Practice: **Today's Date:**

Name: ____ **DOB:** ____ **Chart Number:** ____

Sex: ☐M ☐F **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced **SS#:** ____

E-mail: ____ **Spouse/Partner Name:** ____

E-mail newsletters, reminders, statements, etc. **Emergency Name:** ____ **Phone:** ____

Address: ____ **City:** ____ **State:** ____ **Zip:** ____

Home #: ____ **Cell #:** ____ **Other #:** ____

Employer: ____ **Phone:** ____

Employer Address: ____ **City:** ____ **State:** ____ **Zip:** ____

Primary Insurance: ____ Are you the insured? ☐Yes ☐No

Insured Information

Subscriber Name: ____ Relationship to insured: ☐Spouse ☐ Child ☐Self ☐ other

Phone #: ____ Sex: ☐Male ☐Female DOB: __/__/__

Address: ____

Policy ID: ____ Group ID: ____ Employer: ____

Secondary Insurance: ____ Are you the insured? ☐Yes ☐No

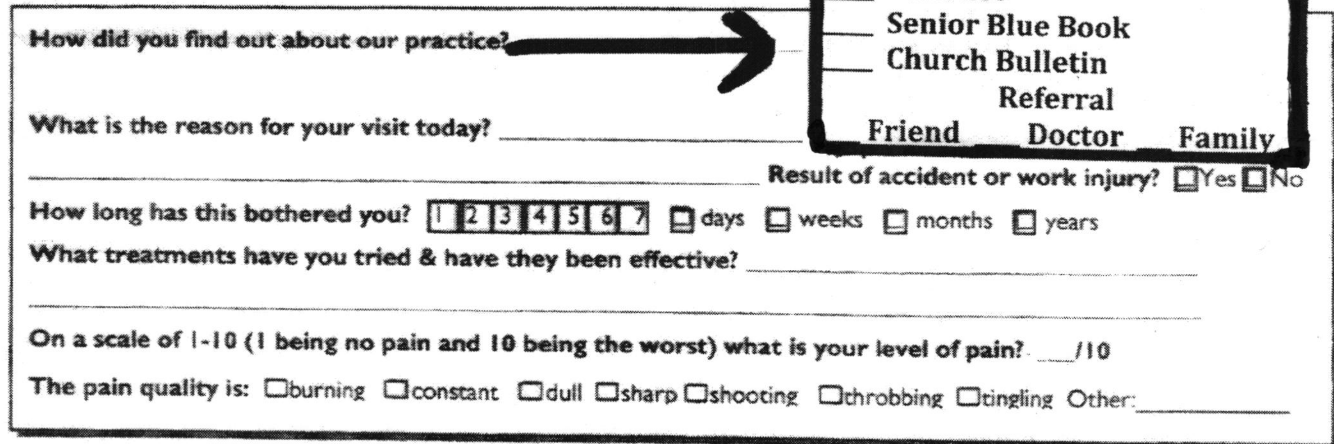
Insured Information

Subscriber Name: ____ Relationship to insured: ☐Spouse ☐ Child ☐Self ☐ Other

Phone #: ____ Sex: ☐Male ☐Female DOB: __/__/__

Address: ____

Policy ID: ____ Group ID: ____ Employer: ____



How did you find out about our practice?

__ **Internet**
__ **Senior Blue Book**
__ **Church Bulletin**
Referral
Friend **Doctor** **Family**

What is the reason for your visit today? ____

____ **Result of accident or work injury?** ☐Yes ☐No

How long has this bothered you? 1 2 3 4 5 6 7 ☐ days ☐ weeks ☐ months ☐ years

What treatments have you tried & have they been effective? ____

____

On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain? __/10

The pain quality is: ☐burning ☐constant ☐dull ☐sharp ☐shooting ☐throbbing ☐tingling Other: ____

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: ____ Date: ____

Rev 1/21/2015

Practice: **Today's Date:**

Name: ______________________ **Chart #:** ________ **Date of birth:** ____________

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to specify

Race: ☐ Asian ☐ American Indian or Alaska Native ☐ Black or African American
☐ White ☐ Native Hawaiian or other Pacific Islander ☐ Declined to specify

Preferred Language: ______________________ ☐ Declined to specify

Pharmacy Name: ______________________ **Pharmacy Phone:** ____________

Pharmacy Address: ______________________ City, State, Zip: ____________

Primary Care Physician: ____________ Phone: ____________ Date Last Seen: ____________

Address: ______________________

Referring Physician: ____________ Phone: ____________ Date Last Seen: ____________

Address: ______________________

Privacy Information Preferences

Do you want to be exempt from public reporting? ☐ Yes ☐ No Can we send mail to the address on file? ☐ Yes ☐ No

Can we call the phone number on file? ☐ Yes ☐ No Can we leave voicemail on machine? ☐ Yes ☐ No

Will you allow us to send internet based (e-mail) delivery of reminders and newsletters? ☐ Yes ☐ No

If yes, please provide your e-mail address: ______________________

Who can we leave messages with? ☐ Wife ☐ Husband ☐ Daughter ☐ Son ☐ Other: ____________

