SCHOLL FOOT CARE
WELCOME TO OUR OFFICE
Please print and complete the following information
PLEASE USE BLACK INK

Patient Name: _____ _____ _____
Last First M.I.

Sex: ___ ___ Date of Birth: _____ Age: ____ Marital Status: S M W D Social Security Number: _____
F M (Circle One)

Ethnic: Caucasian ___Hispanic ___Asian ___Black ___Other____ Preferred Language: _____

Address: _____ _____ _____ _____ _____
Street City State Zip Code County

If Diabetic: Previous or
Second Address: _____ _____ _____ _____
Street City State Zip Code

Preferred method of communication/appointment reminder: Please circle: E-mail Mail Phone; home cell other

E-mail address: _____

Home Phone #: (___) _____ Business/Cell/Other Phone #: (____) _____

Name of Employer/Retired: _____ Occupation: _____

Company Address: _____
Street City State Zip Code

Referred By: _____

Spouse's Name (Parent's or Guardian's Name, if a Minor) _____

Spouse's Date of Birth: _____ Driver's License Number _____

In Case of Emergency: _____ Phone No. _____ Relationship: _____

If other Than Patient, Name and Address of Person Responsible for This Account:

_____

Do you have medical insurance? Yes _____ No _____ **(INSURANCE CARDS WILL BE COPIED)**

Name of Family Physician: _____ Phone: _____

Name of Pharmacy: _____ Address/Phone: _____ City: _____

If applicable Physician treating you for Diabetes or prescribing Coumadin: _____

Are you currently under your physician's care? Yes ___ No___ If yes, for what reason: _____

May we contact your physician for your health records? Yes _____ No_____

Have you had previous treatment by a Podiatrist? Yes ____No ____ For What? _____

When? _____

My chief complaint is: _____

I HEREBY GIVE DR. JOHN M. SCHOLL PERMISSION TO EXAMINE AND TREAT MY FEET.

PATIENT'S, PARENT'S OR GUARDIAN SIGNATURE: _____

DATE: _____

Scholl Foot Care, PA

Patient Name_____ Date_____

NEW PATIENT INFORMATION CHECKLIST

(**CIRCLE** conditions that apply or have applied)

Weight change – loss or gain	Liver Disease	Eczema
Fever or chills or Fatigue	Hepatitis	Lumps or Masses
Weakness	Ankle Sprain	Itching
Sweats	Calluses	Rash
Fainting	Corns	Numbness, tingling, burning
Dizziness	Bunions	Black Outs
Headaches	Gout	Speech Disorders
Asthma	Hammer/Mallet Toes	Fainting
Cough	Heel Pain	Strokes
Bronchitis	Walking Problems	Tremors
Shortness of breath	Joint Stiffness	Unsteady Gait
Wheezing	Joint Pain	Thyroid disorders
COPD	Backache	Excess Thirst
TB	Paralysis	Goiter
Chest pain	Muscle Cramps	Blurred Vision
Palpitations of the heart	Arch Pain	Eyeglasses
Hair Loss on legs	Broken Foot Bone	Cataracts
Varicose Veins	High Arch Feet	Glaucoma
Leg or Foot Ulcers	Flat Feet	Contacts
Cramps in Legs/Feet	Arthritis	Infections
High Blood Pressure	Orthotic Use	
Extremity(s) Cool	Shoe insert Use	
History Heart Attack	Depression	History of Falls or Near Falls
Rheumatic Fever	Memory Loss	Flu Shot Month___Year_____
Antacid Use	Disorientation	Pneumonia Shot Month___Year_____
Gall Bladder Disease	Athlete's Foot	
Trouble swallowing	Fungal Nails	Height___Ft____Inches
Heartburn	Keloid Scar	Weight_____
Nausea and vomiting	Warts	
Constipation or diarrhea	Dryness	
Laxatives	Ingrown Nails	

Scholl Foot Care, PA

Patient Name_____ Date_____

Medical History continued Page two

Past medical history:
(ex: high blood pressure, diabetes, stroke, cancer, heart attack, etc.)

