Patient Information

Patient Name____ Male _______ Female _______

Mailing Address____________________________City______________State______Zip______

Work Number______________________________

Telephone Number_______________________Cell Number______________________________

Date of Birth___________________Social Security___________________

Marital Status/Circle One: Single Married Widow Other

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 Fax (530) 587-4293
Healthy Feet for an Active World

Please choose only 1 box in each section **Name**________________________________

The following information is required by the government for the census bureau.

Race

_____American Indian and Alaskan Native
_____Asian
_____Black or African American
_____Black Hawaiian and Other Pacific Island
_____White
_____White Hispanic or Latino
_____Decline

Ethnicity

_____Hispanic or Latino
_____Not Hispanic or Latino

Language Preference

_____English
_____Chinese
_____French
_____German
_____Italian
_____Japanese
_____Korean
_____Portuguese
_____Russian
_____Spanish

Contact Preference

_____Home Phone
_____Cell Phone
_____Work Phone
_____U.S. Mail
_____Email

Preferred Pharmacy

Truckee
_____CVS
_____RiteAid
_____Safeway
_____Tahoe Forest Hospital Pharmacy

Tahoe City
_____CVS
_____Tahoe City Pharmacy

Kings Beach
_____Safeway
_____Rite Aid

Incline Village
_____Raley's
_____Sierra Health Mart (Formerly Village Pharmacy)

Reno
_____Costco
_____Other______________________________
Please list name of Pharmacy

Sparks
_____Costco
_____Other______________________________
Please list name of Pharmacy

Carson City
_____Costco
_____Other______________________________
Please list name of Pharmacy

_____None
_____Other______________________________
Please list name of Pharmacy

In many cases we like to provide a written recap of your visit for your review. Our preferred contact method is email. Please provide an email address for this service. If you do not have an email address please indicate so here: _____no email address.

____
Email address

WELCOME TO OUR OFFICE

Name________________________________ Date:_______________ Weight__________ Height________Shoe Size____________

Please Complete:

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

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Does your problem limit your/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?

____
____

other______________________

Medicines you take and dosage:

____
____
____
____
____
____
____
____

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:________________________
__ Neurological, numbness, weakness, tremor
__Mental illness, depression, anxiety, psychosis
__Blood clots, swelling of limb, intolerance to cold
__Sweats, chills, fever, recent weight loss/gain
__Disturbance of vision, balance, smell, or taste
__Cancer, chemotherapy, radiation

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

Family history/family member:

____ diabetes/________________
____heart disease/____________
____ Cancer/_________________
____ blood clots/______________
____ foot problems/____________
____

Occupation:________________

List athletic-fitness pursuits/goals

____
____
____
____
____
____

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

Circle and give quantity to all that apply?

Tobacco product: smoke/chew___/D
Recreational Drugs: ____/D, type____

____
____
____

Last known blood pressure/date:

____

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

At worst:________________________
Right now:______________________

Your Primary Care Doctor:__________
date/condition last seen for? ____________
____

date of last Tetanus shot?___________
Preferred Pharmacy_________________

Use this space for additional comment on any sections if you need more room to answer questions.

____
____
____
____
____
____
____
____

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.

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.

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 collection fees up to 50% of the balance owed, accessed in the collection of the debt. These may include collection agency fees and attorney fees.

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______________________________ Date:____________________
Signature of Patient or Responsible Party

For the office of DAVID E. CONDON, D.P.M.

PRACTICE'S REQUIREMENTS

The Practice:

(a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

(b) Under the Privacy Rule, may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.

(c) Is required to abide by the terms of this Privacy Notice.

(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.

(e) Will distribute any revised Privacy Notice to you prior to implementation.

(f) Will not retaliate against you for filing a complaint.

EFFECTIVE DATE

This Notice is in effect as of 04/15/03.

PATIENT ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

____
Print Patient Name

____
Patient/Guardian Signature

Date:__________