

Patient Information

Patient Name _____ Male _____ Female _____

Mailing Address _____ City _____ State _____ Zip _____

Work Number _____ email _____

Telephone Number _____ Cell Number _____

Date of Birth _____ Social Security _____

Spouse _____ Date of Birth _____ SS _____

If patient is minor, Name of parent or guardian _____ SS _____

Date of injury _____ Is this a work related injury? _____

Occupation _____ Employer _____

Address _____ City _____ State _____ Zip _____

Health Insurance Company _____ WE CAN COPY YOUR CARD

Insured Name _____ Relationship to insured _____

ID _____ Group _____ DOB _____

How did you hear about our office? _____

I hereby give my permission to Dr. David Condon to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and treatment of my foot condition.

Signature Date

As a courtesy to you, we can bill your insurance company. If you wish for this service please acknowledge the following release. SIGNATURE ON FILE

- *I authorize the use of this form on all my insurance submissions.
- *I authorize release of pertinent information to all my insurance companies.
- *I understand that I am ultimately responsible for my bill.
- *I authorize my doctor to act as my agent in helping me obtain payment from insurance companies.
- *I authorize payment directly to my doctor.
- *I permit a copy of this authorization to be used in place of the original.

By signing below, you agree to the above statements:

Signature _____ Date _____

David E. Condon, DPM
PO Box 10069 Truckee, Ca 96162 (530) 587-7790 (775) 831-7144 Fax (530) 587-4293
Healthy Feet for an Active World

WELCOME TO OUR OFFICE

Name _____ Date: _____ Weight _____ Height _____ Shoe Size _____

Please Complete:

Problems: Why are you here?
date of onset?:

- 1. _____
- 2. _____
- 3. _____
- 4. _____

Does your problem limit you/how so?

- ____ Occupation _____
- ____ Fitness pursuits _____
- ____ Shoe selection _____
- ____ Just a concern, no limits

Any past treatment/studies/labs for your
Problems? If so explain

Allergic to Medicine/reaction?

Medicines you take and dosage:

Preferred Pharmacy: _____

Mark/circle all that apply, present or past :

- ____ High blood pressure, stroke
- ____ Heart disease, shortness of breath, palpitation
- ____ Respiratory illness, asthma, COPD
- ____ Diabetes, Thyroid,
- ____ Liver disease (hepatitis, jaundice)
- ____ Kidney problems, urinary frequency, stones
- ____ Gastric reflux, blood in stool, diarrhea
- ____ Rheumatoid arthritis/Fever, autoimmune disease
- ____ Arthritis: where: _____
- ____ Mental illness, depression, anxiety, psychosis
- ____ Blood clots, stroke, calf pain with exertion
- ____ Night Sweats, chills, fever, recent weight loss/gain
- ____ Disturbance of vision, balance, smell, taste, hearing
- ____ Cancer, chemotherapy, radiation
- ____ Osteoporosis/stress fractures

List List and date all surgeries
and adverse anesthetic

List any lower extremity
injuries that required a cast
or crutch:

List all hospitalizations: _____

Any present or chronic
injuries to:

- ____ lower leg/ankle
- ____ knee joint
- ____ thigh
- ____ hip joint
- ____ low back
- ____ mid back
- ____ upper back

Circle and give quantity to all that apply?

Tobacco product: smoke/chew ___/D
Recreational Drugs: ___/D, type _____
Caffeinated beverage: ___/D
Supplements: _____

Last known blood pressure/date:

With Regard to your problem. Rate the pain
level: 0(no pain) - 10 (unbearable)

At worst: _____
now: _____

Your Primary Care Doctor: _____
date/condition last seen for? _____

date of last Tetanus shot? _____

Use this space for additional comments
on any section:

Family history/family member:

- ____ diabetes/ _____
- ____ heart disease/ _____
- ____ Cancer/ _____
- ____ blood clots; strokes/ _____
- ____ foot problems/ _____
- ____ other _____

Occupation: _____

List athletic-fitness pursuits/goals

Do you wear orthotic devices/arch
supports in shoes? Yes/no

If female, are you pregnant? _____

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FAX COVER SHEET

DATE _____

TO _____

FAX _____

PHONE _____

REMARKS: Please fill out the following three pages; Patient Information, Medical History and Financial Policy. If possible please fax back to our office @ 530-587-4293 prior to your visit, with a copy of the front and back of your insurance card. If it is not possible to fax them back to us, please fill them out mail them to the above address if time permits before your office visit or bring them with you for your initial office visit.

Number of pages to follow: 3

DISCLAIMER:

The information contained in this facsimile message is intended for the sole confidential use of the designated recipients and may contain confidential information. If you have received this information in error, any review, dissemination, distribution or copying of this information is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone and return the original message to us by mail or if electronic, reroute back to the sender. Thank you. If you do not receive all pages, please call the sender at the above number.

Dr. David E. Condon, D.P.M
P.O. Box 10069
Truckee, CA. 96162
Financial Policy

Patient Name _____ Date of Birth _____

Thank you for choosing us as your health care provider. Our main concern is that you receive the proper and optimal treatment needed to restore your health. Therefore, if you have questions or concerns about our financial policies, please do not hesitate to ask our office manager.

We ask that all patients present a valid insurance card at every visit if applicable and that you sign and complete our Patient Information Form prior to seeing the doctor. Payment for services is due at the time services are rendered.

Commercial Insurance – We will bill most insurance companies as a courtesy if proper information is provided at the time of your visit. Outstanding balances, co-payments and deductibles are due at the time treatment is rendered. We may agree to a payment plan arranged in good faith and honored by you. Please understand that all charges are your responsibility. Some insurance plans arbitrarily select certain services they will not cover. It is important to be familiar with your particular plan. If your insurance company has not paid the doctor correctly within 60 days of claim submission we require you to pay the balance in full. We accept checks, cash, Visa and Master Card for your convenience.

Medicare

The doctor is a Medicare participating provider and will bill Medicare for you. If you have a secondary insurance, and have not signed up for the automatic crossover, we will bill this insurance as a courtesy. Be sure to provide us with a copy of your secondary insurance card. Deductible and non-covered service payments will be due at the time of your visit. Please be aware that some of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. Medicare does not cover castings and functional orthotics.

Worker’s Compensation – If your visit is work-related we will need an authorization, the case number and insurance carrier billing information, along with your employer information prior to your visit.

Missed Appointments

Unless canceled, at least 24 hours in advance, our policy is to charge for missed appointments at the rate of \$40.00 per office visit (which will not be covered by your insurance). Please help us serve you better by keeping scheduled appointments.

Methods of Payment – This office accepts cash, checks, Visa and MasterCard. For returned checks we assess a \$25 NSF charge.

Please understand that our office reports past due accounts to an outside collections agency, if other arrangements have not been made in good faith. The patient agrees to pay all additional fees accessed in the collection of the debt. These may include collection agency fees and attorney fees.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

The patient is ultimately responsible for all fees for services.

I have read, understood and agree to the above financial policy for payments of professional fees.

X _____
Signature of Patient or Responsible Party

Date: _____

