NAME:_____**DOB**: _____

ADDRESS: _____

HOME #:_____**CELL #**:_____

SEX: (CIRCLE) *MALE FEMALE* **RACE**: _____ **ETHNICITY:** _____

MARITAL STATUS: (CIRCLE) SINGLE DIVORCED MARRIED WIDOWED SEPARATED

EMERGENCY/HIPAA CONTACT:_____**PHONE #**: _____

EMPLOYER/ OCCUPATION: _____

PRIMARY INSURANCE: _____ **ARE YOU THE INSURED**: (CIRCLE) *YES NO*

SUBSCRIBER NAME AND ID#: _____**RELATIONSHIP**:_____

SECONDARY INSURANCE: _____**ARE YOU THE INSURED**: (CIRCLE) *YES NO*

SUBSCRIBER NAME AND ID#: _____**RELATIONSHIP:**_____

IS THIS THE RESULT OF AN ACCIDENT? *(Circle) YES NO* **DATE OF INJURY**: _____

IF SO, *(circle) WORKERS COMP or NO FAULT INSURANCE*

PRIMARY CARE PHYSICIAN:_____**DATE LAST SEEN**: _____

ENDOCRINOLOGIST:_____**DATE LAST SEEN**: _____

PHARMACY:_____**ADDRESS**: _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

WHAT IS THE REASON FOR YOUR VISIT? _____

_____

HOW LONG HAS THIS BEEN BOTHERING YOU? _____

METHOD OF CONTACT: ____PHONE (MOBILE OR HOME) ____TEXT ____PATIENT PORTAL

CIRCLE ON

Please Read and Sign below:

The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information whether demographic or medical listed. (Assignment of Benefits): I authorize payment of medical benefits to the practice named above. (Release of Information): I authorize the release of any medical information necessary to process this claim. (HIPAA Privacy): I acknowledge that I received my HIPAA Privacy Practices Notice. (Medication History): I authorize the Doctor's office to retrieve my medication history.

Patient Signature: _____ **Date**: _____

FINANCIAL POLICY

Thank you for trusting your Podiatric care to **Albany Podiatry**. When you schedule an appointment with Albany Podiatry, we set aside enough time to provide you with the highest quality of care. Should you need to cancel or reschedule an appointment kindly give at least 24-hour notice. This gives us sufficient time to schedule other patients who may be waiting for an appointment. You may contact Albany Podiatry 7 days a week at 518-482-4321. You may leave a confidential voice message.

Cancellations/Missed Appointment

- Any established patient who misses an appointment, or cancels less than 24 hours before the appointment time will be assessed $35 fee. A new patient will be assessed a $50 fee. A missed treatment appointment is $50 fee.

Subject to Discharge

- Any patient who no shows or cancels **twice** without proper notification will be discharged from the practice.

Returned Check

- A $35 fee will be assessed on all returned checks.

Past Due Balances

- If balances are not received within 30 days from the date of your statement, a $10 rebilling fee will be added to your next statement. A credit card on file eliminates possibility of a finance charge. Past due accounts, more than 90 days, will be turned over to our collection agency.

Copayments

- It is a requirement of your insurance company that we collect your co-pay at time of your visit. A $10 fee will be assessed if not paid at check out.

Deductible/ Co-Insurance/More than 1 plan

- If you have a deductible, co-insurance plan or more than one plan we require a valid credit card to be encrypted and stored securely.
- We will not charge the card until we receive the explanation of benefits from your insurance company. Your card will be charged only what you are assessed.
- You will receive a paid receipt once your card is charged. **We will never charge more than $300 at a time.**
- **Any remaining balance will be charged the next billing cycle.**

Late Arrival

- Patients arriving more than 15 minutes late may need to reschedule their appointment.

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION: I authorize payment of medical benefits to Albany Podiatry. I authorize the release of any medical information necessary to process any claims to my insurance company.
I have read and understand these financial policies.