Name(s): ______________________

Smoking Status

☐ Current Every Day ☐ Smoker, Current Status Unknown
☐ Current Some Day ☐ Heavy Tobacco ☐ Unknown If Ever
☐ Former ☐ Never ☐ Light Tobacco ☐ decline to answer

Vital Signs

Blood Pressure: ________ / ________

Height: ____________ Weight: ____________

Current Medications

☐ No Known Medications ☐ I take the following medications:

Name / Dose: ______________________
Name / Dose: ______________________
Name / Dose: ______________________
Name / Dose: ______________________
Name / Dose: ______________________
Name / Dose: ______________________
Name / Dose: ______________________
Name / Dose: ______________________

Use the back of this form if more room is needed

Allergies

☐ No Known Allergies ☐ No Known Drug Allergies

Name: ____________ Reaction: ____________
Name: ____________ Reaction: ____________
Name: ____________ Reaction: ____________
Name: ____________ Reaction: ____________
Name: ____________ Reaction: ____________
Name: ____________ Reaction: ____________
Name: ____________ Reaction: ____________
Name: ____________ Reaction: ____________

Last Flu Shot Date: ____________ **Did you get a pneumococcal vaccination?** ☐ Yes ☐ No

Have you fallen in the last 12 months? ☐ Yes ☐ No **Were you injured from the fall?** ☐ Yes ☐ No

Advanced Directives: ☐ Living Will ☐ DNR ☐ Durable Power of Attorney ☐ Surrogate Appointed ☐ None

PLEASE READ AND SIGN: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment. I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. *(Assignment of Benefits)*: I authorize payment of medical benefits to the practice named above. *(Release of Information)*: I authorize the release of any medical information necessary to process this claim. *(HIPAA Privacy)*: I acknowledge that I received my HIPAA Privacy Practices Notice. *(Medication History)*: I authorize the Doctor's office to retrieve my medication history.

Patient Signature: ______________________ Date: ____________

History and Physical

Name: ______________________ **DOB:** ________ **Chart Number:** ________

Medical History:

☐ Alcoholism ☐ Blood disorders ☐ Circulation problems ☐ Musculoskeletal ☐ Breathing issues
☐ Liver ☐ Sleep apnea ☐ Gout ☐ Allergies ☐ Heart disease ☐ Asthma
☐ Heart murmur ☐ Stomach/bowel ☐ Depression ☐ Anxiety disorder ☐ Mental illness ☐ Kidney disease
☐ Blood clot ☐ High cholesterol ☐ High blood pressure ☐ Cancer ☐ Hepatitis
☐ Neuropathy *(specify)* __________ ☐ Thyroid disease *(specify)* __________ ☐ Diabetes (type 1, type 2)
☐ Arthritis *(specify)* __________ ☐ other *(specify)* __________ ☐ HIV ☐ CVA
Are you pregnant? ☐ Yes ☐ No **Are you nursing?** ☐ Yes ☐ No ☐ Skin disorders ☐ Stroke

Surgical History ☐ None ☐ Appendectomy ☐ C-Section ☐ Angioplasty ☐ Bypass ☐ Cataracts ☐ Cholecystectomy

Have you ever had any surgical procedures on foot/ankle or anywhere else on your body? ☐ Yes ☐ No

If yes, please describe: ______________________________

Do you have any artificial joints? ☐ Yes (where? __________) ☐ No Do you have an artificial heart valve? ☐ Yes ☐ No

Social History

Do you smoke? ☐ Yes ☐ No If yes how many packs per day? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 For how long?

Do you drink alcohol? ☐ Yes, everyday (5-7 days/week) ☐ Yes, occasionally/socially ☐ No/Rarely

Substance abuse: ☐ Yes, I have a current substance abuse problem. Please specify: __________

☐ Yes, I had a past substance abuse problem. Please specify: __________

☐ No, I have never had a substance abuse problem

What is your occupation? __________ Does it involve mostly ☐ standing or ☐ sitting

Do you exercise regularly? ☐ No, I do not exercise regularly ☐ Yes, I do the following regular exercise: __________

____

Family History Is there any family history *(blood relative)* of: *(Please indicate family member)*

☐ Alzheimer's	________	☐ Depression	________
☐ Arthritis	________	☐ Diabetes	________
☐ Bleeding disorders	________	☐ Emphysema	________
☐ Blood clot	________	☐ Heart disease	________
☐ Cancer	________	☐ High Blood Pressure	________
☐ Cataracts	________	☐ Neurological	________
☐ Circulation problems	________	☐ Strokes	________
☐ Other (specify):	________		

Review of Systems *(Please check the box if you currently have any of these symptoms or check "NONE")*

