Michael A Wood, DPM, PC
Foot Health Institute

Patient Name:_____

Date of Birth:_____

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold or flu, you may be exposed to COVID-19, also known as "Coronavirus," at any time or in any place. Be assured that we have always followed state and federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of all diseases in our office and continue to do so.

Despite our careful attention to sterilization, disinfection and use of personal barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be at your gym, grocery store or favorite restaurant. Social distancing nationwide has reduced the transmission of the Coronavirus. Although we have taken measures to provide social distancing in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing between patient, doctor, medical assistants and staff and sometimes other patients at all times.

I have read and fully understand the above information. Although exposure is unlikely, I accept the potential risk and consent to treatment at Foot Health Institute.

Patient Signature:_____

Date:_____

May 1, 2020

Foot Health Institute

Name:_____Sex: M___ F___

Date of Birth:_____Age:_____Social Security #:_____

Married____ Widowed____ Single____ Minor____ Separated____ Divorced____

Home Phone #:_____Cell Phone #:_____

Home Address:_____

City:_____State:_____Zip Code:_____

Email:_____

Employer:_____Work #:_____

Race: (circle) Declined Asian Black Indian White **Ethnicity**: Hispanic Non-Hispanic

Emergency Contact:_____Phone#:_____

Do you have insurance? YES NO

Insurance Company:_____

Insured Name:_____SSN:_____

Relation to Patient:_____Insured Date of Birth:_____

If Patient is a Minor, Parent Name:_____

Patient Signature:_____Date:_____

Guardian Signature:_____Relation:_____

Please list or circle where you found out about our office:

Internet/Google Family/Friend Doctor Referral Insurance Facebook

Other:_____

Past Medical/Surgical Data

Operations: Date

_____
_____
_____

Past Hospitalization: Date/Year

_____
_____
_____

Chronic Illnesses: Date

_____
_____
_____

Allergies:

_____
_____
_____
_____

Prescription Medicine:

_____
_____
_____
_____

HAVE YOU HAD?

Gout	YES OR NO
Anemia	YES OR NO
Cancer	YES OR NO
Diabetes	YES OR NO
Hepatitis	YES OR NO
Arthritis	YES OR NO
Phlebitis	YES OR NO
Heart Trouble	YES OR NO
Kidney Trouble	YES OR NO
Liver Disease/Jaundice	YES OR NO
Rheumatic Fever	YES OR NO
T.B./Valley Fever	YES OR NO
Stomach Problems	YES OR NO
Epilepsy/Seizures	YES OR NO
Asthma/Allergies	YES OR NO
Bleeding Problems	YES OR NO
High Blood Pressure	YES OR NO
Neurological Problems	YES OR NO
Metal Implants	YES OR NO
Tobacco Usage	YES OR NO
Alcohol Usage	YES OR NO
Drug Usage	YES OR NO
Medical Marijuana	YES OR NO
Recreational Marijuana	YES OR NO
Are you nursing an infant	YES OR NO

Are you now or could you be pregnant? Y/N

Height_____Weight_____

What brings you in today?

_____
_____
_____

TREATMENT AND MEDICATION CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary and review my past medication history.

_____ _____
Signature of Patient, Parent, Guardian or Representative Date

_____ _____
Please print name of Patient, Parent or Guardian Relationship to Patient

HIPAA Consent for Patient Communication Preferences

Patient Name:_____

Date of Birth:_____ Last 4 Digits Social Security:_____

I authorize my doctor and staff to leave messages including medical information:

I understand that I may notify the doctor's office at any time to request a change or revoke this consent, in writing. I understand this would require a new form and authorization to be completed. Any use or disclosure that occurred prior to the date I revoke or change this consent is not affected.

I understand that I have certain rights to privacy regarding my protected health information. These rights have been given to me under the HIPAA Act of 1996.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA.

I understand that the information sent to me via email from persons at Michael A Wood, DPM, PC will **not be sent securely and will be unencrypted**. I **understand the risks** associated with that including, but not limited to, that **my PHI may be read by an unintended third party.** I have been notified of the risks. I understand said risks and I still prefer to receive protected health information via unsecure communications via email. I understand that Michael A Wood, DPM, PC and its staff are not responsible for any unauthorized access of my protected health information communicated by way of unencrypted email and text and that I bear the risk.

_____ YES May leave message: Home____Work____Cell_____

_____ NO Do Not leave messages on my voicemail.

_____ YES May share information with the following individuals:

_____

_____ YES E-mail Address: _____

_____ _____

Signature Patient/Guardian Date

_____ _____

Signature Witness Date

Michael A Wood, DPM, PC
Foot Health Institute

Patient Financial Policy

We are dedicated to providing the best possible care and service to you and regard your complete understanding of our financial policies as an essential element of your care and treatment.

* As our patient, you are responsible for all authorizations/referrals necessary to seek treatment in our office.

* Payment for office services is due at the time of service. If you have health insurance; copays, deductibles and any co-insurance are due at the time of service.

* Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you. If your insurance company does not pay Dr. Wood within a reasonable period, we will look to you for payment.

* We will attempt to verify benefits for our services; however, you remain responsible for charges to all services rendered. Patients are encouraged to contact their health plans for clarification of benefits prior to services rendered. Actual plan benefits cannot be determined until the claim is received by your insurance company and is based upon their determination of medical necessity. The information received from the above stated is not a guarantee of benefit.

* 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.

* Past due accounts are subject to collection proceedings. All fees, including but not limited to, your current balance, collection fees of 30% of the total owed when sent to Collection Professionals, Inc., attorney fees and court fees shall become your responsibility.

* A service fee of $30.00 will be billed to you for all returned checks.

* A service fee of $25.00 will be billed if you do not show for your scheduled appointment time.

I certify that I have insurance coverage and assign directly to Dr. Michael Wood all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. Dr. Wood may use my health care information and may disclose such information to my insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This assignment will remain in effect until revoked by e in writing. A photocopy of this assignment is to be considered as valid as the original.

Signature of Patient or Responsible Party:_____

Printed Name:_____ Date:_____

1/2019