Mitchell A. Barber, D.P.M., LLC

PATIENT INFORMATION

First Name: _____ **Last Name**: _____ **M.I.:** _____

Date of Birth: _____ **Social Security Number**: _____

E-Mail Address: _____ **Sex**: ___Male ___Female

Address: _____

City: _____ **State**: _____ **Zip Code**: _____

Home Phone: _____ **Work Phone**: _____ **Cell Phone**: _____

Emergency Contact Name: _____

Phone Number: _____ **Relation**: _____

RESPONSIBLE PARTY

First Name: _____ **Last Name**: _____ **M.I.:** _____

Address: _____

City: _____ **State**: _____ **Zip Code**: _____

Employer: _____ **Occupation**: _____ **Phone Number**: _____

INSURANCE INFORMATION

Primary Insurance: _____ **Member ID Number**: _____

Insured Name: _____ **Relation**: _____ **Date of Birth**: _____

Secondary Insurance: _____ **Member ID Number**: _____

Insured Name: _____ **Relation**: _____ **Date of Birth**: _____

Mitchell A. Barber, D.P.M., LLC

FINANCIAL POLICY

- Payment in full is due at time of service unless prior arrangements have been made.

- Office visit co-payments for our participating HMO/PPO insurances are due at time of service. For insurance plans with DEDUCTIBLES and CO-INSURANCE obligations, applicable amounts due for services rendered are also due at the time of service.

- If we are a participating provider with your primary health insurance, we are happy to file a claim on your behalf. However, once the insurance company is billed we allow 60 days for the balance to be paid by your insurance carrier. If the insurance company does not remit payment within 60 days, the balance will be due in full from you. If any payment is subsequently made by your insurance carrier in excess of the balance, we will gladly issue a refund overpayment to you within 30 days, providing that you do not have any outstanding accounts with our office.

- An HMO/PPO claim denial due to no referral or authorization is the patient's responsibility. Office staff will notify and assist you in referral/pre-certification procedures, but final responsibility lies with the patient to comply with their specific insurance's requirements. All referral must be presented to our office before seeing the doctor.

- Please present your most recent insurance card each time you visit if we participate with your plan to insure proper filing of information to submit claims, Otherwise your visit may not be covered and you will be responsible for payment. A **$15 service fee** will be assessed for the refiling of insurance claims due to incomplete or incorrect information given at the time of the appointment.

- There is a $25.00 fee for all returned checks.

- All unpaid balances are subject to a 1.5% interest charge after 30 days. On balances that remain unpaid after 90 days, we will take the appropriate collection actions including registering the amount past due with the EQUIFAX credit rating service. If your account must be forwarded to a collection service and/or attorney because of non-payment, you will be responsible for all collection and/or attorney fees charged by these services.

- Please be on time for your appointment. Barber Podiatry, LLC reserves the right to charge a **fee of $60.00 for all missed appointments ("no shows") and appointments which, absent a compelling reason, are not cancelled with a 24-hour advance notice.** "No Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple "no shows" in any 12 month period may result in termination from our practice. If you are 10 minutes late or more for your appointment, you may be asked to reschedule.

- If you are scheduled for an outpatient surgery, there will be a $150.00 fee for rescheduling or canceling the surgery.

ASSIGNMENT OF BENEFITS

I understand, certify that I (or my dependent) have coverage with _____
And assign directly to Mitchell A. Barber, DPM, LLC all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of my deductibles, co-payments, and/or non-covered services. I herby authorize the doctor to release all information necessary to secure payment of benefits. I authorize release of medical information to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions. By my signature I acknowledge receipt of a copy of this policy and hereby agree to its terms.

Patient Name: _____
Signature: _____ Date: _____

Mitchell A. Barber, D.P.M., LLC

SUMMARY NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. 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.

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

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

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a questions, concern or complaint regarding out privacy practices, please contact Linda Ramkumar, at 301-490-2216.

I, _____, acknowledge that I was provided a copy of the Notice of Privacy Practices
(name of patient)
and that I have read or had the opportunity to read if I so chose and understood the Notice. By signing below, I hereby authorize Dr. Mitchell A. Barber, D.P.M., LLC to obtain Medication History related to the patient above, from Community Pharmacies and/or Pharmacy Benefit Managers for the purpose of Continued Treatment.

In addition, I authorize the following, _____ access to my personal health information upon request.

_____ _____

Signature of patient or legal representative Date

Mitchell A. Barber, D.P.M., LLC

ALLERGIES

(Do you have a history of any Allergies/Skin reactions/Sickness following the administration of any of the following?)

Adhesive Tape	N	Y * List Reaction: _____	Food	N	Y *List Reaction:_____
Anesthesia	N	Y * List Reaction: _____	Iodine	N	Y *List Reaction: _____
Aspirin	N	Y * List Reaction: _____	Latex	N	Y *List Reaction: _____
Caffeine	N	Y * List Reaction: _____	Local Anesthetics	N	Y *List Reaction: _____
Codeine	N	Y * List Reaction: _____	Penicillin	N	Y *List Reaction: _____
Cortisone	N	Y * List Reaction: _____	Sulfa Drugs	N	Y *List Reaction:_____
Demerol	N	Y * List Reaction: _____	Other, Please List:		_____ _____

MEDICATIONS

Current Medications	Dosage	How Often?	What is it taken for?