System					
Cardiovascular	☐ leg pain when walking ☐ fainting	☐ fever ☐ palpitations	☐ chest pain/pressure ☐ vascular disease	☐ leg swelling ☐ valve problems	☐ cold hands/feet ☐ **NONE**
Genitourinary	☐ blood in urine ☐ decreased frequency	☐ hesitancy ☐ excessive urination	☐ incontinence ☐ kidney disease	☐ increased urgency ☐ kidney stones	☐ **NONE**
Gastrointestinal	☐ abdominal pain ☐ diarrhea	☐ heartburn ☐ blood in stool ☐ vomiting ☐ trouble swallowing	☐ decrease appetite	☐ ulcers ☐ increase appetite	☐ constipation ☐ **NONE**
Integumentary	☐ athletes foot ☐ nail abnormalities	☐ keloids	☐ itchiness	☐ dry, scaly skin	☐ **NONE**
Hematologic	☐ lower leg ulcers ☐ sickle cell disease	☐ anemia	☐ blood thinners	☐ clotting disorder	☐ **NONE**
Neurological	☐ tingling ☐ tremors	☐ weakness ☐ paralysis	☐ seizures	☐ numbness	☐ headaches ☐ **NONE**
Musculoskeletal	☐ back pain ☐ joint swelling ☐ sciatica ☐ joint stiffness	☐ muscle weakness ☐ joint pain	☐ joint instability	☐ muscle pain ☐ arthritis	☐ neck pain ☐ **NONE**
Respiratory	☐ chest pain ☐ shortness of breath	☐ wheezing ☐ emphysema	☐ COPD	☐ coughing	☐ snoring ☐ **NONE**

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: ______________________ Date: ______________

Rev 1/21/2015

David N. Gavin, DPM, FACFAS

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Fort Myers, FL 33908
Office: 239-887-4621 Fax: 239-887-4623

David N Gavin, DPM, FACFAS
Board Certified, American Board of Podiatric Surgery
Fellow American College of Foot and Ankle Surgery

Patient Name: ______________________

Date of Birth: ____________________

HIPPA
Health Insurance Portability Accountability Act

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability Accountability Act of 1998, I have certain rights to privacy in regards to my protected health information (PHI). I have been offered a copy, and or read the contents provided in the office, and understand the Notice of Privacy Practice.

David N. Gavin, DPM, FACFAS reserves the right to change the terms of it's Notice of Privacy Practice. I understand the Practice will provide a current Notice of Privacy upon request.

________________________ ____________

Patient's Signature/Guardian Date

A. Notifier:

B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.**____________ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**____________ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
• **Routine Foot Care** • **Orthotics** • **Medical Supplies** • **RX Prescriptions**		

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**____________ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the D.____________ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**____________ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.**____________ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

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Patient Insurance and Payment Responsibility Contract

The staff is fully committed to providing you with the best service and medical care while under our care. We understand that insurance billing and patient responsibility can sometimes be challenging to understand. To ensure you fully understand and comply with our payment policy we require all patients review and sign this contract prior to seeing the doctor for the initial visit. Please read carefully and initial each line.

Insurance

A.____ We participate with may insurance plans. Your plan's benefits is a contract between you and your Insurance company; **we are not a party to the details of the contract**. Knowing the details is your responsibility. Please contact your insurer as soon as possible with any questions you may have regarding your coverage to receive its maximum benefit. Be Aware that not all services are covered by all insurance plans and coverage varies from state to state. **Services not covered are your financial responsibility.**

B.____ If your plan is NOT one in which we participate "in-network", you may want to seek an "in-network" provider. If you choose to see Dr. Gavin a "self-pay" payment is due in full the day of your appointment, prior to leaving the office. We give a15% discount to self-pay patients.

C.____ Insurance co-payments are collected at time of service. Co-insurance and deductibles are due with-in two weeks of receiving a statement in the mail from our office. It is important to note that after the claim is submitted the insurance company sends the provider a remittance of payment; this is where the amount to bill patient is located. If we find the patient has an over payment after the claim has been fully processed a refund will be issued. Once a claim is submitted the insurance company sends the patient an EOB (Explanation of Benefits) please refer to this with any question or call the insurance company with any billing questions.

D.____ We will submit your insurance claim in a timely manner and assist you in any reasonable way that we can, to help get your claim paid. Your insurance company may not approve all services charged and may require more information. We will submit claim a second time; however **it is your financial responsibility to pay what your insurer does not cover.**

E.____ Depending on your medical plan, some medical services may require pre-authorization, either directly through a specific referral from your Primary Care Physician. It is **your** responsibility to request and obtain the appropriate authorization. from you PPC or insurer. You will be responsible for payment of services that are not authorized in advance

PAYMENT COLLECTION RULES

F.____ When an account has a balance that is owed by the patient, we will mail up to two monthly statements. During that time you must make every effort to pay. If this is difficult, call the office to discuss a payment arrangement.

G.____ When an account is more than 90 days past due, and no payment arrangement has been initiated, a final letter will be sent stating that, in 30 days, your account will be sent to our collection agency. Take note: that as per our business policy, we are unable to do continued business with a patient who is currently past due.

The undersigned hereby obligate him/her to pay the patient account balance, as mention above, for the medical services rendered. **If this account is referred to the collection agency for payment, the undersigned agrees to also to pay the collection fees of 30% in conjunction with the delinquent account.**

____
Patient's Signature

____
Print Patient's Name

____
Date