Feet For Life LLC
Dr. Stewart Pierson, DPM

811 - 10th Avenue North, Bessemer, AL 35020-5320
Office Phone: (205) 424-9199 / Fax: (205) 424-9189

Stewart M. Pierson, DPM

THANK YOU FOR CHOOSING OUR OFFICE!

When you arrive for your appointment, you **MUST** have the following items with you in order to be seen by the doctor:

1. Insurance Cards
2. Driver's License or Photo ID
3. Co-Payment or any deductible that may be due per your insurance
4. Current medication list
5. If your insurance requires a referral, it is YOUR responsibility to obtain this
6. The shoes you wear most often
7. New Patient Paperwork (attached)

**Please arrive 15 minutes prior to your appointment time so we can get your information put into our computers. We look forward to meeting you soon!!

PLEASE NOTE

IF YOU DO NOT HAVE YOUR INSURANCE CARDS, PROOF OF IDENTIFICATION WITH PHOTO, AND CO-PAYMENT/DEDUCTIBLE WITH YOU, WE WILL NOT BE ABLE TO SEE YOU AND WILL HAVE TO RESCHEDULE YOUR APPOINTMENT.

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NEW PATIENT INFORMATION

Name:		
Address:		
City:	**State:**	**Zip Code:**
Home Phone: ( )		**Cell Phone: ( )**
Emergency Contact Name:		**Phone: ( )**
Email Address:		
Date of Birth: / /	**Social Security #:**	
Sex: M F	**Marital Status:**	

INSURANCE INFORMATION

Co-Payment: $

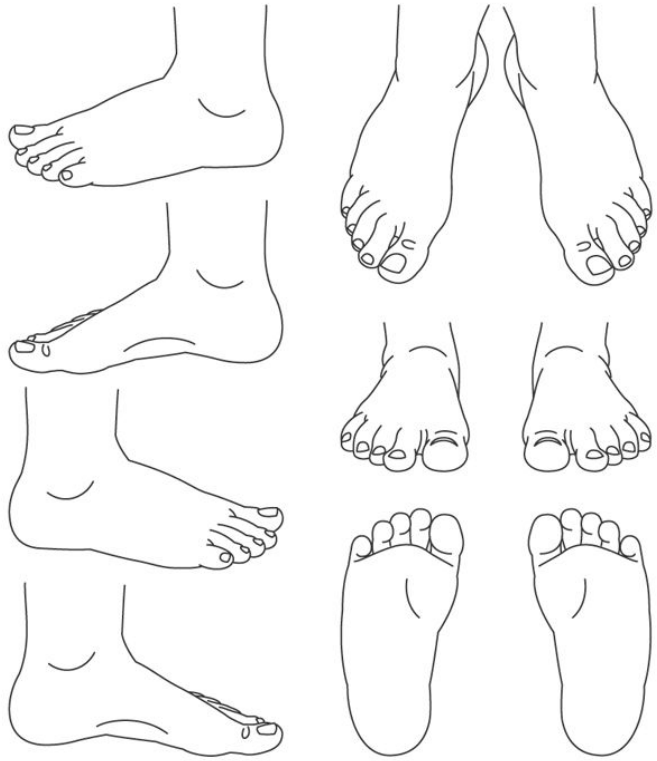
PRIMARY - Name of Insured:	**DOB of Insured:**
Insurance Carrier:	
Policy Number:	**Group Number:**
SECONDARY - Name of Insured:	
Insurance Carrier:	
Policy Number:	**Group Number:**

Describe the reason for your visit today: _____

_____

How long have you had the above problems? _____

Please mark an "X" on the problem areas you have on the diagram below:



Type of Pain: (Circle)
Sharp Burning Stabbing
Aching Tingling Numbness

When does it bother you most?
Morning Mid-day Afternoon
Night Constant

Have you tried any ways to help this problem yourself?

_____
_____
_____
_____

What medications are you currently taking? If you have a list, please attach to this page.

_____

_____

Do you have any allergies to medications? (Please circle) **YES** **NO**
If yes, what medications are you allergic to? _____

_____

Are you allergic to Latex? (Please circle) **YES** **NO**
Any problems with local anesthetics? (Novocain, Lidocaine, etc) (Please circle) **YES** **NO**
Smoking History: (Please circle) Current Smoker Former Smoker Non Smoker
If you smoke, how much do you smoke per day? (Please circle) Less than 1 pack More than 1 pack
Do you drink alcohol? (Please circle) Often Occasionally Never

Shoe size _____ **Special shoes?** _____ **Current Weight** _____ **Height** _____ **BP** _____
Do you use: (Please circle) Walker Crutches Cane Wheelchair Stroller
Are you currently pregnant? (Please circle) **YES** **NO**
Are you currently nursing? (Please circle) **YES** **NO**

Primary Care Physician _____ **Last Seen** _____

Pharmacy (with City)_____

Who referred you? _____

***Past Medical History*:**

	You / Your Family			You / Your Family	
Anemia	□	□	**Hepatitis**	□	□
Asthma	□	□	**Lung Disease**	□	□
Arthritis	□	□	**Mental Illness**	□	□
Cancer	□	□	**Osteoarthritis**	□	□
Diabetes	□	□	**Osteoporosis**	□	□
Alcoholism/Drug Abuse	□	□	**Phlebitis**	□	□
Depression	□	□	**PVD**	□	□
Epilepsy	□	□	**Rheumatoid Arthritis**	□	□
Glaucoma	□	□	**Stroke**	□	□
Heart Disease	□	□	**Thyroid Disease**	□	□
High Blood Pressure	□	□	**Tuberculosis**	□	□
High Cholesterol	□	□	**Stomach Ulcer**	□	□
Kidney Disease	□	□	**Venereal Disease**	□	□
Liver Disease	□	□	**HIV/Immune Disease**	□	□
COPD	□	□	**Hepatitis**	□	□
Psoriasis	□	□	**Gout**	□	□

Past Surgical History: **(Please list complete history of all surgeries/procedures and dates)**

***Review of Systems*:**

Do you have or have you had any of the following conditions? Circle all that apply:

Constitutional:
Appetite Loss Fever Head Injury Chills Dizziness Weight Loss

HEENT (Head, Eyes, Ears, Nose, Throat):
Glasses Double Vision Blurred Vision Balance Loss Ringing in the Ears
Poor Hearing Nose Bleeds Mouth Sores Dry Mouth Sore Throat

Cardiovascular:
Ankle/ Foot Swelling Shortness of Breath Leg Pain Chest Pain Varicose Veins
Palpitations Cold Feet Irregular Heartbeat

Respiratory:
Blood in Sputum Cough Night Sweats Shortness of Breath on Exertion
Shortness of Breath when Lying Down

Gastrointestinal/Urinary:
Nausea Vomiting Heartburn Blood in Stool Stomach Pain Kidney Stones
Frequent Urination

Integumentary:
Unexplained Bruising Skin Rash Skin Discoloration Toenail Problems Open Sores
Thick Scarring/Keloids

Neurological:
Loss of Sensation Burning Sensation Tingling Numbness Seizures Tremor

Musculoskeletal:
Stiffness in the Big Toes Hammer Toe Leg Cramps Joint pain Bumps in feet
Difficulty Walking Poor Balance History of Falling Back Pain Muscle Pain
Stiffness Aching

Endocrine:
Diabetes taking Insulin Diabetes NOT taking Insulin Heat/Cold Intolerance

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ACKNOWLEDGEMENT AND RECEIPT FOR NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understand the Notice of Privacy Practices.

_____ _____

Patient Name (Please Print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature

Questions & Complaints

If you think that we have violated your privacy rights, contact the person named below. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

Cathy Wesson -- Feet For Life, LLC
811 - 10th Avenue North
Bessemer, AL 35020
(205) 424-9199

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NARCOTICS OFFICE POLICY

1. Narcotic prescriptions will **NOT** be refilled early.
2. Lost, stolen, or damaged narcotic prescriptions will **NOT** be replaced.
3. Narcotic prescriptions can **NO** longer be phoned in. All refills will need to be picked up at the office.
4. **NO** new or additional prescriptions for narcotics will be written without first being seen by the doctor in the office.
5. Visits made to the office at any time after the posted **REGULAR OPERATING HOURS** will be subject to a **$50.00** service fee, which is in addition to the standard office visit charge. This fee must be paid at the time of the service and will **NOT** be billed to your insurance provider.

_____ _____

Patient Acknowledgement Date

Feet For Life LLC
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CELL PHONE POLICY

Cell Phone Usage Is No Longer Allowed In Our Office Due To Safety Concerns, Patient Confidentiality As Well As Quality Of Care.

NO CELL PHONES ALLOWED

Please Turn All Cell Phones **OFF** Before Entering The Office.

Patients Who Do Not Comply With This Cell Phone Policy, Will **NOT** Be Seen In This Office.

I Acknowledge That I Have Read And Understand The Cell Phone Usage Policy Of Feet For Life, LLC.

