Sports Injury	○ Walking

Name: Date of Birth:

Referral Source:

- ◯ ER/ Urgent Care
- ◯ Employee
- ◯ Insurance
- ◯ Patient/ Friend/ Family
- ◯ Referring MD / NP / PA
- ◯ Physical Therapy/ Trainer
- ◯ Website/ Facebook
- ◯ Work Comp/ Attorney/ Legal
- ◯ Yellow Pages / Advertising
- ◯ Other: ______________________

Employment / Student Information:

Occupation ____________________ Employer ______________________ Student: ◯ Part-time ◯ Full-time

Responsible Party / Guarantor ◯ Self

◯ Other: Name ______________________________ Number ( ) -

Address ____

Email ______________________________ SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Relationship: __________________________ Date of Birth ____/____/______

◯ Child (Under 18): Name of Father, Mother or Guardian: ______________________

Insurance Information

Policy Holder:

◯ Self ◯ Guarantor ◯ Spouse ◯ Other: ______________________________

Primary Insurance Company____

Policy ID Number ______________________ Group ID Number ______________________

Policyholder's Information [If not Self or Guarantor] Name ______________________

Date of Birth ____/____/______

Address ______________________ City ______________ State ______ Zip ______

Number ( ) - ______________ SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___ ◯ Male ◯ Female

Secondary Insurance Company____

Policy ID Number ______________________ Group ID Number ______________________

Policyholder's Information [If not Self or Guarantor] Name ______________________

Date of Birth ____/____/______ **Relationship** ◯ Self ◯ Spouse ◯ Child ◯ Other

Address ______________________ City ______________ State ______ Zip ______

Number ( ) - ______________ SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___ ◯ Male ◯ Female

Preferred Pharmacy ______________________________ Number ( ) -

Address ____

____

ASSOCIATED PODIATRISTS, PA.

Name: Date of Birth:

ASSIGNMENT of BENEFITS

I hereby authorize release of information necessary to file a claim with my insurance company and ASSIGN BENEFITS TO THE DOCTOR OR ASSOCIATED PODIATRISTS, PA.

I understand that I am financially responsible for all remaining balance due. A photo copy of this form shall be considered valid.

Signature ______________________ Date ______________

MEDICARE PATIENTS

IF YOU ARE A MEDICARE PATIENT, PLEASE SIGN BELOW FOR BENEFIT ASSIGNMENT MEDICARE LIFETIME CERTIFICATE:
I request that payment of authorized Medicare benefits be made either to me or on my behalf to ASSOCIATED PODIATRISTS, PA., for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Administration and its agents any information needed to determine these benefits payable to related services.

Signature ______________________ Date ______________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ______________________, have received a copy of ASSOCIATED PODIATRISTS, PA.'s updated Notice of Privacy Practices.

Signature ______________________ Relationship to the patient ______________
Patient or parent / legal guardian / legally responsible person

Date ______________

YOUR BILL IS YOUR RESPONSIBILITY.

Our pledge to you is to provide the highest quality care to you at the lowest possible cost regardless of insurance coverage or type. Insurance Company coverage and benefits varies with every Plan Type or Group Benefit (through an employer) and it is Your responsibility to verify your coverage, benefits, deductible, co-insurance and co-payments required prior to or after medical care is provided. Our office 'participates' with most insurance companies. In most cases, seeing a 'Participating Provider' has greater payment or services benefit to the patient. You must call your insurance company to verify our participation. If your insurance company requires a referral or other authorization prior to treatment for payment, it is Your responsibility to make sure it has been received or you will be billed for services provided without a referral. If you have a Third Party Liability Claim, you are responsible for payments prior to treatment; we will provide billing and claim information so you can file a claim with your insurance company. We will file medical claims to your Auto Insurance once the claim and coverage limits are verified. Worker's Compensation claims will be your responsibility should the claim be denied by the insurance company.

If you do not have insurance or a high-deductible insurance plan with an unmet deductible, we require you to pay $100 for your initial patient visit and $50 for each subsequent visit prior to being seen by the medical care provider. If you have a co-pay with your insurance company, it must be paid prior to being seen by the medical care provider. The Surgery Scheduling Department will collect up to $250 prior to scheduling your surgery to cover any unmet deductible and co-insurance as determined by your insurance company. Payment for balance due for the portions your insurance company did not pay due to deductible, co-insurance, co-pay and non-covered services is due within 30 days of receipt of a bill. Payment not received within 60 days may be sent to a collection agency. It is Your responsibility to contact our billing office if you are unable to pay your balance in full where Payment Options can be discussed. Any insurance company billing or coverage disputes are Your responsibility and will not stop our collection efforts for payment of medical care provided.

Payment can be made with Cash, Check, Money Order and Credit/Debit Cards (Visa, MasterCard, Discover & American Express) or ACH cards. For your convenience, payment can be made through our Patient Portal (www.YourHealthFile.com). To speak with someone in our billing department call (816) 533-2090 ext. 108.

