Complete Podiatry, PC
Dr. Bryan G. Corum

Please take a few minutes to fill out the following information:

Patient Information/Medical History

Date: ____/____/____

Name: Last_____ First_____ MI_____

Preferred Name (if different from above):_____

Age:_____ **Date of Birth:**____/____/____ **Sex:** [ ] [ ] **Social Security #**_____-____-_____

Male Female

Email Address:_____

Billing Address:_____ **City:**_____ **State:**___ **Zip:**_____

Physical Address(if different):_____

Home Phone:( )_____ **Cell:**( )_____

Which Number is Preferred? [ ]-Home [ ]-Cell

Employer:_____ **Occupation:**_____

Marital Status: [ ]-Married [ ]-Single [ ]-Widow **if married, spouse's name:**_____

How did you learn about our office and/or who referred you to our office:_____

Who is with you today? _____ **Their relationship to you** _____

*****If patient is minor, who is legally responsible?** _____ **Relation:** _____

Medical Information:

Preferred Pharmacy:_____**Phone**_____

Primary Care Physician:_____**Cardiologist:**_____

Please describe current problem(s):_____

Please describe painful feeling/s and pain level/s:_____

How does your problem/s affect your regular activities?:_____

How long have you had this/these problem/s?_____

Height:_____feet_____inches **Weight:**_____lbs. **Shoe Size**:_____ **Shoe Style**:_____

Activity level: [ ]-high [ ]-average [ ]-low

Please list the medications you are currently taking:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Are you taking any of The following:

[ ]-Echinacea [ ]-Garlic

[ ]-Ginger [ ]-Gingko Biloba

[ ]-St.John's Wort [ ]-Ginseng

[ ]-Kava Kava [ ]-Feverfew

[ ]-Ephedra [ ]-Diet Pills

Are you allergic to: [ ]-Penicillin [ ]-Anesthetics [ ]-Codeine [ ]-Aspirin [ ]-Sulfa Drugs [ ]-Iodine/Shellfish [ ]-Latex [ ]-Tape/Adhesives [ ]-Other allergies, please list:_____

Previous Surgeries:

_____

_____

_____

Previous Injuries:

_____

_____

_____

Illnesses: Please mark all illnesses you currently have or have had in the past.

Major Disease:

[ ]Diabetes Mellitus
[ ]Hypertension/High Blood pressure
[ ]Angina
[ ]Heart Disease
[ ]Heart Attack
[ ]Arrhythmia
[ ]Murmur
[ ]Mitral Valve Prolapse
[ ]Stroke
[ ]Chest Pain

Respiratory:

[ ]Asthma
[ ]Bronchitis
[ ]Frequent Colds
[ ]Lung Disease
[ ]Tuberculosis
[ ]Shortness of Breath
[ ]Emphysema

Arthritis:

[ ]Osteoarthritis
[ ]Rheumatoid
[ ]Gout
[ ]Other Arthritic Problems:

_____
_____

Vascular:

[ ]Bleeding Problems
[ ]Sickle Cell
[ ]Poor Circulation
[ ]Anemia
[ ]Toe Pain While Resting
[ ]Foot Infections
[ ]Leg Pain When Walking
[ ]Foot/Leg Ulcers
[ ]Varicose Veins
[ ] Blood Clots
[ ]Transfusions

Gastrointestinal:

[ ]Stomach Ulcers
[ ]Bowel Disorders
[ ]Rectal or GI Bleeding
[ ]Acid Reflux
[ ]Hiatal Hernia
[ ]Other Stomach or GI problems:

_____
_____

Problems with Head, Eyes, Ears, Nose, or Throat:_____

_____
_____
_____

Miscellaneous:

[ ]Cancer History
[ ]Skin Conditions
[ ]Prostate Problems
[ ]Bladder Problems
[ ]Kidney Problems
[ ]Muscle Disease
[ ]Thyroid Disease
[ ]Epilepsy
[ ]Venereal Disease
[ ]Hepatitis
[ ]HIV
[ ] Psychological Disorders
[ ]Bleeding Problems
[ ]Osteoporosis

_____

Please list any other Health Problems/ Conditions we should Know About:_____

_____
_____
_____
_____
_____
_____
_____

Do Consume Alcohol? _____oz. Per day/week **Do you use tobacco?** _____Pks/d for_____yrs.

Family History:_____

I authorize Dr. Bryan G. Corum to administer treatment and to perform such procedures as deemed necessary in the diagnosis and/or treatment of the foot or lower extremity condition. I understand I am responsible for all costs incurred while under the care of Dr. Corum and have financial responsibility for payment of services that are or are not covered by my insurance as stated in my insurance contract. I authorize payment of medical benefits to Dr. Bryan Corum or Complete Podiatry, PC for services rendered, and also request payment of government benefits to either myself or to the party who accepts assignment below. I also authorize the release of any medical or other information necessary to process this/these claim/s.

