Foot, Ankle & Leg Center
Phone: 480.629.5903 Fax: 480.629.8498

PATIENT INFORMATION

Name:_____ Date of Birth:_____/_____/_____
Last First Middle

Address: _____
Street City State Zip

Home phone: ( ) _____ Cell phone: ( ) _____

Work phone: ( ) _____ Fax: ( ) _____

E-mail address: _____ Social Security #: _____

Sex: ❒ Male ❒ Female Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Significant other

Race: ❒ American Indian ❒Asian ❒Black/African American ❒Native Hawaiian/Pacific Islander ❒White

Ethnicity: ❒ Hispanic/Latino ❒Non-Hispanic/Non-Latino

Preferred Language:_____

1) Is today's visit due to an injury at work, please check: ❒ YES ❒ NO
2) If yes, have you notified your personnel department? ❒ YES ❒ NO
3) Please give a brief description of injury:_____
_____

INSURANCE INFORMATION

Primary insurance: _____ Name of insured:_____

ID/Member#: _____ Group#:_____ Expiration date: _____

Insured date of birth: _____Social Security#:_____ Sex: ❒ M ❒ F

Patient's relationship to insured:_____

Secondary insurance: _____ Name of insured:_____

ID/Member#: _____ Group#:_____ Insured date of birth: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Home phone: ( ) _____

Cell phone: ( ) _____ Work phone: ( ) _____Ext.: _____

I hereby give Dr. Richer, Sonoran Foot Specialists, or his associates permission to treat me or my dependents as necessary. I understand my insurance company may assist me in paying my medical costs, but I am ultimately responsible for all medical services rendered and, if necessary, I agree to pay all reasonable and customary collection fees and/or attorney's fees that may be incurred due to any delinquent accounts I may have. I authorize the release of any medical information necessary to process my claim to my insurance company. I authorize my insurance company to pay benefits directly to my physician for services rendered. I understand that I am financially responsible for my bill.

Patient signature: _____ Date: _____

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Patient History Form

Name: _____DOB:_____ Age: _____ Height: _____ Weight: _____ Shoe size: _____

Current foot, ankle or leg problem: _____

_____

When did the problem start: _____

What has been done to treat the problem: _____

Name of family physician: _____ Date last seen: _____

Name of former podiatrist: _____ Date last seen: _____

Referred by: ❒ Doctor _____ ❒ Family ❒ Friend_____ ❒ Insurance
❒ Angie's List ❒ Zoc Doc ❒ Yelp ❒ Google ❒ Other _____

Pharmacy _____ Address/Intersection_____ City/Zip_____

MEDICAL HISTORY List all medical conditions. (Example: diabetes, neuropathy, stroke, heart attack, kidney failure, gout,etc)

1)_____ 6)_____
2)_____ 7)_____
3)_____ 8)_____
4)_____ 9)_____
5)_____ 10)_____
Other**:**_____

ALLERGIES: (penicillin, novacaine, tape, food, metals, etc.) ❒ **NONE**

1) _____ 3) _____
2) _____ 4) _____

MEDICATIONS: (please include dosage) ❒ **NONE**

1) _____ 6) _____
2) _____ 7) _____
3) _____ 8) _____
4) _____ 9) _____
5) _____ 10) _____

SURGERIES: (describe procedure, year, and any complications) ❒ **NONE**

1) _____ 4)_____
2) _____ 5)_____
3) _____ 6)_____

SOCIAL HISTORY

Occupation: _____ Alcohol: if yes, how much? _____
Tobacco: if yes, how much? _____ cigs/packs per day for _____ years

FAMILY HISTORY (diabetes, heart disease, gout, cancer, foot problems, other): _____
_____

Patient signature: _____ Date: _____

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Consent for Release of Information/Records

Date: ____/____/____

Patient's name: _____ Date of birth: _____/_____/_____
First Middle Last

Home phone: ( ) _____

I hereby give my permission for: _____
(doctor, hospital, agency)

Address: _____
Street City State Zip

Phone: ( ) _____ Fax: ( ) _____

To release or disclose to:

L. David Richer, DPM
9767 N. 91st Street, Suite 101
Scottsdale, AZ 85258
Ph: 480.629.5903 Fax: 480.629.8498

The following information, which shall be limited to:

- ❒ History & physical
- ❒ Physician's notes
- ❒ Lab results
- ❒ Operative/procedure reports
- ❒ Radiology reports
- ❒ Insurance card/driver's license
- ❒ Other: _____

This consent is subject to revocation at any time in the form of written notice from me, and shall apply to all future disclosures only.

Signature of patient/guardian: _____

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FINANCIAL POLICY

All patients are responsible for payment at time of service, unless prior arrangements had been made.