I certify that I have read and understand the "Financial Policy" and agree to all terms and conditions stated above. I understand it is my sole responsibility to verify my medical coverage and benefits with my insurance company or medical benefit program. I understand that I am solely responsible for the remaining balances and non-covered amounts from my insurance company. I understand that payment is due within 30 days of receipt of a statement and it is my responsibility to contact the billing office if an Extended Payment Plan is needed. I understand that unpaid balances after 60 days will be placed with a collection agency.

Signature ______________________ Date ______________

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual/Representative refused to sign the form
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) ______________

ASSOCIATED PODIATRISTS, PA.

HEALTH HISTORY FORM

Patient Name:
Patient #:
Date of Birth:
Primary Care Physician:

Date:

PATIENT MEDICAL HISTORY. Check all that apply.

- ☐ None
- ☐ AIDS/HIV
- ☐ Acid reflux/GERD
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Cancer______________
- ☐ Cataracts
- ☐ Congestive heart failure
- ☐ Concussion
- ☐ Chronic obstructive pulmonary disease
- ☐ Dementia/Alzheimer's
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Eczema
- ☐ Emphysema
- ☐ Fracture_____________
- ☐ Gout
- ☐ Heart attack
- ☐ Hepatitis
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Kidney disease/stones
- ☐ Lupus (erythematosis)
- ☐ Mitral valve prolapse
- ☐ Neuropathy
- ☐ Osteoarthritis
- ☐ Osteoporosis/osteopenia
- ☐ Parkinson's disease
- ☐ Peptic ulcer disease
- ☐ Peripheral vascular disease
- ☐ Polio
- ☐ Psoriasis
- ☐ Renal failure/Dialysis
- ☐ Rheumatoid arthritis
- ☐ Schizophrenia
- ☐ Seizure disorder
- ☐ Sickle cell disease
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Valvular heart disease
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________

PAST SURGICAL HISTORY. Check all that apply.

- ☐ None
- ☐ Appendectomy
- ☐ Arthroscopy__________
- ☐ Back Surgery________
- ☐ Bowel resection
- ☐ Breast______________
- ☐ Bunionectomy
- ☐ Carpal tunnel release
- ☐ Cataract excision
- ☐ Caesarean section
- ☐ Coronary artery angioplasty
- ☐ Cholecystectomy
- ☐ Fracture repair
- ☐ Heart bypass
- ☐ Hernia repair
- ☐ Hip replacement
- ☐ Hysterectomy
- ☐ Knee replacement
- ☐ Removal of both ovaries
- ☐ Sinus surgery
- ☐ Tonsillectomy/ Adenoidectomy
- ☐ ____________________
- ☐ ____________________

REVIEW OF SYSTEMS. Check all that apply.

Musculoskeletal

- ☐ Joint pain
- ☐ Joint stiffness/swelling
- ☐ Weakness of muscles/joints
- ☐ Muscle pain/cramps
- ☐ Back pain
- ☐ Cold extremities
- ☐ Difficulty in walking

Constitutional Symptoms

- ☐ Bad general health lately
- ☐ Recent weight change
- ☐ Fever
- ☐ Fatigue
- ☐ Headaches

Neurological

- ☐ Numbness or tingling
- ☐ Tremors
- ☐ Paralysis
- ☐ Lightheaded/Dizzy

Hematologic

- ☐ Cuts slow to heal
- ☐ Tendency to bleed/bruise
- ☐ Anemia
- ☐ Enlarged glands

Integumentary (Skin)

- ☐ Rash or itching
- ☐ Changes in skin color
- ☐ Varicose veins

Allergies

- ☐ No known allergies
- ☐ Tape______________
- ☐ Erythromycin
- ☐ Codeine
- ☐ Sulfa
- ☐ Metal
- ☐ Latex
- ☐ Penicillin
- ☐ Exam dye (iodine)
- ☐ Topical iodine
- ☐ ____________________
- ☐ ____________________

(over)

CURRENT MEDICATIONS

☐ None
☐ See attached list

Drug Name		

MARITAL STATUS

☐ Married
☐ Single
☐ Widowed
☐ Divorced

OCCUPATIONAL HISTORY

☐ Retired
☐ Student
☐ Not presently employed
☐ Disabled
☐ Homemaker
☐ Employed
Occupation:____________

ALCOHOL HISTORY

☐ Never
☐ Rarely (1-2 times per month)
☐ Moderately (1-2 times per week)
☐ Heavy

TOBACCO HISTORY

☐ Never smoked
☐ Not currently, quit _ yrs ago
☐ Chew tobacco
☐ Smoke_____ packs per day

DRUG DEPENDENCY HISTORY (NARCOTIC DRUG USAGE)

☐ Never
☐ Not currently, ____ yrs ago
☐ Moderately
☐ Daily

FAMILY HISTORY

☐ Anemia
☐ Anesthesia problems
☐ Bleeding disorder
☐ Cancer
☐ Diabetes
☐ Heart disease
☐ Osteoarthritis
☐ Osteoporosis
☐ Rheumatoid arthritis
☐ Stroke
☐ ____________________

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any changes in my medical status. I also authorize the medical staff to perform the necessary services I may need.

Patient Signature ______________________________ **Date** ______________

______________________________ ______________

______________________________ ______________

OFFICE USE ONLY
MA INIT:
DATE: