Foot Care of Northeast Arkansas, P.A.

Dr.Eddy Caldwell

New Patient Paperwork

Please fill out completely

First Name_____ Middle_____ Last Name_____

Circle One: Male Female Social Security_____-___-_____ Date of Birth _____

Email Address_____

Address:_____City/State_____Zip_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Primary Physician_____ Date Last Seen_____

Primary Language_____ Race_____Ethnicity: Hispanic? Yes or No

Emergency Contact:_____Phone_____

Describe Foot problem_____

What Pharmacy do you use?_____

Did another doctor refer you? If so, who?_____

Marital Status: M S D W Student Status: Yes or No Employed? Yes or No

Employed Where? _____Address_____

Do you have legal representative, like a guardian, who will be responsible for bill? Yes or No

Name _____ Relationship_____

Address_____Phone Number_____

Social Security number_____ Date of Birth_____

I understand I am responsible for any portion of my bill not covered by my insurance company. I understand that this office will bill my insurance out of courtesy and that if my insurance doesn't remit timely payment I will be billed for services rendered. I understand that I will be required to pay a co-payment or co-insurance today if applicable. I also understand that a collection fee will be charged to me in the event my account is referred to collection. I hereby authorize the release of my medical information for insurance purposes only. Medical records will be sent to other doctors if requested on your behalf. I agree to all the above and hereby state that the information I have given is correct to the best of my knowledge.

Signature_____ Date_____

Patient History

Medications: List all of your medications and dosages. If you have a sheet please attach it.

Past Medical History: If you have or ever have had any of the following conditions, please circle :

Alzheimers Disease Arthritis Asthma Back Pain Cancer Cardiovascular History COPD Depression/Anxiety Diabetes DVT Fibromyalgia GERD Gout Headache Hepatitis HIV/AIDS Kidney Disease Liver Disease Multiple Sclerosis Neck Pain Neuropathy Obesity Parkinson Seizures Sleep Apnea Stroke Thyroid Disease Urinary Infections

Allergies: Circle any of the following which caused an allergic reaction:

None Penicillin Sulfa Drugs Adhesive Tape Codeine Latex

Social History: Do you smoke? Y N Not anymore Do you drink alcohol or beer: Y N

What best describes your lifestyle? Circle all that apply

Athletic Caffeine Intake Disabled Moderately Active Retired Sendentary

Do you use recreational drugs on a daily basis? Y N

Family History: Please mark M for Mother of F for Father B for Both

Arthritis____ Bleeding Disorders____ Circulation Disorders____ Diabetes____ Heart disease____ Neurological Disorders_____ Stroke_____

Past Surgeries: Please circle all that apply

C-Section Gall Bladder Hernia Repair Hip Replacement Hysterectomy Kidney Removal Knee Surgery Lower Back Surgery Should Surgery Foot Surgery R or L Carpal Tunnel

Review of Systems: Circle all that apply

Constitutional: Chills Fatigue Fever Headache

CV: Chest Pain Palpitations Irregular Heartbeat High Blood Pressure

Endocrine: Excessive Thirst Too Hot/Cold Tired/Sluggish

GU: Urine Retention Painful Urination Urinary Frequency

Lymphatic: Swelling Bleeding Lymphadenopathy

MSK: Joint Pain Neck Pain Back Pain

GI: Abdominal Pain Nausea/Vomiting Indigestion/ Heartburn

Eyes: Blurred Vision Lightsensitivity Watery Eyes Foreign Body

Neurological: Tremors Dizzy Spells Numbness/ Tingling

Psychiatric: Alcohol Addiction Drug Addiction Anxiety Depression Sleep Disturbance

Immunologic: Rheumatoid Arthritis Gout Hepatitis HIV Autoimmune Disorders

Respiratory: Difficulty Breathing Oxygen Therapy Chronic Cough Coughing Up Blood

Thank you for choosing **Foot Care of Northeast Arkansas, P.A.** We are committed to providing you with high quality, convenient, and affordable healthcare. We have developed this policy to answer our patients questions regarding patient and insurance payment responsibilities for services rendered. Please read and ask any questions then sign in the space provided.

