



Blue Ridge Footcare and Surgery, PLC

Legal Name: _____ Date: _____

Date of Birth (_____) Race (____) Gender (____) Marital Status (_____)

Mailing Address: _____

Physical Address: _____

Home Phone: _____ Cell: _____ Work: _____

Email: _____ Employer: _____

Social Security # _____ If Patient is a Minor, Parent Name(s): _____

Preferred Pharmacy (List Name and Location) _____

Emergency Contact: _____ Phone: _____

Primary Insurance Plan: _____ Secondary Insurance: _____

Have you seen a podiatrist before? Please list their name, if possible _____

Primary Care Doctor: _____ Referring Physician: _____

Is this a work related injury/ Workman's Comp Case? _____ Date of Injury: _____

Patient's Medical History *(Please fill out the following information as thoroughly as possible)*

Previous Surgeries:

Tobacco Usage: ___ Currently ___ Former Smoker ___ Never A Smoker

Vaccinations: Pneumonia Yes No Date: _____

Flu Shot Yes No Date: _____

Time Spent On Your Feet Daily (circle): Minimal 25% 50% 75% 100%

Drug Allergies: () Penicillin () Amoxicillin () Bactrim () Keflex
() Cipro () Sulfa () Erythromycin () Aleve () Advil () Aspirin
() Iodine () NSAIDs () Codeine () Tape () Latex () Contrast Dye
() Shellfish () Other _____

Current Medications: (___ See List)*

Name: _____ Dose: _____ Frequency Per Day: _____

Name: _____ Dose: _____ Frequency Per Day: _____

Name: _____ Dose: _____ Frequency Per Day: _____

Name: _____ Dose: _____ Frequency Per Day: _____



Patient Name: _____

PATIENT REPORTS A POSITIVE HISTORY OF THE FOLLOWING CONDITIONS: *Please mark in column to the left of the condition*

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypotension | <input type="checkbox"/> Night Cramps |
| <input type="checkbox"/> Amputation(s) | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Joint Implants | <input type="checkbox"/> Organ Transplant |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Foot/Ankle Swelling | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> GERD | <input type="checkbox"/> Joint Stiffness | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Blood Clot(s) | <input type="checkbox"/> Gout | <input type="checkbox"/> Kidney Problem | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Leg Cramps | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Charcot Foot | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Herpes | <input type="checkbox"/> Muscle Spasms | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Nerve Disorder | <input type="checkbox"/> Walking Leg Pain |

Reason(s) for your visit: _____

Previous Treatment: _____

How would you rate your pain? Mild Moderate Severe

How long has your foot issue bothered you? Days Weeks Months Years

How did your pain start? Suddenly Gradually I don't recall

How would you describe your pain? Dull Sharp Burning Aching Throbbing Shooting

Has your foot issues caused issues with the following? Wearing shoes Exercise Walking

Which foot are you having problems with? Right Left Both

Height: _____ Weight: _____ Shoe Size: _____ BP: _____ / _____ Pulse: _____

Information Below Is For Office Use Only:

History of Present Podiatric Issue/History and Physical Exam

Class Findings:

Class A- Amputation[s] ()

Class B- Absent DP Pulse() PT Pulse() Decreased Hair Growth() Trophic Changes() Thick Nails() Pigmentary Changes ()

Class C- Claudication () Edema () Burning () Cold Feet () Paresthesias ()

Updated: _____

Consents and Releases

Name of Patient: _____

- Consent for Treatment:** This is to certify that I, the patient or the patient's legal representative, hereby consent to and authorize the administration and performance of all treatments and/or diagnostic services which, in judgement of Theodore McKee DPM, the podiatrist, may be considered necessary or advisable including the administration of blood products or derivatives. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a results of examination, treatment, surgery, and/or diagnostic services to be performed.
- Permission for Release of Medical Information:** I hereby authorize Blue Ridge Footcare and Surgery, PLC to release any and all information obtained in the patient's medical record which may be requested by my insurance company or other third party payer in order to compete the processing of the patient's claim for benefits.
- Assignment of Benefits:** I hereby assign to Blue Ridge Footcare and Surgery, PLC to the extent necessary to satisfy the patient's outstanding indebtedness, if any, all sums payable by the patient pursuant to any health benefits policy, policy of insurance including, but not limited to: health, liability, uninsured, or underinsured motorist, workers compensation, or medical payment insurance and/or pursuants to any settlement or judgement arising out of or related to any incident which caused the patient's need for medical or surgical treatment. I understand and agree that neither Blue Ridge Footcare and Surgery, PLC, nor its physicians have any obligations to collect benefits covered by this assignment other than benefits payable by a health maintenance organization or patient responsibility amounts. **For Medicare Patients:** "I request that payment of authorized Medicare benefits be made on my behalf to Blue Ridge Footcare and Surgery, PLC for any services furnished to me by my podiatric physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services."
- Notice of Deemed Consent for HIV, Hepatitis B/C and Blood Testing:** I understand and acknowledge that Virginia Code 32.1-45.1 authorizes health care providers to test patients for HIV antibodies as well as Hepatitis B and C when the health care provider or any person employed by or under the direction of the health care provider is exposed to the bodily fluids of patients in a manner which may transmit blood borne pathogens. Pursuant to this law, the patient will be deemed to have consented to such testing and to have consented to the release of test results to the health care provider who may have been exposed. Positive test results will be disclosed as medically necessary for the patient's treatment or as required or permitted by law. I understand that the patient will be given an opportunity to have appropriate counseling in connection with such test results. The patient will make the provider aware per state law if they are positive for HIV, Hepatitis B or C.
- Use of Specimens and Tissues:** I hereby authorize Blue Ridge Footcare and Surgery, PLC to retain, photograph, preserve for scientific or teaching purposes, or dispose of at its convenience, any specimens taken from the patient's body during operation or procedure.
- Financial Policy:** Payment is requested at time of service, unless prior arrangements have been made. In the event that my account is turned over for collections, I agree to pay all costs related to collection, including court costs and 25% attorney fees that may ensue from collection proceedings. Any amounts that are patient responsibility will be collected at the time of service per our Office Financial Policy, which will be reviewed and signed by the patient.