Patient Name (print): _____**Date:**_____

Patient Signature/Responsible Party: _____

NAME: _____ **DOB:** _____

MEDICAL HISTORY: ***check all that apply***

___ ALCOHOLISM
___ BLOOD DISORDERS
___POOR CIRCULATION
___ BREATHING ISSUES
___ LIVER
___THYROID DISEASE
Specify: _____

___ NEUROPATHY
___ GOUT
___ ALLERGIES
___ HEART DISEASE
___ ASTHMA
___ ARTHRITIS
Specify: _____

___ KIDNEY DISEASE
___ BLOOD CLOT
___ HIGH CHOLESTEROL
___ HIV
___ CVA
___ CANCER
Specify: _____

___ HYPERTENSION
___ SKIN DISORDERS
___ STROKE
___ DIABETES:
TYPE 1 or TYPE 2
___ HEPATITIS
Specify: _____

CURRENT MEDICATIONS: _____

_____

ALLERGIES: _____

LAST FLU SHOT DATE: _____ **PNEUMOCOCCAL VACCINATION DATE** if over 65: _____

SURGICAL HISTORY: _____

ARE YOU PREGNANT? *(circle)* yes no **ARE YOU NURSING?** *(circle)* yes no

FAMILY HISTORY: ***check all that apply & indicate family member***

___ ALZEIMER'S:
Family member: _____

___ DEPRESSION:
Family member: _____

___ ARTHRITIS:
Family member: _____

___ DIABETES:
Family member: _____

___ BLEEDING DISORDERS:
Family member: _____

___ EMPHYSEMA:
Family member: _____

___ BLOOD CLOT:
Family member: _____

___ HEART DISEASE:
Family member: _____

___ CANCER:
Family member: _____

___ HIGH BLOOD PRESSURE:
Family member: _____

___ CATARACTS:
Family member: _____

___ NEUROLOGICAL:
Family member: _____

___ CIRCULATION PROBLEMS:
Family member: _____

___ STROKE:
Family member: _____

___ OTHER: _____
Family member: _____

SOCIAL HISTORY:

DO YOU SMOKE? (*circle)* current former no IF CURRENT, HOW MANY PACKS PER DAY? _____

DO YOU DRINK ALCOHOL? *(check)* ___ yes, 5-7 days a week ___ yes, occasionally ___ no, rarely

SUBSTANCE ABUSE: *(circle)* yes no (current or past) *specify*: _____

DO YOU EXERCISE REGULARLY? *(circle)* yes no *specify:* _____

REVIEW OF SYSTEMS: ***check all that apply***

CV:

___ anticoagulant therapy
___ atrial fibrillation
___ blood clots
___ chest pain/ pressure
___ cold extremities (hands/feet)
___ heart disease
___ dizziness
___ hypertension
___ irregular heart beat
___ pacemaker
___ palpitations
___ pain in calves when walking
___ PVD
___ varicose veins
___ other: _____
___ none

RESPIRATORY:

___ asthma
___ breathing difficulty
___ chest pain
___ COPD
___ cough
___ emphysema
___ oxygen use
___ sleep apnea
___ shortness of breath
___ respiratory disease
___ snoring
___ wheezing
___ other: _____
___ none

GI:

___ abdominal pain
___ constipation
___ diarrhea
___ gallstones
___ heartburn
___ hernia
___ IBS
___ reflux
___ stomach ulcers
___ stool – blood
___ swallowing – difficulty/ pain
___ none

GU:

___ difficulty urinating
___ frequency
(cicle) <1hr >1hr
___ hesitancy
___ kidney stones
___ kidney disease
___ urgency
___ other: _____
___ none

MUSCULO:

___ arthritis
___ fibromyalgia
___ instability
___ muscle aches
___ osteoarthritis
___ pain in back
___ pain in joints
___ pain in muscles
___ pain in neck
___ stiffness in joints
___ swelling of joints
___ weakness of joints
___ weakness of muscles
___ other: _____
___ none

SKIN:

___ calluses
___ cellulitis
___ dryness
___ itchy skin
___ psoriasis
___ rash
___ skin cancer
___ sweating excessive
___ warts
___ nail symptoms
___ nail brittleness/ peeling
___ nail cracking
___ nail ingrown
___ other: _____
___ none

NEURO:

___ dizziness
___ headaches
___ imbalance
___ neuropathy
___ numbness/ tingling in feet
___ paralysis
___ Parkinson's disease
___ seizures
___ stroke
___ tremor
___ none

HEMA/LYMPH:

___ anemia
___ anticoagulant use- long term
___ bleeding/ clotting disorder
___ bleeding/ bruising tendency
___ blood disease
___ vitamin B12 deficiency
___ vitamin D deficiency
___ other: _____
___ none

SHOE SIZE: _____ HEIGHT: _____ WEIGHT: _____ BLOOD PRESSURE: _____