BIG HORN ANKLE & FOOT

Dr. Lael Beachler, DPM

Powell Office:
Big Horn Ankle & Foot
777 Ave H
Powell, WY 82435
P: (307)754-9191
F: (307)754-1291

Cody Office:
Big Horn Ankle & Foot
424 Yellowstone Ave
Cody, WY 82414
P: (307)527-9191
F: (307)754-1291

Patient Name:_____ Date of Birth: _____

PATIENT INFORMATION FORM

(Please Print)

Today's Date:_____ Patient's Social Security # _____

Age:_____ Sex: ☐ Male ☐ Female Height:_____Weight: _____

Mailing Address:_____ City:_____State:_____Zip:_____

*Using your cell number our Automated Service will send you a reminder about the date, time, & location of your appointment.

May we leave a message?

Home Phone:_____ ☐YES ☐NO

Alternative Work Phone:_____ ☐YES ☐NO

Cell Phone:_____ ☐YES ☐NO

Do you have a legal guardian or healthcare power of attorney? ☐YES ☐NO

If yes, Name:_____Relationship:_____Phone:_____

Emergency Contact:_____ Relationship:_____Phone:_____

Primary Care Doctor:_____Date you last saw Primary Doctor:_____(mon/year)

Pharmacy:_____Location:_____Phone:_____

Is there a family member or other person you would like for us to share your medical information?

☐YES Name(s): _____

☐NO

Who is responsible for payment?_____Relationship to Patient?_____

Address:_____Phone:_____

Name of family member not living in your home:_____Phone:_____

Patient's Employer:_____Address:_____Phone:_____

☐Full Time ☐Part Time ☐Students ☐Retired

INSURANCE INFORMATION

Primary Insurance Company: _____ Contact #:_____

Address:_____

Policy Holder's Name:_____Policy Holder's Date of Birth:_____

Policy Holder's Employer:_____Group #:_____

Secondary Insurance Company:_____Contact #:_____

Address:_____

Policy Holder's Name:_____Policy Holder's Date of Birth:_____

Policy Holder's Employer:_____Group #:_____

Workman's Comp:

Claim #:_____Date of Injury:_____

Patient Name:_____
Date of Birth:_____

Please list all medications you are currently taking (including prescriptions, over-the-counter medications and herbal supplements):

Name	**Dose**	**How often do you take?**

Please list all prior surgeries:

Type of Surgery	**Date**	**Type of Surgery**	**Date**

Please list all prior hospitalizations (other than for surgery):

Reason for Hospitalization	**Date**	**Reason for Hospitalization**	**Date**

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Use of Alcohol: ☐ Never ☐ No longer use ☐ History of alcohol abuse
☐ Current Use – Type_____ ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily

Use of Tobacco: ☐ Never ☐ Quit – How long ago?_____ ☐ Smoke_____ Packs/day for_____ years

Use of Recreational Drugs: ☐ Never ☐ Quit – How long ago?_____ Type _____
☐ Current Use – Type_____ ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily

How much are you on your feet at work? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

Exercise: ☐ Never ☐ Rare ☐ Occasional ☐ Weekly ☐ Several times a week ☐ Daily
Types of Exercise:_____

FAMILY HISTORY

Do you have a family history of: ☐ Diabetes ☐ Cancer ☐ Heart Disease ☐ High Blood Pressure ☐ Stroke ☐ Thyroid Disease
☐ Coronary Artery Disease ☐ Rheumatoid Arthritis Other:_____ Who: ☐ Parents ☐ Grandparents

YOUR MEDICAL HISTORY

Allergies: ☐ None Known ☐ Medications:_____
☐ Anesthesia:_____ ☐ Foods:_____
☐ Tape ☐ Latex ☐ Shellfish ☐ Iodine ☐ Other:_____

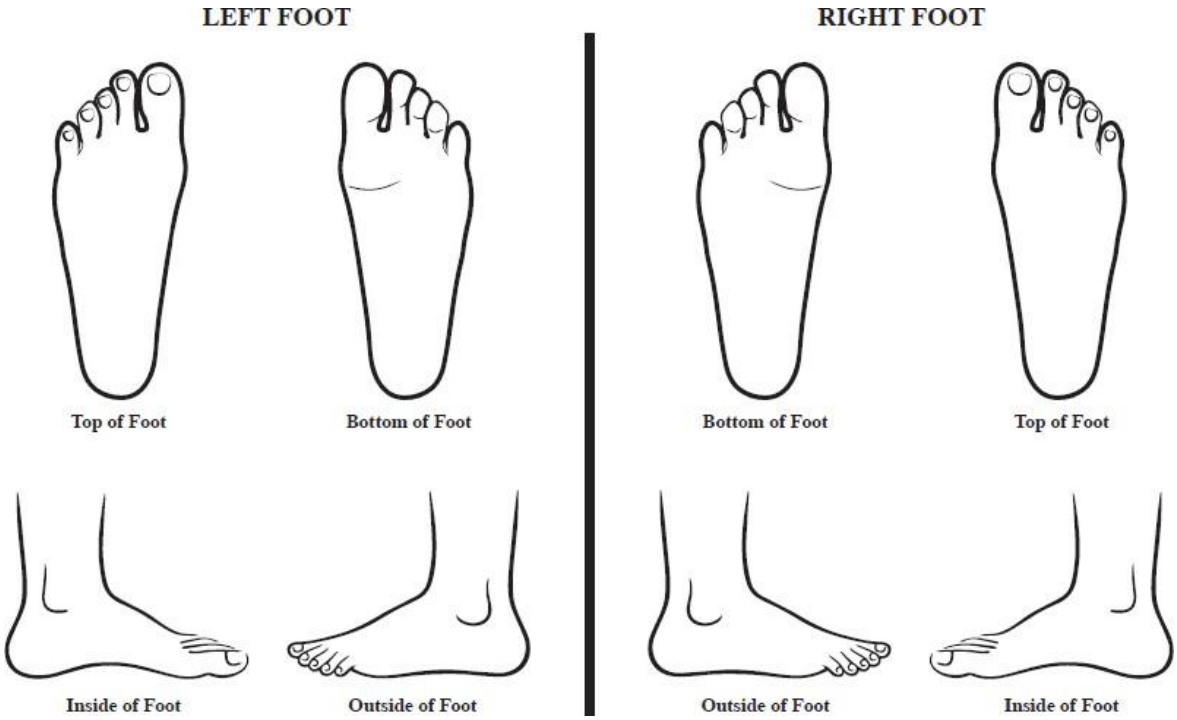
Have you ever had any of the following?