_____ _____

Patient Acknowledgement Date

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MEDICAL RECORDS RELEASE FORM

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name _____ **Date of Birth** _____

Patient/Guardian Authorization

You may use or disclose the following health care information:

- ❑ All my health information including, but not limited to, AIDS/HIV and other Communicable Disease Information, Behavioral Health Care/Psychiatric Care, Alcohol and/or Drug Abuse Treatment, if any, unless specifically expected:_____
  _____
- ❑ Other: _____

You may disclose this health information to:

Name: Feet For Life, LLC

Address: 811 - 10th Avenue North, Bessemer, AL 35020

Phone: (205) 424-9199 Fax: (205) 424-9189

_____ _____

Patient or Legally Authorized Individual Signature Date

_____ _____

Printed Name if Signed on Behalf of the Patient Relationship (Parent, Legal Guardian)

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Payment Agreement Policy And Insurance Filing Procedures for This Office Agreement to Pay:

By signing this agreement to pay, you the patient agree to the following:

1. I will pay any COPAY, DEDUCTIBLE, NON COVERED SERVICES, OVER THE COUNTER PRODUCTS or BALANCE that is left after my health insurance has been exhausted with-in 90 days of the balance being due to me.
2. If I cannot pay any balance that is due from me "the patient" with-in the 90 day time frame, I will contact the billing department of Family First FootCare, LLC. (Feet For Life, LLC), at 205-454-4840 to make payment arrangements.
3. I will follow any and all payment arrangements made by me "the patient" with the billing department.
4. I understand that if my account is not paid with-in 90 days and no payment arrangements have been made with Family First FootCare, at 205-454-4840, my account may be turned over to Franklin Collections Services for collections.
5. I understand that a fee of 40% will be added to my balance due at the time my account is turned over to Franklin Collections.
6. I understand that if I have Medicare my annual deductible is due at the time of service and may not be billed.
7. I understand that if my insurance requires a REFERRAL that it is my "the patient's" responsibility to obtain the initial referral, and inform Family First FootCare, LLC. (Feet For Life, LLC), that my insurance requires a referral for each visit. It is also my "the patient's" responsibility to obtain any referral needed for insurance payment when being seen at an outpatient surgical facility or hospital.
8. I understand that if I have any health insurance my COPAY / CO-INSURANCE / DEDUCTIBLE is due before any services are rendered.
9. I understand that there will be a fee of $35.00 if any check written to this office is returned as NON-SUFFICIENT/ACCOUNT CLOSED, etc. I also understand that I will also not be allowed to write checks to this office in the future. Your bank will notify you if your check has been dis-honored and it is your responsibility to contact this office to make good on the check. Only cash, debit or credit card will be accepted to pay any dishonored check written to this office.
10. I understand that it is my responsibility to report to this office any change of Insurance, address or phone number. Some insurance companies have only a very limited filing limit. If you do not report a change to us a change in your health insurance and it is rejected due to timely filing, you are responsible for the entire visit cost.
11. I understand that Medicaid does not cover Podiatry services unless I am 19 years of age or younger. If you have a Medicare QMB Policy, I am responsible for all Medicare deductibles and Co Insurances.
12. I understand that I will be charged $150 if I do not show or do not cancel any appointment for surgery within 24 hours. This includes office surgeries and any out-patient surgery.

_____ _____

Patient's Signature Date Witness Signature Date

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Our Insurance Filing Policy

We will electronically file your primary insurance for you as Dr. Stewart Pierson is PMD/PPO with most insurance companies in Alabama. We will also file your secondary/Tertiary insurance for you as a courtesy. We will not file any claims to third parties, such as AFLAC, DISABILITY, LIFE INSURANCE companies unless we have an agreement on file with them to do so. We will honor any health insurance's fee scheduled payment that we have an agreement with. You "the patient" will only be responsible for any balance up to that fee schedule. Some insurance policies require all appointments to this office be Pre-authorized. It is essentially up to you "the patient" to notify us if any Pre-authorization is required by your insurance.

As your Podiatrist, I want to provide you with the best care possible. There may be certain services that I feel necessary for the maintenance of good health that are not covered by your insurance. You will be expected to pay for these services in full. For example, I may need to request additional office visits or order orthotics which may be considered non-medical by your insurance company, although I consider them necessary for surgical procedures, diagnostic purposes, or other treatments. Most insurance companies require a medical diagnosis according to the terms of your contract with them. Let me assure you that we will only order or perform the procedures, tests or items that we feel necessary for your treatment and care. If you have any questions about your insurance, someone in our office will be happy to assist you.

I authorize the release of any medical information necessary to process and request payment of benefits to the party that accepts assignment. I also understand there is a minimum charge of $20 to request copies of my medical records and $5 charge for statement copies.

_____ _____

Patient's Signature Date Witness Signature Date

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No Show/Cancellation Policy

We schedule our appointments so that each patient receives the appropriate amount of time to be seen by our physicians and staff. That's why it is very important that you keep your scheduled appointment with us, and arrive on time.

If you do not cancel or reschedule your appointment within at least 24 hours notice, we may assess a **$25 "no-show"** service charge to your account. This "no-show charge" is NOT reimbursable by your insurance company. You will be billed directly for it.

After three consecutive no-shows to your appointment, our practice may decide to terminate its relationship with you.

Patient's Signature _____ Date _____ Printed Name _____