Dr. Bradley Herbst, DPM
Medicine and Surgery of the Foot & Ankle
Podiatry Associates of Florida, Inc.

Phone: (904) 268-6993
Fax: (904) 260-1523
www.herbstpodiatry.com

NEW PATIENT INFORMATION

First Name:		Middle Name:		Last Name:
Date of Birth:		Gender:		SSN:
ADDRESS:				
City:		State:		Zip:
Cell #:		Home #:		Email:
MARITAL STATUS (*circle one*):	Married	Divorced	Single	Other/Decline:

IF PATIENT IS A MINOR – PARENT INFORMATION

First Name:	Last Name:
Date of Birth:	SSN:

INSURANCE COMPANY #1	**INSURANCE COMPANY #2**
Policy Holder Name:	Policy Holder Name:
Member ID:	Member ID:
Policy Holder's DOB:	Policy Holder's DOB:
Policy Holder's SSN:	Policy Holder's SSN:
Relationship to patient:	Relationship to patient:

PATIENT CONTACTS

Primary Care Provider:	PCP Phone #:
PCP Address:	
Pharmacy:	Pharmacy Phone #:
Pharmacy Address/Location:	
Emergency Contact:	Relationship to Patient:
Emergency Contact Phone #:	
Place of Employment:	Employer Phone #:
What type of work do you do?	

HOW DID YOU HEAR ABOUT US? _____

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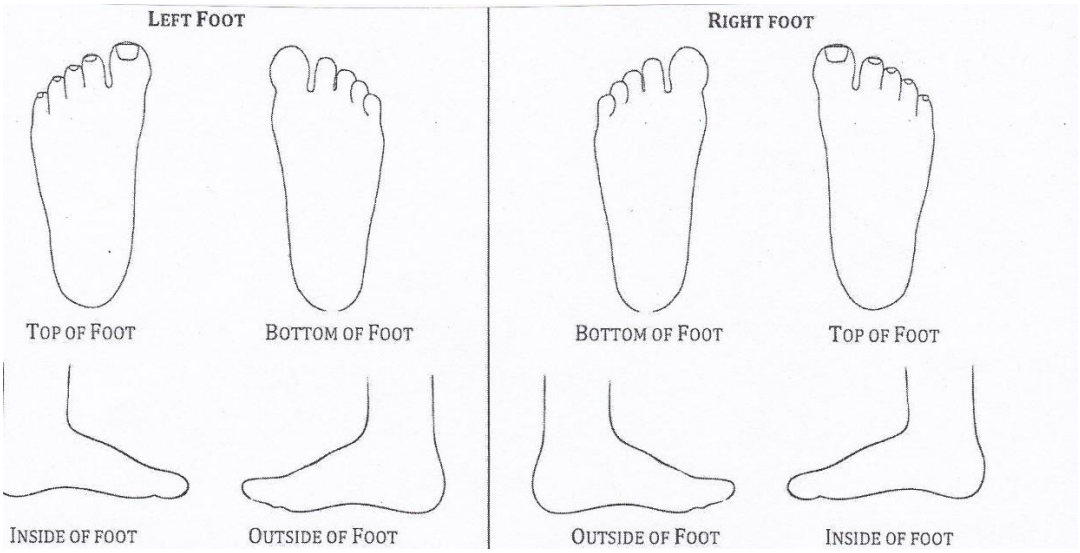
REASON FOR TODAY'S VISIT: _____

_____

PLEASE MARK ON THE PICTURE BELOW WHERE YOUR ISSUE(S) IS



CURRENT MEDICATIONS *(list below or attach list)*	**ANY KNOWN ALLERGIES** *(list below)*
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

PAST MEDICAL HISTORY *(check any of the following if you still have, or have ever had)*

Abnormal Bleeding		Fibromyalgia		Pneumonia	
Acid Reflux		Gout		Problems with Anesthesia	
AIDS / HIV		Heart Attack		Psychiatric Care	
Anemia		High Blood Pressure		Rheumatic Fever	
Arthritis		Kidney Disease		Sickle Cell Disease	
Back Trouble		Liver Disease		Skin Disorder	
Blood Clots		Low Blood Pressure		Sleep Apnea	
Blood Transfusion		Migraines		Stomach Ulcers	
Cancer		Mitral Valve Prolapse		Swelling Ankle/Feet	
Diabetes		Neuropathy		Stroke	
Emphysema		Open Sores		Tuberculosis	

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Are you Diabetic? *(circle one)* YES NO

If yes, who is your supervising provider? (PCP or Endocrinologist)? _____

Date of last PCP/Endocrinologist Appointment: _____

SURGICAL HISTORY *(list all your surgeries in the past 10 years)*

1.	Year:
2.	Year:
3.	Year:
4.	Year:
5.	Year:

YOUR FAMILY HISTORY *(check all that apply)*

Cancer		Heart Disease	
Coronary Heart Disease		High Blood Pressure	
Diabetes		Rheumatoid Arthritis	
Gout		Thyroid Disease	
Heart Attack		Stroke	

YOUR SOCIAL HISTORY

Do you use tobacco?	If yes, what form?	Former smoker?
Do you use alcohol?	If yes, how often?	History of alcohol abuse?
Do you use recreational drugs?	If yes, what type?	How often?