WE ACCEPT:

CASH, CHECK, DEBIT CARDS, MASTERCARD, VISA, DISCOVER

INSURANCE AND CO-PAYMENTS:

Insurance Co-pays are collected at the time of service. We do not bill for Co-pays.

DEDUCTIBLE/CO-INSURANCE:

If your insurance deductible is not met, full payment will be collected at the time of service.
If your deductible is met, your co-insurance amount will be collected at the time of service.

PRIVATE PAY:

If you have no insurance coverage or insurance that we do not participate with, full payment is expected at the time of service.

HMO INSURANCE:

Authorization is required in our office on the date of service.
If we have not received your authorization, your options are:

1. Reschedule appointment.
2. Accept charges as your responsibility and pay services in full.

DISABLILITY/WORK RELATED DOCUMENTS FILLED OUT BY PHYSICIAN:

A fee of $30.00 will be charged to complete documentation by the physician outside of normal medical charting.

RETURNS:

- Due to the unique nature of custom made items (foot orthotics, braces, etc), no refunds can be given.
- All other (non-custom) items may be returned within 14 days and will be assessed a 20% restocking fee.

COLLECTIONS:

Once an account is placed in collection, all future services must be paid in full at the time of service. Any balance assigned to collections will be assessed a 35% fee for recovery expense.

RETURNED CHECKS:

A $25.00 fee will be assessed for returned checks.

MISSED APPOINTMENTS:

Patients who fail to show up for their scheduled appointment and fail to notify the office 24 hours prior to their scheduled appointment will be charged a $30.00 No Show fee.

I HAVE READ AND AGREE TO ABIDE BY THIS FINANCIAL POLICY.

SIGNATURE:_____ DATE:_____

Do you have any of the following? Please mark an (X) in the spaces provided:

Constitutional Symptoms	X	Respiratory	X	Dermatologic	X
Cancer (type):		Are you on oxygen?		Calluses/corns	
Chills		Cough		Change in lesions or moles	
Excessive tiredness		Coughing up blood		Easy bruising of skin	
Fever		Coughing up mucus		Excessive scar tissue	
Night sweats		Shortness of breath		Lower leg/foot wounds or ulcers	
Poor appetite		Wheezing		Nail abnormalities	
Unintentional weight loss		**Other:**		Rash on feet or legs	
Other:				**Other:**	
Eyes	**X**	**Gastrointestinal**	**X**	**Neurological**	**X**
Blurred vision		Abdominal pain		Numbness in feet	
Cataracts		Blood in stool		Paralysis	
Glaucoma		Constipation		Poor balance	
Poor vision		Diarrhea		Sciatica	
Wears contacts		Heartburn		Seizures	
Wears glasses		Nausea		Tingling in feet	
Other:		Vomiting		**Other:**	
		Other:			
ENMT	**X**	**Genitourinary**	**X**	**Psychological**	**X**
Difficulty hearing		Blood in urine		Anxiety	
Difficulty swallowing		Currently pregnant		Depression	
Nose bleeds		Enlarged prostate		Difficulty concentrating	
Ringing in ears		Frequent urination		Seeing a psychiatrist	
Sore throat		On dialysis		Seeing a mental health professional	
Other:		Painful urination		Sleep disturbances	
		Other:		**Other:**	
Cardiovascular	**X**	**Musculoskeletal**	**X**	**Endocrine**	**X**
Ankle swelling		Joint pain		Cold intolerance	
Chest pain		Joint stiffness		Cuts take long time to heal	
Cold feet		Joint swelling		Extreme thirst	
High blood pressure		Low back pain		Frequent urination	
Irregular heartbeat		Muscle cramps		Heat intolerance	
Low blood pressure		Muscle weakness		**Hematologic**	**X**
Pain/cramping in legs with walking		**Other:**		Blood clotting disorder	
Tightness/heaviness in chest				Hepatitis: Type _____	
				HIV/AIDS	
Other:				Swollen glands	
				Other:	

► ►ALL PATIENTS PLEASE SIGN BELOW:

Patient Signature: _____ **Date:** _____

Printed Name: _____

12-Jun

NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. You have the right to obtain a copy of this Notice upon request.

