Patient Information & Health Records

In order to help us render the proper podiatric services to you, please complete this form entirely. We are not a part of Mercy or the Mercy Mychart. We have our own Patient Portal. Ask for your login. We thank you for your cooperation.

First Name:_____ Last Name:_____

DOB:_____/_____/_____ Sex: M/F/U Race:_____

Language:_____ Social Security:_____

Address:_____ APT:_____

City:_____ State:_____ Zip:_____

Martial Status:_____ Spouse Name:_____

Employment status: _____ Employer:_____
Occupation: _____

Patients Home Phone: (_____)-_____-_____ Patients Cell Phone: (_____)-_____-_____

Email:_____

Emergency Contact:_____ Phone: (_____)-_____-_____

Relation of Emergency Contact:_____

Primary Care Doctor:_____ Location:_____

Date Last Seen:_____/_____/_____ Phone:_____
**This is necessary for Medicare*

If patient is a minor or you are the primary caretaker, please fill out the following

Responsible Party:

First:_____ Last:_____

Relation:_____ Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

Primary Insurance Information

Name of Card Holder: _____

Relationship to Patient: _____

Name of Insurance Company: _____

Insurance Address: _____

City: _____ State: _____ Zip: _____

Insurance Phone: (____)-_____-_____ Employer of Card Holder:_____

Policy Number: _____ Group Number: _____

Date of Birth of Card Holder: ____/_____/_____

Secondary Insurance Information

Name of Card Holder: _____

Relationship to Patient: _____

Name of Insurance Company: _____

Insurance Address: _____

City: _____ State: _____ Zip: _____

Insurance Phone: (____)-_____-_____ Employer of Card Holder:_____

Policy Number: _____ Group Number: _____

Date of Birth of Card Holder: ____/_____/_____

Patient Information & Health Records

How were you referred to this office? _____

Please describe your foot problem: _____ Left/ Right

Is this an Accident? Yes/No Date of Injury?___/____/_____ Is this a Motor Vehicle Accident? Yes/No

Pharmacy Name: _____ Phone: (_____)- _____-_____

Address: _____ City:_____ Zip:_____

Height:_____'_____" Weight:_____lbs Age:_____ Shoe Size:_____ Reg/Wide/XW

Allergies

	Adhesive Tape		Cortisone		Novocain
	Aspirin		Environmental		Penicillin
	Barbiturates		Foods		Sulfa Drugs
	NSAIDS		Iodine Dyes		Tetracycline
	Codeine		Latex		

Other:_____

Medication- *Please include dosage if known.*

Medical Health- *Please circle if multiple*

	Anemia		Cholesterol		Hemophilia (Bleeding)		Peripheral Vascular Disease
	Arthritis		Diabetes		Hypertension (HPB)		Phlebitis/ Thrombosis
	Asthma		Emphysema		HIV/AID		Polio, Cerebral Palsy, Muscular Dystrophy
	Cancer (Type)		Epilepsy		Liver Disease (Hepatitis)		Renal Disease
	Cardiac Disease		Glaucoma/ Eye		Mental Disease (Anxiety, Depression, ETC)		Thyroid
	Stroke		Gout		MRSA/VRE		Tuberculosis

Other:_____

Social

Smoke? YES / NO/ Former Per day?_____ Drink? YES/ NO Per week?_____

Surgical- *Please list previous surgeries.*

_____

Are you under a Doctors Care currently? Yes / No

Foot Centers of Maryland

Dr. Sean Sider, Dr. Branden R. Rhodes, Dr. David Deiboldt, Dr. Chris Sohn, and Dr. Andrew Wilson

OUR FINANCIAL POLICY: We are pleased that you have chosen us as your podiatric care provider. We are committed to your treatment being successful, and are certain you will be happy with the care provided by our staff. The following is a statement of our financial Policy which we ask that you read and sign PRIOR to any treatment. ALL patients must complete our Patient Information Record before being examined by the doctor.

REGARDING INSURANCE: Your insurance policy is a contract between you and your insurance company. As a convenience to our patients, we submit claims to your insurance company on your behalf. WE CANNOT bill your insurance company UNLESS you bring ALL insurance information (this may include claim forms or referrals). Patients who are in an HMO program must present a referral prior to being seen by the doctor. Failure to do so will result in a rescheduling of the appointment. If you do not have a referral and you choose to be seen by the doctor, payment in full for that visit/treatment will be required at the time of visit. The insurance industry is changing every day. We will make every effort to assist you, however, it is the patients' responsibility to know and be aware of his/her plan's coverage, deductibles, co-pays, and limitations. If your insurance company should change or if any information pertaining to yourself, your employer, and/or your dependents, it is your obligation to notify us as soon as possible to avoid delays in processing, as we cannot be held responsible.

