Acct. #_____

WOODLAKE PODIATRY, LLC

****(PLEASE FILL OUT ALL SECTIONS COMPLETELY- We are private practice; we do not have access to your St. Luke's records)****

LAST NAME_____FIRST NAME_____ MIDDLE INIT._____

STREET_____ CITY_____ STATE_____ ZIP_____

SSN_____ DOB_____/_____/_____ MALE / FEMALE

HOME PHONE_____ CELL PHONE_____

WORK PHONE_____ E-MAIL ADDRESS _____

EMPLOYER_____ YOUR OCCUPATION _____

Primary Care Doctor_____ Phone _____ Date Last seen_____

How did you hear about our office? ☐ Insurance Directory ☐ Website ☐ St. Luke's

Referred by Physician (name) _____ Referred by friend _____

****(DO NOT repeat if same as above)****

RESPONSIBLE PARTY: (If Minor or POA) **RELATIONSHIP TO PATIENT: _____**

LAST NAME_____FIRST NAME_____ MIDDLE INIT._____

STREET_____ CITY_____ STATE_____ ZIP_____

SSN_____ DOB_____/_____/_____ MALE / FEMALE

HOME PHONE_____ CELL PHONE_____

INSURANCE INFORMATION:

PRIMARY INS._____MEMBER # _____GROUP #_____

SUBSCRIBER_____ DOB ____/_____/_____

SECONDARY INS._____MEMBER # _____GROUP #_____

SUBSCRIBER_____ DOB ____/_____/_____

PLEASE READ AND SIGN [I HEARBY GIVE MY PERMISSION TO THE DOCTORS OF WOODLAKE PODIATRY, LLC TO ADMINISTER TREATMENT AND TO PERFORM SUCH PROCEDURES AS MAY BE DEEMED NECESSARY IN THE DIAGNOSIS AND/OR TREATMENT OF MY FOOT CONDITION. I HEARBY AUTHROIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO WOODLAKE PODIATRY, LLC AND THE RELEASE OF ANY INFORMATION REQUIRED BY THIRD PARTY PAYORS IN CLAIM PROCESSING AND UNDERSTAND THAT I AM FINANICALLY RESPONSIBLE FOR ANY REMAINING BALANCE.]

_____ _____

SIGNATURE (PATIENT/RESPONSIBLE PARTY) DATE

Podiatry History:

Reason for today's visit: *(Describe in Detail)*_____

_____

Nail care: Y / N **Callus care:** Y / N **Do your nails and/or calluses cause any pain or irritation?** Y / N

Are you having foot pain? Yes or No **If Yes, how long have you had this pain?** _____

Which Foot: Left | Right | Both

Rate your pain on a scale of 1 - 10 (1 is minimal to no pain)_____

Have you been to a podiatrist before? Yes | No **If Yes:** Dr._____ Date Last Seen _____

Allergies:

☐ **No Known Drug Allergies (PLEASE✓ ALL THAT APPLY OR WRITE IN OTHER)**

Allergy	YES	Reaction	Allergy	YES	Reaction
Adhesive/Tape			Novocain		
Aspirin			Penicillin		
Codeine			Shellfish		
Iodine			Sulfa Drugs		
Latex			X-Ray Dye		
Other (please list):					

Current Medications:

Attach a list OR Please list medications and dosage below:

Medication	Dosage	5.	
1.		**6.**	
2.		**7.**	
3.		**8.**	
4.		**9.**	

Pharmacy: _____ **ZIP:** _____ **Phone:** _____

Medical History:

✓ **YES** below if you are **currently** being treated for **OR have been** treated for in the past, **list any not provided**.

Problem	Yes	Problem	Yes	Problem	Yes
Anxiety		Heart Attack		Psoriasis	
Arthritis		Heart Disease		Psychiatric	
Asthma		Hepatitis **(A B C)**		Pulmonary Embolism	
Cancer **(specify below)**		High Blood Pressure		Rheumatoid Arthritis	
Diabetes **(type I or II)**		High Cholesterol		Seizure Disorders/ Epilepsy	
Emphysema		HIV/AIDS		Stomach Ulcer	
Fibromyalgia		Kidney Disease		Stroke/ TIA	
GERD (acid reflux)		Mitral Valve Prolapse		Thyroid Disorder	
OTHER:					

Previous Surgeries:

_____

_____

_____

Social History:

	Yes	No	Only in Past	**Current Employment Status**	Yes	No
Drink Alcohol				Are you currently employed?		
Use Illegal Drugs				How many hours do you stand at work (daily)?		
Tobacco Use				What type of work do you do?		

Family History: (PLEASE LIST ANY NOT PROVIDED UNDER OTHER)

Condition	Yes	Relationship	**Other (list below):**	Yes	Relationship
Diabetes					
Heart Disease					
Foot Problems			Cancer		

Review of Systems:

Please ✓any symptoms you are **currently experiencing, please list any not provided.**

Symptom	Yes	**Symptom**	Yes	**Symptom**	Yes
Back Pain		Fatigue		Numbness/Tingling	
Bleeding Problems		Fever		Ringing in the ears	
Chest Pain		Headaches/Migraines		Skin Problems	
Chills		Heartburn/Indigestion		Swelling	
Difficulty Breathing		Joint Discomfort/Pain		Urinary Problems	
Dizziness		Muscle Pain		Excessive Weight Gain	
Eye/Vision Problems		Nose Bleeds		Excessive Weight Loss	
Other (please list):					

Demographics:

Language?	□ English □ Decline to answer □ Spanish □Other _____
What is your race?	□ American Indian or Alaska Native □ Decline to answer □ Asian □ Black/African American □ Caucasian (white) □ Native Hawaiian or Other Pacific Islander
What is your ethnicity?	□ Hispanic or Latino □ Decline to answer □ **Not** Hispanic or Latino

