High Plains PODIATRY

306 West D
McCook, NE 69001
(308)345-3773

725 Burlington
Holdrege, NE 68949
(308)995-4044

Robert C. Hinze, D.P.M.

Confidential Patient Information

Date: _____ Social Security #: _____

Name: _____ Age: _____ Date of Birth: _____ Sex: M F

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Email: _____

Employer: _____ Employer Address: _____

Marital Status: Married Single Widow Divorced

Race: White Hispanic Asian Black/African American

Ethnicity: Hispanic Non-Hispanic Unknown **Preferred Language:** English Spanish

Spouse Information

Spouse Name: _____ Spouse Social Security #: _____

Spouse Employer: _____ Spouse Employer Phone: _____

Referral Information

Referred by: _____

Primary Physician: _____ Date last seen by primary physician: _____

Miscellaneous Information

May we call you at work? YES NO

May we call you at home? YES NO

May we leave a message on your answering machine? YES NO Don't have one

Person **not** living with you in the event of an emergency: _____

Relation to patient: _____ Phone: _____

Current Height: _____ Current Weight: _____ Shoe Size: _____ Width: _____

Pharmacy:_____ City, State: _____

PLEASE COMPLETE BACK OF FORM

Health Information

1. Are you having any pain or discomfort at this time? If yes, where? YES NO

   _____

2. Have you been under the care of a medical doctor or been a patient in the hospital during the last 2 years? YES NO
   If yes, for what? _____

   Have you ever had surgery? YES NO
   If yes, please specify: _____

3. Are you currently taking any medications? YES NO
   If yes, please list current medications: _____

   _____

   _____

4. Do you have any drug or food allergies? YES NO
   If yes, please list allergies: _____

   _____

5. Have you ever had any excessive bleeding requiring special care? YES NO

6. Do you have any reason to believe you may be immunosuppressed or unable to fight infections? YES NO

7. Do you smoke? YES NO How many years? _____ How much? _____

   Are you an ex-smoker? YES NO

Circle any of the following which you have had or have at the present time:

Alzheimer's Disease	Drug or Alcohol Addiction	High Blood Pressure	Stroke
Anemia	Emphysema-COPD	Kidney Trouble	Thyroid Disease
Angina Pectoris	Epilepsy or Seizures	Liver Disease	Tuberculosis
Arthritis	Fainting or Dizzy Spells	Lung Disease	Ulcers
Artificial Heart Valve	Glaucoma	Motion Sickness	Venereal Disease
Artificial Joint	Hay Fever	Pacemaker	Yellow Jaundice
Asthma	Heart Disease or Attack	Psychiatric Treatment	
Blood Transfusion	Heart Murmur	Radiation	
Chemotherapy	Heart Surgery	Rheumatic Fever	
Diabetes	Hemophilia	Sickle Cell Disease	
	Hepatitis	Sinus Trouble	

I understand the information I provide on this form is essential to determine my podiatric needs and the provision of the treatment. I understand that if any change occurs in my health I will report it to the office as soon as possible. I have read and understand these questions and answered them truthfully and to the best of my ability, and I have had an opportunity to discuss my health history with the doctor.

Signature of Patient/Parent/Guardian: _____ Date: _____

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Patient Name: _____

Patient DOB: _____

Responsible Party: _____

Responsible Party DOB: _____

Financial Policy

Thank you for choosing High Plains Podiatry PC for your foot care needs! The following is a statement of our FINANCIAL POLICY. ALL patients must accept our FINANCIAL POLICY before receiving treatment.

Please understand that full payment of your bill is considered part of your treatment.

METHOD OF PAYMENT: We accept cash, checks, VISA, MASTERCARD and CARE CREDIT. Payment plan may be arranged on an individual basis with the Office Manager.

INSURANCE: As a courtesy to you, we will submit medical claims to your insurance company. Any balance after processing of your claim by your carrier is your responsibility. Your insurance policy is a contract between you and your insurance company. You are responsible for verifying if providers are in-network, with your insurance company. We cannot bill your insurance company unless you give us your complete insurance information. If your insurance information is not received prior to treatment, then payment is due in full. It is your responsibility to verify the benefits covered by your plan as the insurance company may not cover all of the services provided to you. If your insurance company has paid its portion of your account, then any balance left will become your responsibility to pay in full by the statement due date.

Definitions:

Co-payment: A fixed dollar amount set by your insurance contract that is to be paid at the time of an office visit. This amount is usually between $15 and $50.

Deductible: An annual dollar amount established by your insurance plan that is deducted from your insurance benefits. This amount is your obligation and must be paid prior to health care services.

Co-insurance: A percent set by your insurance plan that is deducted from your insurance benefits. This percent usually ranges between 10% to 30% and is your obligation to pay.

ALL COPAYS, DEDUCTIBLES AND CO-INSURANCE REQUIRED BY YOUR INSURANCE COMPANY ARE DUE PRIOR TO TREATMENT.

LATE FEE: A late fee of $20 will be added to any accounts that are 60 days past due and have no payment activity.

MISSED APPOINTMENTS: Please notify our office at least three (3) hours in advance if you cannot make your appointment. We reserve the right to discharge you from our practice if you have three(3) no-shows for scheduled appointments.

RETURNED CHECKS: A $25 service fee will be added to all checks returned for insufficient funds. If your check is returned, you will be required to pre-pay in full by cash, Visa or Mastercard.

COLLECTIONS: We reserve the right to forward your account to a collection agency if it is determined to be uncollectible.

I have read the above financial policy and agree to its terms.

Patient/Guarantor Signature _____ Date _____