USUAL AND CUSTOMARY RATES: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You will be responsible for payments that your insurance company considers to be above the "usual and customary rate". We do require that all co-pays, deductibles, and services not covered by your insurance be paid at the time of service. (This may include post-operative supplies and medications considered "over the counter" items.) If you do not have your copay with you, we reserve the right to either reschedule your appointment or impose a Delayed Payment of Copay Surcharge of $10.00 to your account. We cannot "write off" any amount that is your responsibility.

MISSED APPOINTMENTS: Please help us serve you better by keeping scheduled appointments. If you are unable to keep an appointment, we require that you notify our office at least 24 hours in advance. We reserve the right to charge for appointments not cancelled at least 24 hours in advance.

PAST DUE ACCOUNTS: In the event that your insurance company has not paid your account within 45 days, the responsibility to pay the balance will automatically transfer to you. Please be aware that some or all services provided by our doctors may not be covered and not considered reasonable or necessary under the Medicare Program and/or other insurance plans. Any non-covered services or amounts not paid by your insurance company are due within 30 days of the billing date. An interest charge of 1½ % per month will be added to any unpaid balance of your bill that is 60 days or more overdue. Any account that needs to be rebilled will be charged a Rebilling Finance Charge of $10.00 per month. No Rebilling Charge is added when regular monthly payments of at least $20 are made on your bill. A service charge of $35.00 plus the rebilling fee will be added to your account if your check is returned from your bank for any reason. You are responsible for any fees and costs incurred if your account is turned over to a collections company or an attorney. Any additional medical services will be suspended until your account is paid in full.

Thank you for reviewing our financial policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I hereby authorize Foot Centers of Maryland to apply for benefits on my behalf for services rendered by Drs. Sider, Rhodes, Deiboldt, Sohn, and Wilson. I request payment to be made directly to Foot Centers of Maryland/ Sean Sider, DPM. I certify the information given is true and correct to the best of my knowledge. I further authorize the release of necessary information, including medical information for this or any other related claim to my insurance company. I permit copy of this authorization to be used in the place of the original. I hereby give permission to Foot Centers of Maryland to examine and treat my feet medically and orthopedically. I understand and acknowledge this statement.

_____ _____

Signature of Patient or responsible party *Date*

_____ _____

Co-responsible party *Date*

Dr. Sean Sider
Dr. Branden Rhodes
Dr. David Deiboldt
Dr. Chris Sohn
Dr. Andrew Wilson

Foot Center at Overlea
Mercy Personal Physicians Bldg.
7602 Belair Road
Baltimore, MD 21236
P: 410.844.4700
F: 410.844.4777

Foot Center at Mercy
Mercy Medical Center
301 St. Paul Place, Suite 818
Baltimore, MD 21202
P: 410.844.4700
F: 410.844.4777

Foot Center at Glen Burnie
Mercy Personal Physicians Bldg.
7927 Ritchie Highway, Suite D
Glen Burnie, MD 21061
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Foot Center at Lutherville
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Lutherville, MD 21093
P: 410-844-4700
F: 410.844.4777

Foot Center at Reisterstown
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Reisterstown, MD 21136
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www.MyFootDoctor.com

Foot Centers of Maryland
Medical/Surgical Foot and Ankle Care ®

Acknowledgement of Privacy Practices

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the HIPPA Act of 1996. I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care provides who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my podiatric providers Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected healthy information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my podiatric provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

For office use only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to one or more of the following reasons:

_____ The patient refused to sign

_____ Emergency situation

_____ Communication barriers

_____ Other _____

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Regarding Referrals:

Date: _____

Patient Name: _____

I have been duly informed by this office that if I am seen and/or treated by Drs. Sider, Rhodes, Deiboldt, Sohn, and Wilson during any visits without proper referral or authorization from my PCP and/or insurance company, I will be responsible for any charges not covered by my referral, my failure to obtain a referral or rejection by my insurance company to honor such referral.

Signature: _____

Insurance Carrier: _____

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Cancellation and Payment Policies

As a courtesy to our doctors and their time, we would like to make you aware of the following:

- We require patients to provide **at least 24-hour notice** if you are canceling or rescheduling an appointment. If you do not provide appropriate notice, you may be subject to a $25 cancellation fee.
  This fee must be paid prior to being rescheduled.
- **No-Show policy:** If you No-Show to a scheduled appointment you will be subjected to a $30 No-Show fee. If there are three or more No-Shows within a year period, you will be discharged from our practice. **This fee must be paid prior to being rescheduled.**
- **Late Policy:** If you arrive 15 minutes or more late to your scheduled appointment, you may be rescheduled for a later date. Our schedules vary from day to day, so there is no guarantee we can fit you in the same day if you are late.

Payments for all services rendered must be made at your visit. This includes co-pays, balances, and fees.

We understand emergencies occur and we will handle those situations on an individual basis.

Patient Name: _____

Signature: _____

Date: _____