_____

_____

List any surgeries that you have had and include approximate year:

_____ **Date/Year** _____

_____ **Date/Year** _____

_____ **Date/Year** _____

List any time you have been hospitalized other than for surgery:

_____ **Date/Year** _____

_____ **Date/Year** _____

_____ **Date/Year** _____

Medications, Dosage and Frequency that you are presently taking:

_____

_____

_____

Medication Allergies/Circle type of reaction from list below;

_____

_____

Skin: Rash localized/Rash generalized/Itchiness/Patchy swelling skin/Facial swelling/Hives
Local: Conjunctivitis (pink eye)/ Runny nose/ Cough
Abdominal: Pain/Cramping/Bloating/Gas/Vomiting Diarrhea/ Nausea
Systemic/anaphylactic: Shortness of breath/Tongue swelling/Difficulty speaking or swallowing/Dizziness Lightheadedness/Loss of consciousness/Chest Pain Irregular heartbeat/Respiratory distress
Severity: Very mild/Mild/Moderate/Severe

Scholl Foot Care, PA

Patient Name_____ Date_____

Medical History continued **Page three**

Family History:

	Medical Problems:		If deceased, state age and cause of death:
Father			
Mother			
Brother/Sister			
Relatives			

Do you smoke or did you smoke? (cigarettes/cigar/pipe)? _____

How many years have you smoked or did you smoke? _____

How many packs a day? _____ When did you quit? _____

Do you use tobacco? _____ How often? _____

Do you drink alcohol? _____ Quantity: _____

What kind of work do you do, or if retired,
what kind of work did you do? _____

SCHOLL FOOT CARE, P.A.
1501 US HWY 441 N., SUITE 1304
THE VILLAGES, FL. 32159
TEL. # (352) 753-5600--FAX # (352) 750-3365

Authorization of Protected Health Information

Scholl Foot Care is concerned about the privacy of our patient's health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights.

I acknowledge and agree that Scholl Foot Care may (CHECK ALL THAT APPLY):

___ Leave a message regarding upcoming appointments and/or surgery scheduling
___ Brief Message ___ Extended Message

___ Leave a message regarding lab or biopsy results, treatment options/imaging studies/medication refills, etc.
___ Brief Message ___ Extended Message

___ Leave a message regarding billing questions
___ Brief Message ___ Extended Message

I acknowledge and agree that Scholl Foot Care may disclose my protected health information and medical record information to the following individuals who are either, my family members, legal representatives, guardians, health care surrogates, or have power of attorney on my behalf:

Name	Relationship	Phone Number	Medical	Non-Medical
_____	_____	_____	____	_____
_____	_____	_____	____	_____
_____	_____	_____	____	_____

Print Name of Patient or Legal Guardian: _____

Signature of Patient or Legal Guardian: _____

Date: ____/____/_____

SCHOLL FOOT CARE, P.A.
1501 U.S. HWY 441, N., SUITE 1304
THE VILLAGES, FL. 32159

Financial Policy

Thank you for choosing **Scholl Foot Care.** Your understanding of our financial policies is an essential element of your care and treatment. If you have questions, please discuss them with our front office staff or office manager.

As our patient, you are responsible for all authorizations/referrals needed to seek treatment in our office. As our patient, you are responsible for informing our front office staff of any changes to your information, such as insurance, address, and phone number.

Unless you, or your health insurance carrier, have made other arrangements payment for office services are due at time of service. We will accept cash, check or most major credit cards.

Your insurance policy is a contract between you and your insurance company. As a courtesy, we file your insurance claim for you if you assign benefits to the doctor. If your insurance company does not pay the practice within a reasonable period, we will look to you for payment.

Please call your insurance company prior to your visit to make sure if our physician is a participating provider or not with your insurance plan and that your services are a "covered benefit."

If your insurance requires a **co-pay/ co-insurance/or deductible, this will be collected at the time of service.** For all private insurance patients, we will collect your deductible, co-pay or 20% at time of service.

- **All self-pay patients will be expected to have payment at the time of service.**
- **Any and all past due account balances will be collected before your appointment.**
- **Cancellations will need to be arranged 24 hours in advance, if you do not cancel 24 hours in advance, there will be a $25.00 No-Show Fee.**
- **Returned checks are subject to a $40.00 service fee. Your insurance company does not cover this fee.**
- **The Financial Policy statement must be signed prior to any treatment.**

We thank you for your understanding.
I have read the Financial Policy. I understand and agree to this Financial Policy.