1) **Insurance:** We bill participating insurance companies as a courtesy to you. It is your responsibility to give us correct insurance information at the time of service. You are expected to pay deductible, co payments and co insurance at the time of service. If we have not received payment from your insurance company within 60 days of the date of service, you will be expected to pay the balance in full. You are responsible for all charges. If you are not insured by a health insurance plan that will pay us directly, payment in full is expected at time of each visit. We accept personal checks, cash, Master Card, Visa, and American Express. If you are insured by a plan that will pay us directly, but you don't have an up to date insurance card, payment in full for each visit is required until we may verify your coverage.
2) **Co Payments, deductibles, and non covered medical services:** All payments must be paid at time of service. Your agreement to pay these expenses is part of your contract with your insurance company. Failure on our part to collect these Co-payments, deductibles, and fees for non covered services would be a violation of our contract with the insurance company. Please help us both comply with our contracts and the law by paying your portion of the expenses at the time of visit.
3) **Proof of Insurance:** All patients are asked to complete our patient information form before seeing the doctor. . . obtain a copy of a photo id and current insurance card in order to obtain proof insurance. If you do not provide us with correct insurance information, you will be asked to pay for your medical services at the time services are rendered.
4) **Claims Submission:** We will submit your claims to your insurance carrier and otherwise assist in any way we reasonably can in order for your medical services to be paid for by your insurance company as a courtesy to you. Your insurance may need for you to provide certain information directly to them.
5) **Coverage changes:** If your insurance coverage changes, please notify us prior to seeing the doctor so we may make the appropriate changes to our records and assist you in receiving your maximum benefits. If your insurance company does not pay your claim in 60 days the balance will be billed to you.
6) **Nonpayment and Communications:** If your account is 60 days past due, you will receive a letter stating that you have 10 days to pay your account in full. Partial payments will not be accepted unless you call our office at 870-933-8900 in order to make other payment arrangements. Please be aware that if a balance remains unpaid, we will refer your account to an outside collection agency and you and your immediate family members may be discharged from this practice. If discharge occurs, you will be notified by certified mail that you have 30 days to find alternative medical care. During that 30 day period, our physicians will only be able to treat you on an emergency basis. I agree that this facility, Foot Care of Northeast Arkansas, P.A., or any other collection or servicing agency or agencies retained by the facility(together referred to hereafter as 'collectors') to collect any money that I owe to the facility may contact me by telephone or text message as any number which may result in my incurring fees for the call or the message. I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre recorded messages, artificial voice messages or voicemail messages. I further agree that the collectors may contact me using e-mail at any e-mail address I provide to the facility or is otherwise associated with my account.

Our fees are representative of the usual and customary charges for medical services in our area. Thank you for understanding our payment policy. Please let us knows if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____

Signature of patient or legal representative Date

Foot Care of Northeast Arkansas P.A.

Eddy L Caldwell

General Consent To Treatment And Tests

I desire to be treated by Dr. Eddy Caldwell and Foot Care of North East Arkansas, P.A. I permit my attending and counseling physician and/or nurse practitioner, and its employees right to ask questions and to receive information about my care and treat and give medical advice. I release the physician (s) and/or nurse practitioner(s) from any liability. I consent to examinations, x-rays, blood tests, laboratory procedures, medications, and other medical services or treatments. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge and agree that no guarantees have been made to me as to the results of outcome of my medical care.

Missed Appointments / Late Cancellations

I understand broken appointments represent a cost. Cancellations are required 24 hours prior to the appointment. Foot Care of Northeast Arkansas P.A. reserves the right to charge your account for missed or late-cancelled appointments. Excessive abuse of schedule appointments may result in discharge from the practice.

Authorization To Treat A Minor

I authorize the above named Physician to provide such medical services including surgery, if necessary, as may be determined in the best interest to above named patient of which I am the parent or legal guardian. This authorization is effective this date and until revoked in writing by me.

Acknowledgement Of Receipt Of Notice

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

Signature_____ **Date**_____