Feet For Life LLC
Dr. Stewart Pierson, DPM

731 9th 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:

- ☐ Insurance card(s)
- ☐ VALID Driver's License or Photo ID
- ☐ Current medication list
- ☐ The shoes you wear most often
- ☐ Co-Pay or any deductible that may be due per your insurance **

****If your insurance requires a referral, it is YOUR responsibility to obtain this****

*****Please arrive 30 minutes prior to your appointment. We look forward to meeting you soon*****

****** PLEASE NOTE******

IF YOU DO NOT HAVE YOUR INSURANCE CARD(S), PROOF OF IDENTIFICATION WITH PHOTO THAT IS VALID, AND CO-PAY/DEDUCTIBLE WITH YOU, WE WILL NOT BE ABLE TO SEE YOU AND WILL HAVE TO RESCHEDULE YOUR APPOINTMENT.

NEW PATIENT INFORMATION

Name:		
Address:		
City:	**State:**	**Zip:**
Home Phone:	**Cell Phone:**	
Emergency Contact:	**Phone:**	
Email Address:		
Date of Birth: / /	**SSN:**	
Sex: ☐ **M** ☐ **F**	**Marital Status:** Single	

Reason for your visit: _____

_____

How long have you had these problems: _____

Type of Pain:

Sharp ☐ Burning ☐ Stabbing ☐ Aching ☐ Tingling ☐ Numbness ☐

When does it bother you the most:

Morning ☐ Mid-day ☐ Afternoon ☐ Night ☐ Constant ☐

Previous Treatments: _____

_____

What medications are you currently taking ***(If you have a list, please attach to this page)*****:**

_____

_____

Do you have any allergies to medications: ☐ YES ☐ NO

If yes, what medications are you allergic to: _____

Are you allergic to Latex: ☐ YES ☐ NO

Any problems with local anesthetics–Novocain, Lidocaine, etc : ☐ YES ☐ NO

Smoking History: ☐ Current smoker ☐ Former smoker ☐ Never smoker

If you smoke, how much do you smoke per day: ☐ < 1 pk ☐ > 1 pk

Do you drink Alcohol (CIRCLE): ☐ Often ☐ Occasionally ☐ Never

Shoe size _____ **Special shoes** _____ **Current weight**_____ **Height**_____

Do you use: ☐ Walker ☐ Crutches ☐ Cane ☐ Wheelchair

Are you currently pregnant: ☐ YES ☐ NO **Nursing:** ☐ YES ☐ NO

Current Flu Vax: YES_☐_ **NO**_☐_ **If No, reason:**_____

COVID-19 Vax: Full_☐_ **No**_☐_ **Blood thinners: YES**_☐_ **NO**_☐_

Pacemaker: YES_☐_ **NO**_☐_ **Defibrillator: YES**_☐_ **NO**_☐_

Pneumonia Vax: YES_☐_ **NO**_☐_ **Living Will/POA: YES**_☐_ **NO**_☐_

Primary Care Physician _____ **Last Seen** _____

Pharmacy and Location _____

Referred by: _____

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

_____

_____

Past Medical History for You and Your Family:

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

Other:_____

Review Of Systems–Do you have or have you had any of the following conditions?

Musculoskeletal:
- Joint pains ☐
- Bumps in feet ☐
- Joint swelling ☐
- Joint stiffness ☐
- Unsteady gait ☐
- Back pain ☐
- Muscle pain ☐
- Hammertoe ☐

Neurological:
- Numbness ☐
- Tingling ☐
- Burning ☐
- RSD ☐
- Headaches ☐
- Tremors ☐

Constitutional:
- Fatigue ☐
- Dizziness ☐
- Unexpected weight los ☐
- Loss of appetite ☐
- Fever ☐
- Chills ☐
- Weight gain ☐

Integumentary:
- Poor healing wounds ☐
- Toenail problems ☐
- Rash ☐
- Itching ☐
- Scarring/Keloids ☐
- Easy bleeding ☐
- Easy bruising ☐
- Enlarged lymph nodes ☐

Cardiovascular:
- Chest pain ☐
- Palpitations ☐
- Ankle/Foot swelling ☐
- Cold feet ☐
- Fainting ☐
- Night sweats ☐
- Heart murmur ☐
- Leg cramps ☐

HEENT:
- Nose bleeds ☐
- Balance loss ☐
- Ringing in ears ☐
- Poor hearing ☐
- Sore throat ☐
- Dry mouth ☐
- Corrective lenses ☐
- Blurred vision ☐

Gastrointestinal:
- Heartburn ☐
- Nausea/Vomiting ☐
- Constipation ☐
- Diarrhea ☐
- Bloody/Tarry stools ☐
- Frequent urination ☐
- Difficult/Painful Urination ☐
- Blood in urine ☐

Respiratory:
- Shortness of breath ☐
- Cough ☐
- Hurts to breathe ☐

Endocrine:
Type 1 Diabetes ☐ Type 2 Diabetes ☐ Heat/Cold Intolerance ☐

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 (PRINT) **Date**

_____ _____

Parent/Authorized Representative **Signature**

Questions and 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 US Department of Health and Human Services. We will provide you with the address to file your complaint with the US Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

Feet For Life, LLC
811 10th Ave N
Bessemer, AL 35020
Office: 205-424-9199
Fax: 205-424-9189

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**

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 treatment room.

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**

NO SHOW/CANCELLATION POLICY

We schedule our appointments so that each patient receives the appropriate amount of time to be seen by our physician and staff. That's why it is essential 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 $50 "**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 Acknowledgement **Date**

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 information to:
Feet For Life, LLC – 811 10th Ave N, Bessemer, AL 35020

_____ _____
Patient or Legally Authorized signature **Date**

_____ _____
Parent/Authorized Representative Signature **Relationship (Parent or Legal Guardian)**

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, or LIFE INSURANCE companies unless we have an agreement on file with them to do so. We will honor any health insurance 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 to 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 are 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 are 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 the assignment. I also understand there is a minimum charge of $20 to request copies of my medical records and a $5 charge for statement copies.

_____ _____
Patient Signature **Date** **Witness Signature** **Date**

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"** within the 90-day time frame, I will contact the billing department of **Feet For Life, LLC** at **205-454-5525** 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 within 90 days and no payment arrangements have been made with **Feet For Life, LLC** at **205-454-5525**, 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 Services**.
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,** it is my **"the patient's"** responsibility to obtain the initial referral and inform **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 **$50.00** if any check written to this office is returned as **NON-SUFFICIENT/ACCOUNT CLOSED**, etc. I also understand that I will not be allowed to write checks to this office in the future. Our bank will notify you if your check has been dishonored 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 I have a **Medicare QMB Policy**, I **"the patient"** am responsible for all Medicare deductibles and co-insurances.
12. I understand that I will be charged **$150** if I **DO NOT** show up or do not cancel any appointment for surgery at least 24 hours prior to my surgery. This includes office surgeries and any out-patient surgery.

Patient Signature **Date** **Witness Signature** **Date**