Quarryville Family Foot Care, P.C.

Dia D. McCaughan, D.P.M., F.A.C.F.A.S., F.A.S.P.S., F.A.P.W.H.
Diplomate, American Board of Podiatric Surgery

To our new patients,

Welcome to the practice!

Enclosed are forms for you to ***complete and bring*** with you to your upcoming appointment. Please take the time to fill them out ***completely*** at home ***prior*** to this appointment. If you forget your paperwork or do not have it filled out, ***we may have to reschedule your appointment***. If you have a long list of medications, we will be more than happy to make a photocopy of your list for your chart.

Please bring your ***insurance card(s) to our office*** so that we may make a photocopy of them to include in your chart. If your visit involves a worker's compensation or liability case, please bring all appropriate paperwork and any claim numbers assigned to your claim to expedite processing of your visit. Also, if you are part of an HMO plan or if you know that your plan requires a referral, ***it is your responsibility*** to bring the completed insurance referral form from your family physician's office. You will be responsible for payment if you don't have the appropriate referral obtained prior to your visit.

We ask that you arrive to the office ***at least 20 minutes prior to your scheduled appointment time*** to allow sufficient time to scan in all required documents such as those listed above, and prepare your chart for the doctor.

If you have seen, or are currently seeing, another physician/specialist for ***this*** issue, please bring any ***test results and/or imaging studies***, as well as the ***doctor's notes***, with you to your appointment.

If you have any questions, please contact our office. If you are unable to make your appointment, or need to reschedule, please call our office at least 24 hours prior to your scheduled appointment. We are happy that you have chosen us as one of your specialist providers and look forward to seeing you soon!

Sincerely,

Quarryville Family Foot Care, P.C.

Section 1557 Notice of Nondiscrimination

Quarryville Family Foot Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. *Quarryville Family Foot Care* does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Quarryville Family Foot Care:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Amanda 717-786-8896 or email at info@qffc.com.

If you believe that *Quarryville Family Foot Care* has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Amanda Eddleman (Office Manager), 104 Fite Way Suite B Quarryville, PA 17566. Phone: 717-786-8896. Fax: 717-786-8367.
E-mail: info@qffc.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Amanda Eddleman is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

SPANISH
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-717-786-8896.

CHINESE
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-717-786-8896。

PATIENT INFORMATION FORM

(PLEASE PRINT)

DATE: ___/___/___

PATIENT NAME: _____ _____ ___ DATE OF BIRTH: __/__/___ AGE: ___ SEX: M F
LAST FIRST MI

HOME ADDRESS: _____ CITY/STATE: _____ ZIP: _____

SOCIAL SECURITY #: _____ SHOE SIZE: _____

MAY WE LEAVE A MESSAGE?

HOME PHONE #: (___) ___-_____ YES NO

WORK PHONE #: (___) ___-_____ YES NO

CELL PHONE #: (___) ___-_____ YES NO

E-MAIL: _____ YES NO

WHO REFERRED YOU TO OUR OFFICE?: _____

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO

IF YES, NAME: _____ RELATIONSHIP: _____ PHONE #: (___) ___-_____

(MAY BE ASKED TO PROVIDE POWER OF ATTORNEY PAPERWORK)

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE #: (___) ___-_____

PRIMARY CARE DOCTOR: _____ PHONE #: (___) ___-_____

PHARMACY: _____ LOCATION: _____ PHONE #: (___) ___-_____

PLEASE LIST ALL PERSONS WE MAY SHARE YOUR MEDICAL INFORMATION WITH (SPOUSE, CHILDREN, SIBLINGS):

NAMES AND RELATIONSHIPS _____

_____

WHO IS RESPONSIBLE FOR PAYMENT? _____ SS# _____ D.O.B:___/___/_____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (___) ___-_____

RELATIONSHIP TO PATIENT:_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____

INSURED NAME: _____ D.O.B: ___/___/_____ SS#_____

EMPLOYER _____ ID # _____ GROUP # _____

SECONDARY INSURANCE COMPANY NAME: _____

INSURED NAME: _____ D.O.B: ___/___/_____ SS#_____

EMPLOYER _____ ID # _____ GROUP # _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS 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