Signature of Responsible Party:_____ ***Date*** ____/____/____

Office Use Only:

Physician Signature: _____ **Date** ____/____/____

Summary of Notice of Privacy Practices

Health Information Use and Disclosures
The office(s) of Dr. Bryan G. Corum understand that medical information about you and your health is personal and we are committed to protecting that information. With that understanding, we will use and disclose your health information for the following purposes: to treat you, to assist other health care providers in treating you, to allow insurance companies to process claims for services rendered to you, to obtain payment for services rendered to you and for certain limited operational activities, such as quality assessment, licensing, accreditation and training. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization. We reserve the right to change this notice and will post a copy of the current (dated) notice in effect in our facility.

Additional Disclosure Authority
In addition to the allowable disclosure described in the State of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

Name:_____ Relation:_____ D.O.B.:_____
Name:_____ Relation:_____ D.O.B.:_____
Name:_____ Relation:_____ D.O.B.:_____

Health Information Use and Disclosure Not Requiring your Authorization
We may disclose you health information without written authorization under these circumstances:

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include surgeries, follow-up care, administering medication, etc.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be billing your medical health plan for your medical services.
- Health Care Operations include the business aspect of running our practice, such as conducting quality assessment and improvement activities. Auditing functions, cost management analysis and customer service. An example would include a periodic assessment of our documentation protocols, etc.

Patient Rights:
As our patient, you have the following rights:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to access, inspect and copy your protected health information.
- The right to request and amendment to your protected health information.
- The right to receive an accounting of disclosures of protected health information outside of treatment, payment and health care operations.
- The right to obtain a paper copy of the Notice Of Privacy Practices from us upon request.

If you have any questions, concerns or complaints regarding our Summary of Privacy Practices, please refer to the actual Notice Of Privacy Practices for the person(s) whom you may contact.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
I acknowledge that I was provided a copy of the Privacy of the Practices and have read (or had the opportunity to read if I so chose) and understand the Notice.

_____ _____
Patient or Authorized Representative (Signature) Date

PLEASE NOTE THAT IF XRAY OR LABS ARE ORDERED, WE DO NOT DISCLOSE RESULTS OVER THE PHONE OR EMAIL.

Financial Policy

Payment Policy

Thank you for choosing Complete Podiatry, PC with Dr. Bryan Corum as your foot care provider. We are committed to providing you with quality and affordable health care. Please read the following office payment policy and feel free to ask us any questions that you may have. Once you accept this policy, kindly sign in the space provided. A copy will be provided to you upon request.

1. **Insurance:** We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. We accept cash, credit cards, debit cards and checks. If you are insured by a plan we participate with but do not have an up to date insurance card, payment in full for each visit is required until we can verify coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Returned Check Policy:** If a payment is made on an account by check and the check is returned as a Non – Sufficient Funds (NSF), Account Closed (AC), or Refer to Maker (RTM), the patient or the Responsible Party will be responsible for the original check amount, a $35.00 Service Charge and interest (may be applied).
3. **Co-Payments and Deductibles:** All Co-Payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co – payment at each visit.
4. **Non-Covered Services:** Please be aware that some and perhaps all of the service you receive may be uncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of the visit.
5. **Proof of Insurance:** All patients must complete our patient information form before seeing Dr. Corum. We must obtain a copy of your drivers license / Picture and ID, current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. If required, obtaining the proper referral from your Primary Care Physician is your responsibility.
6. **Claim Submission:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.
7. **Coverage Changes:** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.
8. **Nonpayment:** Invoices are sent out every 30 days. Your prompt payment will assist us in keeping the cost of health care down. If your account is over 60 days past due, you will receive a letter requesting immediate payment. Please be aware that if a balance remains unpaid, we may refer your account to a collections agency. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative podiatric care. During that 30-day period, Dr. Corum will only be able to treat you on an emergency basis.
9. **Forms, Documents and Medical Records:** For the completion of all forms and medical records it is our policy to charge $25.00 for the first 20 pages and .25 per page there after, please allow 3-5 business days for completion.
10. **Fees:** Our fees are representative of the usual and customary charges for our area.
11. **Missed Appointments:** If you miss 3 or more scheduled appointments you will be subject to a $25.00 cancellation fee per appointment. Canceling or rescheduling within 24 hours of an appointment is considered a miss.

I have read, understand and agree to the above Complete Podiatry Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co – payments, co – insurance and deductibles are my responsibility.
I authorize my insurance benefits to be directly paid to Complete Podiatry, PC.

_____ _____

Signature of Patient or Authorized Representative Date

Updated 01/01/2019