MEDICAL HISTORY and FAMILY HISTORY

(Please circle "**P**" for patient history and "**F**" for family history)

Alzheimer's/Dementia	P F	Headaches/Migraines	P F	Poor Circulation/PVD	P F
Anemia	P F	Hearing Problems	P F	Rheumatic Fever/Scarlet Fever	P F
Arrhythmias	P F	Heart Disease	P F	Schizophrenia	P F
Arthritis	P F	Hepatitis A B C/Liver Disease	P F	Seizures/Epilepsy	P F
Asthma	P F	High Blood Pressure	P F	STD's (sexually transmitted disease)	P F
Bleeding/Clotting Disorder	P F	High Cholesterol	P F	Sickle Cell Trait/Disease	P F
Cancer-Type: _____	P F	HIV/Aids/ARC	P F	Stroke/TIA's	P F
Depression/Anxiety disorder/Bipolar disorder (circle)	P F	Kidney/Renal Disease	P F	Thyroid Problem (Hyper – Hypo)	P F
Diabetes – Type: _____	P F	Lung Disease/Pulmonary Embolus	P F	Tuberculosis	P F
Emphysema/COPD	P F	Lyme's Disease	P F	P F Other, Please Specify:	
Glaucoma	P F	Nerve Condition	P F		
Gout	P F	Osteoporosis/Osteopenia	P F		
GERD (Reflux) / GI Ulcers	P F	Phlebitis (blood clots in legs)	P F	None of the above	

SURGICAL HISTORY

Procedure	Date	Complications

Signature: _____ **Date:** _____

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PATIENT HISTORY

(Please complete all forms to the best of your ability. The staff will answer any question you may have.)

Patient Name: _____ **Date of Birth**: _____

Current Height: _____ **Current Weight**: _____ **Shoe Size**: _____

Employer: _____ **Occupation:** _____

Primary Care Physician: _____ **Phone**: _____

Pharmacy: _____ **Location**: _____

Reason for your visit: _____

How long as this been a problem? _____

When does it occur (please circle): Morning - Afternoon - Evening - Off and On - All Day

Type of pain (please circle): Burning–Tingling–Sharp–Dull Ache–Throbbing–Shooting–Stabbing – Numbness

List current sports and/or activities: _____
_____

Type of Pain: (please circle)

Burning - Tingling - Sharp - Dull Ache - Throbbing - Shooting Stabbing - Numbness

When is it painful? (please circle)

Upon Standing - During Walking - After Walking - During Sports - Worse with Activity – Lying in Bed
Worse When Standing - With Shoes - Without Shoes - A.M. - P.M. - Always

How painful is your condition? If 0 = 'NO Pain' and 10 = 'the worst pain' Please circle your pain level.

0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

H**ave you had foot and/or ankle care before**? (please circle) **YES NO**

If yes, by whom? _____ **When**: _____

Social History

SMOKING
Have you ever smoked? YES NO
If yes, how many years? _____ How long ago did you quit? _____
ALCOHOL USE
Do you or did you ever drink alcoholic beverages? YES NO
How many drinks will you consume in a day? ___ Week? ___
How long ago did you quit? _____

RECREATIONAL DRUG USE:
Do you or have you used illicit/recreational drugs? YES NO
If yes, which ones? _____
How long ago did you quite? _____
Women:
Are you currently pregnant? YES NO
If yes, what is your due date? _____

Signature: _____ **Date:** _____

Mitchell A. Barber, D.P.M., LLC

REVIEW OF SYSTEMS

If you are experiencing any of the following please circle

Head: Chronic headaches, concussions, dizziness, loss of consciousness.

Eyes: Glasses, contacts, double vision, blurred vision, blindness, cataracts.

Ears: Decreased or loss of hearing, ringing in the ears, chronic earaches

Nose: Draining or infection, blockage, bleeding, sinusitis.

Throat: Chronic tonsillitis, laryngitis, difficulty swallowing, loss of speech.

Cardiovascular: Chest pain, shortness of breath, palpitations, murmur, heart valve disease, anemia, leg cramps.

Respiratory: Bronchitis, pneumonia, difficulty breathing, wheezing, chronic cough.

Gastrointestinal: Nausea, vomiting, diarrhea, constipation, weight gain or loss, blood in stool, black in stool, excessive gas, loss of appetite.

Genitourinary: Chronic kidney or bladder infections, problems voiding, pain with urination, dark or bloody urine, discharge from penis or vagina.

Gynecologic: Irregular or painful periods, absence of period if not menopause, vaginal discharge.

Other: _____

□ Do your legs swell? ____Yes ____No

□ Do you have back problems or have had a back injury? ____Yes ____No

□ I am not experiencing any of the above symptoms**.**

Signature: _____ Date: _____

Consent for Treatment: I certify that the information above is true and correct to the best of my knowledge. I have been informed that if I am uncertain about any question on the form I should ask the doctor or a member of the office staff for assistance. By signing below, I hereby authorize Dr. Mitchell A. Barber, D.P.M., LLC to obtain medication history from community pharmacies and/or pharmacy benefit managers for the purpose of ongoing treatment.

_____ _____

Patient or Guardian Signature Date