EMPLOYER: _____ OCCUPATION: _____

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? ☐ CHILDREN–AGE(S) _____ ☐ PET(S)–WHAT KIND? _____
☐ ELDERLY OR DISABLED FAMILY MEMBER ☐ OTHER _____

EXERCISE: ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY

TYPES OF EXERCISE: _____

FAMILY HISTORY (PARENTS, SIBLINGS, CHILDREN)

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES ☐ CANCER ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE
☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE ☐ RHEUMATOID ARTHRITIS
☐ OTHER _____

YOUR MEDICAL HISTORY

ALLERGIES: ☐ MEDICATIONS _____

☐ ANESTHESIA _____ ☐ FOODS _____

☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER _____

☐ NONE KNOWN

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ANXIETY/DEPRESSION	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ARTHRITIS	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
ASTHMA	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BACK TROUBLE	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
BLADDER INFECTIONS	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
ABNORMAL BLEEDING	Y	N	HIGH CHOLESTEROL	Y	N	SLEEP APNEA	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	STOMACH ULCERS	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STROKE	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	THYROID DISEASE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	TUBERCULOSIS	Y	N
DIABETES	Y	N	MITRAL VALVE PROLAPSE	Y	N			

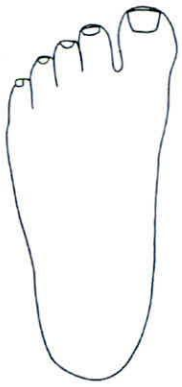
OTHER CONDITIONS:

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

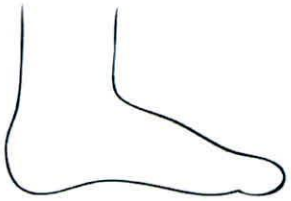
WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

LEFT FOOT

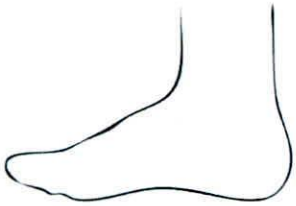


TOP OF FOOT

BOTTOM OF FOOT

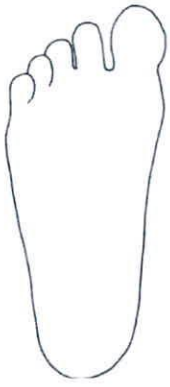


INSIDE OF FOOT

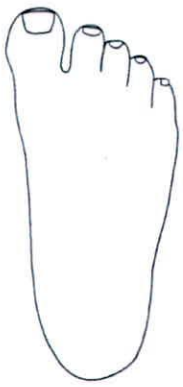


OUTSIDE OF FOOT

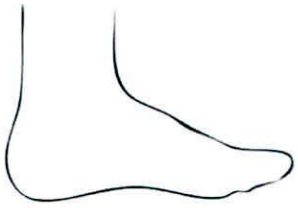
RIGHT FOOT



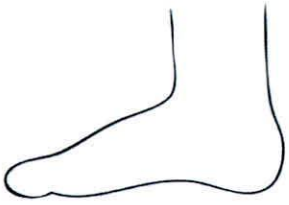
BOTTOM OF FOOT



TOP OF FOOT



OUTSIDE OF FOOT



INSIDE OF FOOT

PATIENT NAME: _____

DATE OF BIRTH: ____/____/____

PLEASE **CONTINUE** LISTING ALL YOUR MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS).

NAME	DOSE	HOW OFTEN DO YOU TAKE?

PLEASE **CONTINUE** LISTING ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

PLEASE **CONTINUE** LISTING ALL PRIOR HOSPITALIZATIONS:

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATIONS	DATE

PLEASE **CONTINUE** LISTING ALL ALLERGIES **AND** REACTIONS TO ANY MEDICATIONS, OINTMENTS, FOODS, ANIMALS, AND OR ANESTHESIA.

ALLGERY	REACTION

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 0 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 TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? _____

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? _____

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ YES (DESCRIBE) _____ ☐ NO

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.