Purpose of Content: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices (NPP) before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities and health care operations, of the uses and disclosures we may make of your protected health information (PHI), and of other important matters about your PHI. A copy of our notices is posted and a copy will be provided to the patient upon request. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our NPP. If we change our privacy practices, we will issue a revised NPP, which will contain the changes. Those changes may apply to any of your PHI we maintain. *You may obtain a copy of our NPP, including any revisions, by contacting: Dr. Theodore B. McKee, 111 Fairway Lane, Staunton, VA 24401 Phone# 540-885-8891 or Fax# 540-885-0016.*

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the office. Please understand that revocation of the consent will not affect any action we took in reliance on the consent before we received your revocation, and that we may decline to treat your or to continue treating you if you revoke this consent. I have had full opportunity to read and consider the contents of this consent form and the Notices of Privacy Practices. I understand that by signing this form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations. I acknowledge receipt of having received a copy of the Notice of Privacy Practices.

Patient Signature: _____

Date: _____

Witness _____

Date: _____

I grant permission to receive and discuss my protected health and financial information with this office to the following person(s)

Name: _____ Is this your Power of Attorney? _____

By checking this box, I grant Blue Ridge Footcare and Surgery, PLC permission to leave voicemails and/or text reminders to the number provided.

I grant Blue Ridge Footcare and Surgery, PLC to retrieve my prescription history.



Office Policy for Doctors Appointments, Surgery, & Patient Accounts

1. Deductibles and Co-Payment

We are committed to providing exceptional podiatric care for our patients. In order to do so, we must run the financial aspects of our practice as efficiently as possible; therefore, **deductible and co-payment amounts will be collected at the time of service.** Co-payments, coinsurance, and payment for non-covered services are due the day of the appointment unless prior arrangement have been made with the billing department. For your convenience we accept cash, credit card, or check.

2. Scheduled Appointments

Our office understands that delays can happen and life is hectic; however, we must try to keep other patient’s appointments with our doctors on a timely schedule. **If a patient is 20 minutes or more past their scheduled appointment time, we reserve the right to reschedule your appointment.**

3. Cancellation/ No Show Policy for Doctor’s Appointment

We understand there are times when you must miss an appointment due to emergencies or obligations for work or family; however, when you do not call to cancel an appointment, you may be preventing another patient from receiving much needed treatment. **If an appointment is not cancelled with at least four hours advance notice OR you do not show for your appointment, you will be charged a \$50.00 fee per visit; this will not be covered by your insurance company.** **Cancellation/ No Show Policy for Surgery:** Due to the large block of time needed for surgery, last minute cancellations can cause problems with our appointment schedule and prevent another patient from receiving treatment. **If surgery is cancelled the same day or you do not show for a surgical appointment, you will be charged a \$200.00 fee; this will not be covered by your insurance company.**

4. Account Balances

Our office requires that patients with self-pay accounts pay for their visit in full at the time of service. Patients with a balance over **\$100.00** must make payment arrangement prior to future appointments being scheduled. Please contact the billing department with any questions.

5. FMLA/ Short Term Disability Paperwork

Effective June 1, 2013 there will be a **\$25.00 fee** for FMLA or Short Term Disability paperwork to be filled out. This fee is to be paid *before* paperwork is filled out.

I have had the opportunity to read and consider the contents of this office policy and guidelines. I understand, that by signing this form, I am consenting to the policies carried out by Blue Ridge Footcare and Surgery, PLC.

Print Patient Name

Signature Patient/Guardian

____/____/____
Date