Acid Reflux	Y	N		Cancer	Y	N		Kidney Disease	Y	N		Rheumatic Fever	Y	N
Anemia	Y	N		Diabetes	Y	N		Liver Disease	Y	N		Sickle Cell Disease	Y	N
Arthritis	Y	N		Fibromyalgia	Y	N		Low Blood Pressure	Y	N		Rash	Y	N
Asthma	Y	N		Gout	Y	N		Migraine Headaches	Y	N		Sleep Apnea	Y	N
Back Trouble	Y	N		Heart Disease/Failure	Y	N		Neuropathy	Y	N		Stroke	Y	N
Bladder Infections	Y	N		Hepatitis	Y	N		Ulcers	Y	N		Thyroid Disease	Y	N
Bleeding Disorder	Y	N		HIV+AIDS	Y	N		Pneumonia	Y	N		Tuberculosis	Y	N
Bronchitis/Emphysema	Y	N		High Blood Pressure	Y	N		Polio	Y	N				
Other Conditions:														

CURRENT PROBLEM

What specific problems bring you to our office today? _____

Where is the pain/problem located? Please mark on the pictures below.



How long ago did this problem first start?_____Days/Weeks/Months/Years

Did your pain or problem: ☐ Begin all of a sudden ☐ Gradually develop over time

How would you describe your pain? ☐ No Pain ☐ Sharp ☐ Dull aching ☐ Burning ☐ Radiating ☐ Itching ☐ Stabbing ☐ Other:_____

How would you rate your pain on a scale from 1 to 10? (Please Circle)

(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain possible)

Since the time your pain or problem began, has it: ☐ Stayed the same ☐ Become worse ☐ Improved

What makes your pain or problem feel worse? ☐ Walking ☐ Standing ☐ Daily Activities ☐ Resting ☐ Dress Shoes ☐ High Heels ☐ Flat Shoes ☐ Any closed toe shoe ☐ Running ☐ Other:_____

What makes your pain or problem feel better? _____

What treatment have you had for this problem? _____

How has this problem affected your lifestyle or ability to work? _____

Was this problem caused by an injury? ☐ No ☐ Yes (Describe) _____

If yes, was it a work-related injury? ☐ Yes ☐ No

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status. I agree to allow Big Horn Ankle & Foot to monitor recently prescribed medications from other practice/providers that have been submitted through my insurance.

_____ _____

Print name of patient, parent or guardian Date

_____ _____

If other than patient, relationship to patient Signature

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NOTICE OF PRIVACY PRACTICES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on users and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Acknowledgement of Receipt of Disclosures of Health Information

I hereby acknowledge that I have received a copy of Big Horn Foot Clinic's Notice of Privacy Practices.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone _____
Okay to leave message with regarding appointment time or request to call our office.

☐ Cell Phone _____
To leave message with information.

☐ Work Telephone _____
Okay to leave message with call back number.

☐ Verbal Communication
Okay to release information verbally to: Name: _____

Name: _____

Name: _____

Please understand that we may send information to your healthcare providers in order to better coordinate your medical care.

_____ _____ _____
Printed Name | Signature of patient or representative | Printed name of representative

_____ _____
Date | Relationship to patient

It is the patient's responsibility to provide updates or changes to this information.

The Privacy Rule Generally requires health providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. NOTE: Uses and disclosures for Treatment, Payment, and Healthcare Operations may be permitted without prior consent in an emergency.

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PATIENT FINANCIAL POLICY

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- As our patient, you recognize our time is valuable and agree to give 24 hrs. notice when you will not be able to show up for your scheduled appointment. If you do not give us 24 hrs. notice we will require you to keep a credit/debit card on file to schedule your next appointment. If you do not show up for any following appointments we reserve the right to charge your card $50 for your missed appointment.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, American Express, Mastercard, cash or check. There maybe a service fee to run your card.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insuranceclaim for you so that they may pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, you will be responsible for payment.
- We have made prior arrangements with certain insurers and other health care plans to accept an assignment of benefits.We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/ deductible at the time of service.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send theclaim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- Not all health plans are same and do not cover the same services. In the event your health care plan determines a service "not covered," or you do not have authorization, you will be responsible for the charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any services rendered.
- You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- For most services provided in the hospital, we will bill your health care plan. Any balance due is your responsibility.
- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due. A monthly interest rate of 1.5% monthly or 18% annually will accrue on unpaid accounts.
- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party: _____ Date: _____

Witness Signature: _____ Date: _____

Printed Name of Witness: _____

_____Patient initials to indicate copy received.