X_____ _____

Signature of Patient or Responsible Party **Date**

Scholl Foot Care, P.A.
1501 U.S. Hwy 441 North, Suite 1304
The Villages, FL 32159
Tel. #(352) 753-5600 – Fax #(352) 750-3365

WRITTEN ACKNOWLEDGEMENT FORM
RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____,
Patient Name

__(1) asked for and have received a copy of Notice of the Privacy Practices of Scholl Foot Care PA, or

__ (2) was offered a copy of Scholl Foot Care PA Notice of the Privacy Practices but declined to accept a copy.

_____ _____
Signature of Patient Date

WRITTEN ACKNOWLEDGEMENT OF PATIENT REFUSAL TO SIGN A RECEIPT OF NOTICE OF PRIVACY PRACTICES

On the _____ day of _____, the Notice of Privacy Practices of

Scholl Foot Care was ___ offered/or___ given to _____.
Patient Name

_____The Patient accepted a copy of the Notice of Privacy Practices but refused to sign an acknowledgement that it was given to the patient.

_____ The Patient refused to accept a copy of the Notice of Privacy Practices and refused to sign an acknowledgement that it was offered to the patient.

_____ _____
Signature of Scholl Foot Care Employee Who offered the Patient the Notice Date

Scholl Foot Care, P.A.
1501 U.S. Hwy 441 North, Suite 1304
The Villages, FL 32159
Tel. #(352) 753-5600 – Fax #(352) 750-3365

SINCE YOU ARE COVERED BY MEDICARE OR OTHER INSURANCE, PLEASE SIGN THE FOLLOWING:

LIFETIME MEDICARE OR OTHER INSURANCE SIGNATURE AUTHORIZATION:

For service beginning _____, I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to other billing agents of SCHOLL FOOTCARE PA, any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits; either to myself or to the party who accepts assignment.

BENEFICIARY/PATIENT'S SIGNATURE: _____

SIGNATURE BY (if patient unable to sign): _____

Reason patient is unable to sign _____

_____

SECONDARY INSURANCE

I request that payment of authorized SECONDARY INSURANCE Benefits be made on my behalf to SCHOLL FOOTCARE PA, for any services furnished me by SCHOLL FOOTCARE PA. I authorize any holder of medical information benefits payable for related services. I understand that I do not need to provide my supplement insurer with information concerning this Medicare claim, because my signing this authorization will cause Medicare payment information to be supplied to my secondary insurance.

Patient Signature: _____

Scholl Foot Care, P.A.
John M. Scholl, DPM
1501 Hwy. 441 North, Suite 1304
The Villages, FL 32159

Tel. # (352) 753-5600 – Fax # (352) 750-3365

REQUEST FOR MEDICAL RECORDS RELEASE

I, _____, give permission for my medical records/protected health information to be released from/to other health care professionals, insurances, home health agency, or any other facilities that may be applicable to provide, coordinate or manage treatment, payment and health care. This form will be effective indefinitely.

To/From: John M. Scholl, D.P.M.
Scholl Foot Care PA
1501 US Hwy 441 N Suite 1304
The Villages, FL 32159
Phone (352) 753-5600
Fax (352) 750-3365

PRINT NAME:_____

Date of Birth: ____/____/_____

DATE:_____

SIGNATURE: _____

Diplomate, American Board of Podiatric Surgery,
Certified Wound Specialist

Scholl Foot Care, P.A.
John M Scholl, DPM
1501 US Hwy 441 North, Suite 1304
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To Diabetic Patients or Patients taking Blood Thinners

Medicare and other insurances require a podiatrist (Dr. Scholl) to submit the name of the physician treating your diabetes/ or the name of the physician prescribing your Coumadin or other blood thinner for medically necessary foot care or diabetic foot care. Medicare and other insurances require that the podiatrist also submit the **date you last saw** the physician treating you for your diabetes or prescribing your Coumadin or other blood thinner. The date last seen must be within 6 months prior to your appointment with Dr. Scholl.

If you do not provide Dr. Scholl's office with this information, Medicare and other insurances will not reimburse Dr. Scholl and you will be billed for the services provided.

Please be prepared at the time of your appointment with Dr. Scholl to provide the physician's name, phone number, and the **date you last saw this physician, if you are diabetic also your A1C from your lab work.** For diabetics if future visits are covered you will be required to provide the **date last seen and A1C from your lab work** at each visit. If you are on Coumadin and future visits are covered you must provide **the date you last saw the physician prescribing your Coumadin** at each visit.

Thank you for your cooperation.

Signature: _____ Date: _____

Diplomate, American Board of Podiatric Surgery
Certified Wound Specialist