PATIENT HISTORY

(Please Print)

Date:________________

WELCOME TO OUR OFFICE

Patient's Name:________________________ /Spouse:________________________

Address:____

Street City State Zip

Home Phone:____________________ Business Phone : ____________________

Date of Birth:____________________ Marital Status: ____________________

Spouse Employer: ____________________

Occupation:____________________ Employer:____________________

Guardian's Name (if patient is a minor): ________________________________

Address (if different than patient's):________________________________

Person to call in case of emergency:____________________ Phone:________________

Address:____

Street City State Zip

Referred by: ☐ Coupon ☐ Friend ☐ Doctor ☐ Phone Book

Insured by:____

Group#:____________________ Contract #:____________________

Medicare#: ____________________ Medicaid#:____________________

Social Security #:____________________ License # :____________________

PLEASE ANSWER THE FOLLOWING TO THE BEST OF YOUR KNOWLEDGE:

Are you subject to prolonged bleeding or healing difficulties? ☐ Yes ☐ No

Do you bruise easily? ☐ Yes ☐ No Do you have low back pain? ☐ Yes ☐ No

Are you under the care of a doctor? ☐ Yes ☐ No

If yes, state the reason:

____

____

ADVANCED FOOT CARE CENTERS • 41400 Dequindre Road • Suite 100 • Sterling Heights, MI 48314 • Phone: (586) 731-7873

Form 119-1/93

Physician's name:______________________ Phone:______________________

Physician's address:____

Are you on a diet? ☐ Yes ☐ No

What medications are you now taking?______________________________

____

Are you pregnant? ☐ Yes ☐ No

DO YOU: Smoke ☐ Yes (amount) __________ Drink Alcohol ☐ Yes (amount)__________

☐ I am not allergic to anything to my knowledge

☐ I am allergic to: (please check)

☐ Aspirin
☐ Novocaine
☐ Codeine
☐ Demerol
☐ Penicillin
☐ Sulfa

☐ Mercurials
☐ Merthiolate
☐ Iodine
☐ Adhesives/Tape
☐ Nylon/Plastics
☐ Antihistamines

☐ Sutures
☐ Other__________
☐ __________
☐ __________
☐ __________

PLEASE CHECK APPROPRIATE PLACES. I have, or have had the following:

☐ Diabetes
☐ Bleeding tendencies
☐ Epilepsy
☐ Heart trouble
☐ Nervousness
☐ Stroke
☐ Varicose Veins
☐ Sickelcell or Trait

☐ Asthma
☐ Cancer
☐ Glaucoma
☐ Kidney trouble
☐ Rheumatism/Arthritis
☐ Tuberculosis
☐ Leg cramps
☐ Arteriosclerosis (Hardening of Artery)

☐ Aids/Positive H.I.V.
☐ Hepatitis
☐ Anemia Tumors
☐ High blood pressure
☐ Stomach Ulcers
☐ Polio

If you have not had diabetes, are you aware of any family member has had it?
If so, who? ____

Is there anything else we should know?______________________________

I hereby give permission to Dr. ______________________________
to treat my foot condition and ankle conditions. I also certify all the above information is correct.

______________ Date ______________________ Signature of patient

______________ Date ______________________ Parent or guardian (if patient in a minor)

HIPPA Compliance

PATIENT QUESTIONAIRE

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis:

   ____

   ____

2. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

   ____

   ____

3. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL": (excluding statements)

   YES____ NO____

4. Please print the telephone number, if any, where you want to receive calls about your appointments, lab and X-ray results, or other health care information if other than your home phone number: ______________________

5. Can confidential messages (i.e. appointment reminders) be left on your home answering machine or voicemail?

   YES____ NO____

6. If you do not have voicemail, can a confidential message be left at your place of employment?

   YES____ NO____

Patient name____________________________________ (guardian if under 18 years)

____ ______________

Patient/guardian signature Date

ADVANCED FOOT CARE P.C.
Michael L. Gerber D.P.M.
41400 Dequindre Rd., ste. 100
Sterling Heights, MI 48314

SIGNATURE ON FILE

___I authorize use of this form on all my insurance submissions.
___I authorize release of information to all my insurance companies.
___I understand that I am responsible for my bill.
___I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.
___I authorize payment direct to my doctor.
___I permit a copy of this authorization to be used in place of the original.

Name________________________________Medicare#___________
Please print

Signature____________________________________Date__________

PAYMENT POLICY for Advanced Foot Care, P.C.

Payment Policy

Thank you for choosing **Advanced Foot Care, P.C./ Dr. Michael L. Gerber** as your foot care provider. We are committed toproviding you with quality and affordable health care. Please read the following office payment policy 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. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles 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 and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

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.

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 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 claim. 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.

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

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

______________________________ ____________

Signature of patient or responsible party Date