Patient Health Information
Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We Use Your Patient Health Information
We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

***Examples* of Treatment, Payment, and Health Care Operations**
Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.
Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.
Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Special Uses
We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures
We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:

Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
Research: We may use or disclose information for approved medical research.
Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
Judicial and Administrative Proceedings: We may disclose information in response to an appropriate subpoena or court order.
Law Enforcement Purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.
Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.
Serious Threat to Health or Safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
Military and Special Government Functions: If you are a member of the Armed Forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
Workers' Compensation: We may release information about you for Workers' Compensation or similar programs providing benefits for work-related injuries or illness.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights
You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.
Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.
Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.
Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.
Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.
Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty
We arc required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices
We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints
If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person named below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person
If you have any questions, requests, or complaints, please contact:

Privacy Officer
Foot, Ankle & Leg Center
9767 N. 91st St, Ste 101
Scottsdale, AZ 85258
Effective Date: May 19, 2005

I, _____,
hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed:_____

Date: _____

If not signed, reason why acknowledgment was not obtained:

_____

_____

_____

_____

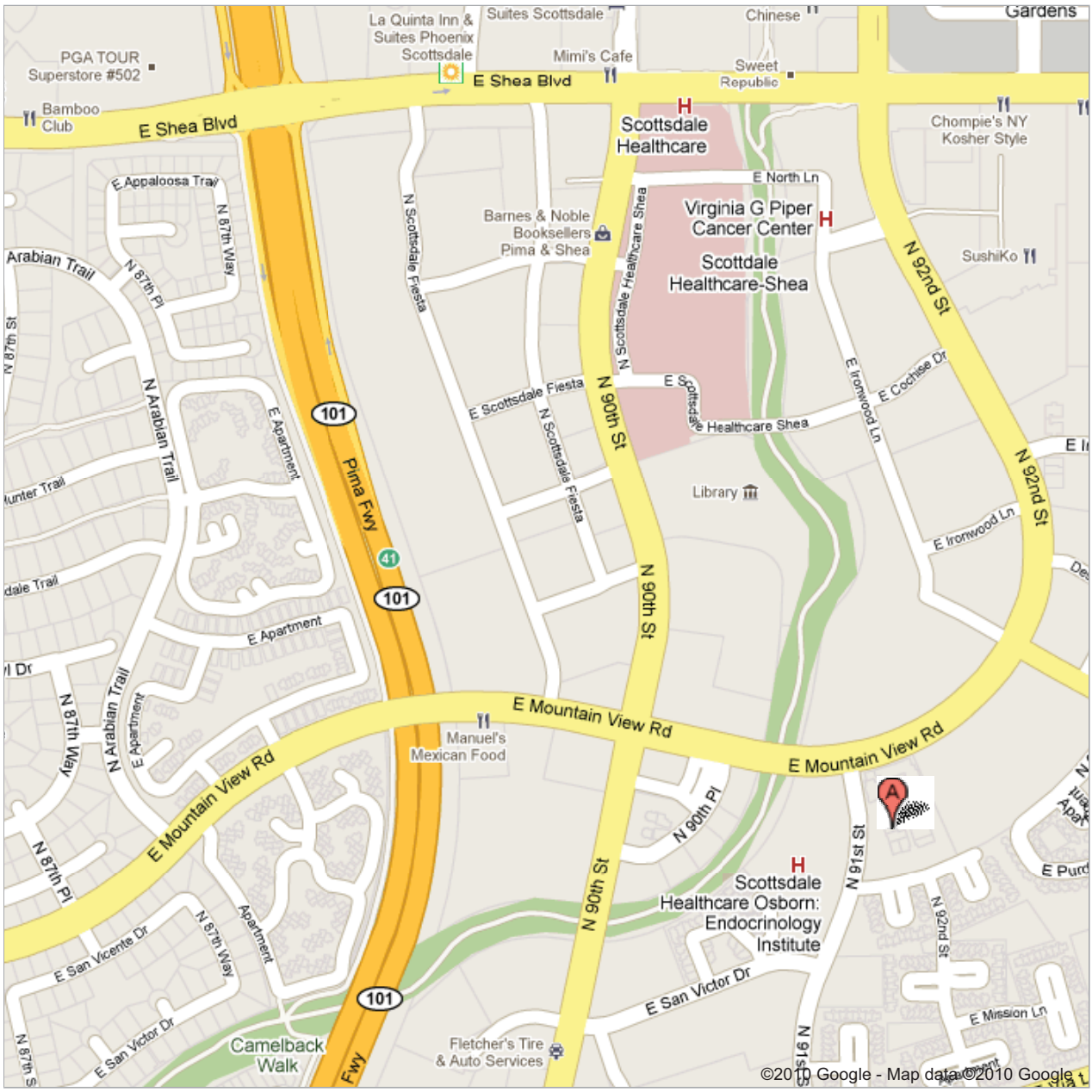
SFS rev 1/2010

Print

Google maps

Address **9767 N 91st St**
Scottsdale, AZ 85258

Notes Foot, Ankle & Leg Center
L. David Richer, DPM
480.629.5903



This symbol on the map represents our office location.

We are located in Mountain View Office Suites on the corner of E. Mountain View Road and N. 91st Street.

Mountain View Office Suites is a 1 story, red stucco medical complex. Make your second right turn once you enter the complex.