Marital Status? □ Married □ Divorced □ Widowed □ Single □ Other_____

If you have:

□ Diabetes: Last checked blood sugar: _____ Result: _____

Managing Dr.: _____ Last HbA1c Result: _____

□ History of Hypertension (High BP): Are you currently taking medication? Y / N

Smoking Status:

□ **Current Smoker** *Every Day* (Patient smokes every day)

□ **Current Smoker** *Some Day* (Patient smokes infrequently but has smoked more than 100 cigarettes)

□ **Former Smoker** (Patient was a "Current Smoker" in the past, but no longer smokes)

□ **Never a Smoker** (Patient has smoked less than the equivalent of 100 cigarettes in his/her life)

□ **Unknown if ever smoked** (patient is unable or refuses to answer)

□ **Current Other Tobacco products** (vape, cigar, dip)

Do you have an Advanced Care Directive: Y / N

Do you have a Power of Attorney: Y / N (Please provide documents)

Flu Vaccine: Y / N **If yes, Date or Dates:** ____/_____/_____

If no, why: Allergy / Decline

Pneumonia Vaccine: Y / N

COVID-19 Vaccine: Y / N **List Full Dates**: 1.____/____/____ 2.____/____/____ 3.____/____/____

Vaccine Type: Pfizer / Moderna / J&J

Height: _____ **Weight:** _____ **Shoe Size:** _____

Woodlake Podiatry, LLC

Privacy Policies

To make communications concerning appointments, treatment and billing matters easier, law requires your consent to release personal health information.

Please list specific names of family members and/or friends that have your permission to obtain information for this office regarding your care and personal information.

NAME: RELATIONSHIP:

_____ _____

_____ _____

_____ _____

EMERGENCY CONTACT: _____ PHONE: _____

I give my permission to leave a message pertaining medical or account information on my:

Home voicemail_____ Cell Voicemail_____ Work Voicemail_____ E-mail_____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES:

I have received/have access to a copy of this office's updated Notice of Privacy Practices.

_____ _____

Signature of patient/legal guardian (POA must present documentation) Date

Woodlake Podiatry, LLC
Financial Policies

Thank you for choosing Woodlake Podiatry LLC for your foot, ankle, and wound care. We are committed to the success of your medical treatment and care. Please understand that payment of your bills is part of this treatment and care.

Your Financial Responsibilities:

Our office will file insurance for all reimbursable services, to your primary and secondary insurance carriers. We will verify your insurance information at every visit to prevent any billing issues. It is the responsibility of the patient to notify us of any insurance changes. **We will not refile claims if insurance was not reported to the office correctly**. Please remember that **you are responsible for all deductible, co-pay, and non-covered service amounts**. We accept payment by cash, check, Master Card, Visa, and Discover. You will receive billing statements from our office for account balances that are your responsibility. Balance in full is due within 15 business days. If you would like to set up a payment plan, please contact our office and we will discuss the amount that is due each month. It will be your responsibility to send in the amount the same day of every month.

- **HMO, POS, and PPO plans that Woodlake Podiatry LLC contracts with:** If the services you receive are covered by your plan **you are responsible for all applicable co-pays, deductibles, and balances, and these are to be paid at the time of service**. If the services you receive are not covered by the plan, payment in full is requested at the time of service unless other arrangements have been made.
- **Referrals:** If you have an HMO insurance plan, we are contracted with, you need a referral from your primary care physician authorizing this treatment. Referrals must be received 24 hours prior to appointment, if you are unable to obtain a referral for your visit, your appointment will be rescheduled.
- **Commercial insurance or PPO's that Woodlake Podiatry LLC does NOT contract with:** Woodlake Podiatry LLC will submit your claims to your carrier as a courtesy if all current and accurate information is provided. You will be billed for any remaining balance with the total amount due within 15 days of billing unless other prior arrangements have been made.
- **Medicare:** You will be responsible for any portion of your Medicare deductible that is not paid or covered by your secondary insurance. You will be responsible for any service not covered by Medicare. If you do not have secondary insurance, you will be responsible for the 20% co-pay once deductible has been met. Woodlake Podiatry LLC will submit Medicare and secondary claims. All patient balances remaining after Medicare and secondary payment will be billed to you and will be due within 15 days of billing by this office.
- **Medicaid:** Woodlake Podiatry LLC does not accept Missouri Medicaid and Missouri Health Net insurance as a primary insurance, only as a secondary insurance.
- **Workers Compensation:** Woodlake Podiatry does NOT accept Workers Compensation.
- **No Insurance (self-pay):** Woodlake Podiatry, LLC does NOT accept self-pay, our office only accepts contracted insurances.
- **Collections:** If the patient portion of your account is not paid and is delinquent 90+ days, collection efforts will be made through an outside agency. **Any collection agency fees incurred will be at your expense.**

Appointment policy: Woodlake Podiatry LLC requires 24-hour notice for cancelled appointments; otherwise, it will be considered a missed appointment. We will overlook up to 3 missed appointments, after that any missed appointments will be subject to a $50 charge. This is not covered by your insurance and is due before your next appointment can be made. If you do not wish to make any further appointments, payment will be due in a timely manner or will be subject to collections.
Cancelled/Returned Checks: Any cancelled or returned checks will be subject to a $25 fine. This is required to be paid before any future appointments will be scheduled.

- I authorize Woodlake Podiatry LLC to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.
- I authorize my insurance benefits be paid directly to Woodlake Podiatry LLC.
- I authorize WOODLAKE PODIATRY, LLC to obtain/have access to my medication history
- **_____ (please initial) I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-pays, deductibles, self-pay charges, and any charge from missed appointments are my responsibility.**

_____ _____

Signature of Patient or Responsible Party Date