_____ PRINT NAME OF PATIENT, PARENT OR GUARDIAN

_____ SIGNATURE OF DOCTOR

_____ IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

_____ DATE

_____ SIGNATURE

_____ DATE

The Responsible Parties whose signatures appear below agree as follows:

- The Doctor and Staff of Quarryville Family Foot Care, P.C., hereafter referred to as QFFC, are authorized to medically treat the patient named on this form and to exchange past, present, and future medical information with the patient's other medical caregivers for the purpose of enhancing and promoting the continuity of care for the patient.
- The Responsible Parties agree to pay for all fees and charges for supplies, services and treatment that are incurred by the patient per the terms of this agreement and authorize QFFC, or agents hereof, to make credit investigations including employment verifications. All charges shown on billing statements are agreed to be correct and reasonable unless disputed in writing within 30 days of the billing date. The Responsible Parties remain, jointly and severally, financially responsible for the patient until QFFC receives their notification in writing to the contrary. If the patient is currently a minor, their guarantee is continuing even after the patient reaches the age of maturity.
- Not all services and/or fees are covered by the benefits plan of the Responsible Parties' health care insurance, (i.e., insurance company, HMO, employer or government benefits provider) hereafter referred to as the PLAN. **Therefore, the Responsible Parties agree to pay for all deductibles, co-payments, non-covered services and any portions of covered services not paid in full by the PLAN and understand that such payments are due at the time of service or immediately upon presentation of the bill.**
- The Responsible Parties agree to obtain all necessary referrals PRIOR to appointments, and acknowledge responsibility of payment due if proper referrals have not been obtained.
- The Responsible Parties, or those person(s) acting on behalf of Responsible Parties, acknowledge that any type of verbal or physical threats, or any type of harassment, will not be tolerated and will result in immediate dismissal from QFFC.
- If any account balance should remain unpaid for 60 days and QFFC refers the account to a collection agency or attorney for collection, the Responsible Parties agree to pay the costs of collection and that such fees and costs may be added to the account balance ($10.00). In a legal action between the parties to this agreement to collect an unpaid balance due for medical services rendered, the prevailing part shall be entitled to recover reasonable attorney's fees and costs.
- There will be a $30.00 fee for **any** check returned due to insufficient funds.
- Payments will not be delayed or withheld, regardless of any lawsuits, liens, insurance coverage, the pending of claims thereon or the outcome of medical treatment. All proceeds from the PLAN are assigned to QFFC where applicable. As they are responsible for all charges the Responsible Parties will assist QFFC in every way to collect payments from the PLAN to the extent their help is required.
- **The Responsible Parties agree to pay $25.00 for missed appointments, or those cancelled within 24 hours of appointment time.**
- The Responsible Parties acknowledge receipt of Quarryville Family Foot Care's Financial Agreement & Authorization for Treatment.

Agreed to and accepted by the Responsible Parties

X_____ **Date:** _____

(Responsible Party or Parent/Guarantor)

ASSIGNMENT OF BENEFITS

ALL NON-MEDICARE PLANS: I hereby name Quarryville Family Foot Care, P.C., as my/our assignee. I instruct my health care benefits plan administrator (i.e.: The Plan) to pay QFFC directly for all professional and medical services provided by QFFC, though the means of electronic fund transfer(s) or by check(s) made payable to and mailed to QFFC.

MEDICARE/MEDIGAP RECIPIENTS: "I request that payments of authorized Medicare/Medigap benefits be made either to me or on my behalf to Quarryville Family Foot Care, P.C., for any services furnished by that physician or supplier. I authorize any holder of medical information about me released to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services."

X_____ **Date:**_____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICE NOTICE

I acknowledge that I was provided a copy (if requested) of the Notice of Privacy Practices for Quarryville Family Foot Care, P.C., and that I have read (or had the opportunity to read if I so choose) and understood the Notice.

X_____ _____ **X**_____

Patient Name (Please Print) Date Patient Signature

_____ Name of Parent or Authorized Representative (if applicable)