RE: REASON FOR TODAY'S VISIT - WHAT MAKES YOUR PAIN/ISSUE FEEL <u>WORSE</u>? *(check all that apply)*

Running		Dress Shoes	
Walking		High Heels	
Standing		Flat Shoes	
Daily Activities		Any closed toe shoe	
Resting		Other?	

RE: REASON FOR TODAY'S VISIT - HAVE YOU HAD ANY PREVIOUS TREATMENTS FOR THIS PROBLEM?

No	Yes	If yes, what treatment, and when?

RE: REASON FOR TODAY'S VISIT - WAS THIS PROBLEM/ISSUE CAUSED BY AN INJURY?

No	Yes	If yes, describe & was it work related?

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RE: REASON FOR TODAY'S VISIT - HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR YOUR ABILITY TO WORK?

EXERCISE? *(circle one)*

Daily	Occasionally	Rare	Never	Type:

HOW MUCH ARE YOU ON YOUR FEET AT WORK? *(circle one)*

N/A	0%	25%	50%	75%	100%

We are required to ask the following questions; however, you may choose not to answer:

Ethnicity: *(circle one)* Hispanic or Latino Not Hispanic or Latino	**Race:** *(circle one)* White American Indian/Alaska Native Black/African American Native Hawaiian/Pacific Islander Hispanic/Latino Other/Decline

PAYMENTS: Copays or co-insurance are due at the time of service (which includes Medicare patients). Self-pay patients are required to pay in full at the time of service. Your medical claim will be forwarded to your secondary insurance (if any) after payment is received from your primary insurance. You are required to follow the guidelines of your managed care plan.
You will be sent up to three notices for your financial responsibility after payment is received from your insurance company. After the third notice, your account will be forwarded to collections.
An additional $40.00 will be added to your account for all returned checks.
It is your responsibility to inform us of any changes to your health insurance information.
You agree to pay Podiatry Associates of Florida for any remaining balance after insurance payment has been made.

To the best of your knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous for my health. I understand that it is my responsibility to inform the doctor and/or office staff of any changes in my medical status.

_____

Print name of patient, parent or guardian

_____

If other than patient, relationship to patient

_____

Signature Date

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ACKNOWLEDGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided with a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understand the Notice.

_____

Patient Name Date

_____

Signature

_____

Parent or Guardian Signature

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PATIENT FINANCIAL AGREEMENT

This letter sets forth the financial policy for Podiatry Associates of Florida, Inc.

I understand that, as a recipient of medical care, I, the undersigned, am responsible for all charges regardless of any circumstances. Upon signing below, I acknowledge and agree that payment in full is due on the date of service. I agree that the determination of the professional services to be rendered by my doctor and the fees to compensate him/her for these services are matters which concern my doctor and myself. I understand that I have the primary duty and obligation to pay my doctor for his/her services, notwithstanding any contract I may have with a third party (i.e., insurance company, employer, etc.).

I, the undersigned, do hereby authorize the release of all information or documents to all parties related to obtaining my insurance benefits for claims submitted on my behalf or my dependents' behalf. Further, I expressly agree and acknowledge that my signature on this document authorizes my physician and all necessary parties to submit claims for services rendered, without obtaining my signature on each claim. Additionally, I will be bound by this signature as if the undersigned had personally signed the particular claim.

I hereby authorize my insurance company to pay and assign directly to Podiatry Associates of Florida, Inc. all benefits. I understand that I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received and paid will be credited to my account. All unpaid charges are my responsibility.

Patient balances are due immediately and are not contingent upon receiving a statement. Insurance companies provide an explanation of benefits outlining payments and patient balances.

Should I fail to pay outstanding charges for more than thirty (30) days, I will incur a service fee of $30.00. Accounts with no activity for sixty (60) days will be forwarded to further collection action. If I default and my account is referred to a collection agency or attorney, I will be responsible for all the costs of collecting monies owed, including interest, court costs collection agency and/or attorney fees.

Should I fail to show for an appointment, or give at least 24 hours' notice of cancellation, I agree to pay a fee of $30.00 per occurrence.

I understand that it is my responsibility to know what the terms of my insurance are, and in compliance with those terms, agree to the following:

- I agree to provide Podiatry Associates of Florida, Inc. with complete and accurate billing information, including, but not limited to, a current insurance card, authorization numbers and/or referral forms for each visit and/or procedure. I am responsible for all visits and procedures not properly authorized.
- I will pay for all applicable copays and any outstanding patient balances as they become due. Copays and any outstanding patient balance is due at each visit.
- Deductibles are due at the time of service.
- Surgery copays/co-insurance/deductibles are due two (2) days prior to surgery.

I give my consent to Podiatry Associates of Florida, Inc. to provide medical care and treatment, deemed necessary and proper in diagnosing or treating his/her/my physical condition, to the below named patient.

I HAVE READ AND AGREE TO THE TERMS OUTLINED ABOVE

Print name: _____

Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____