valley foot & ankle pc

Dr. Brandon D. Wilde

Patient Information

Date:_____

Name: _____ Phone: _____ Cell:_____
(First) (Last) (Initial)

Date of Birth: _____Sex:_____SS#:_____ Email Address: _____

Address: _____ City:_____ ST: _____ Zip: _____

Emergency Contact: _____ Relationship:_____ Phone: _____

Ethnicity: ☐ Hispanic or Latino ☐ Non Hispanic or Latino ☐ Decline to answer

Race: ☐ American Indian ☐ Asian ☐ African American ☐ Pacific Islander ☐ White ☐ Decline to answer

How did you hear about us?: Doctor_____Friend _____Patient_____

Internet/Social Media_____Other(Please Specify)_____

Primary Insurance: _____ Policy #: _____ Group #:_____

Policy Holder: _____Relationship: _____Date of Birth: _____

Are you a Hospice patient covered by Medicare? ❑ YES ❑ NO

Secondary Insurance: _____ Policy #: _____ Group #:_____

Policy Holder: _____ Relationship: _____Date of Birth: _____

Is this visit work related? ❑ YES ❑ NO

*This is for children under the age of 18. The Responsible Party is the parent or legal guardian of the child.

Responsible Party: _____ Phone: _____ Cell: _____

Address: _____ City: _____ ST: _____ Zip: _____

Date of Birth: _____ Age: _____ Sex: _____ Relationship: _____ SS# _____

Please note: As a service to you, we may send a report to your Primary Physician about your foot problem and our treatment plan. If you object to this, please let us know.

Agreement: I authorize Dr. Brandon D. Wilde and/or assistants to render proposed examination and treatment. I authorize release of any medical records necessary to facilitate consultation on my care, or to process insurance claims. I also authorize direct payment of all related insurance benefits to Valley Foot & Ankle. I accept full responsibility for professional services and materials provided in rendering treatment, as well as any account service charges which apply.

Written Acknowledgement for the Receipt of the Notice of Privacy Practices: (HIPAA)

I (patient/representative) have been informed of Dr. Brandon D. Wilde Notice of Privacy Practices.
I also understand a copy is available to me upon request.

Date:_____ Signature: _____
(Patient or Responsible Party)

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Brandon D. Wilde, DPM

Authorization for Release of Information

Patient Name:_____ Date of Birth:_____

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members, you must sign this form. Signing this form will only give information to the people indicated below.

I give permission to contact the below individuals regarding fee estimates for medical equipment and/or surgical procedures in the event I can not be contacted: ☐ **YES** ☐ **NO**

I authorize Valley Foot & Ankle to release my medical and/or billing information to the following individual(s):

1. Name:_____ Relation to Patient:_____

Phone Number_____

2. Name:_____ Relation to Patient:_____

Phone Number_____

3. Name:_____ Relation to Patient:_____

Phone Number_____

Patient Information

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.

You have the right to revoke this consent in writing.

Signature:_____ **Date:** _____

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Medical History Questionnaire

Name: _____ **Date of Birth:** _____ **Shoe Size:** _____

Marital Status: [ ]Single [ ]Married [ ]Divorced [ ]Widowed

Do you drink alcohol? [ ]**Yes** [ ]**No** If **Yes**, [ ]Occasional [ ]1/day [ ]2-3/day [ ]4+/day

Do you use Recreation Drugs? [ ]**Yes** [ ]**No** If **Yes,** please specify:_____

Primary Care or Family Doctor (Name or Clinic Name):_____

This information is required for insurance reporting purposes: **Height:**_____ **Weight:**_____

Have you had a Pneumonia Vaccine in the last YEAR: [ ]**Yes** [ ]**No**

Have you had an Influenza Vaccine (Flu Shot) in the last 6 MONTHS: **Yes** [ ] **No** [ ]

Do you Smoke? [ ]**Yes** [ ]**No** If **Yes**, [ ] Less than 5/day [ ]1/2 Pack/day [ ]1 Pack/day [ ]1+ Pack/day

Do you Vape or use E-Cigarettes?
[ ]**Yes** [ ]**No** If **Yes,** [ ]Less than once a day [ ]Once a day [ ]2 times day [ ]3 times day

Major Illnesses: Circle any conditions that YOU have:

High Blood Pressure Lung Disease HIV Positive Hepatitis (A, B or C) Stroke Heart Attack (date)_____

Diabetes(Insulin or Non-Insulin Dependant) Cancer (type)_____ Bleeding Disorders(explain)_____

List any Injuries (concussion, broken bones, etc)**:** _____

_____

List ALL surgeries you have had, include the year (tonsillectomy, appendectomy, heart by-pass, etc.):

_____

_____

Lower Extremity/Primary Complaint
Please Circle any condition that you **CURRENTLY** have:

Skin Disorders/Infections/Skin Breaks Circulation Problems Numbness/Burning/Tingling/Twitching Gout

Joint Pain/Deformity Localized Weakness/Sprains/ Strains Excess Fatigue with Walking Area of Redness and Pain

General Health: Do you **CURRENTLY** have any of the following problems?

Problem	Yes	No	Problem	Yes	No	Problem	Yes	No
Headaches			Emphysema			Arthritis		
Sinus			Shortness of Breath			Seizures/Fainting Spells		
Hard of Hearing or Hearing Aids			Tuberculosis (Active/Non-Active)			Chronic Infection/Weak Immune System		
Fever			Chronic Cough			Alzheimer's Disease/Dementia		
Artificial Heart Valves			Oxygen Use			MRSA(Current or History of)		
Pacemaker			Sleep Apnea (CPAP?)			Anxiety/Depression		
Chest Pain/Irregular Heart Beat			Stomach or Intestinal Disease			Insomnia		
Blood Clots			Liver Disease			Thyroid		
High Blood Pressure			Genital/Prostate			Sjorgrens		
Bleed or Bruise Easily			Kidney(Dialysis?)			Lupus/Autoimmune Disorder		
Asthma			Bladder			Paralysis		

PLEASE TURN OVER TO COMPLETE

General Health (continued):

[ ]**Yes** [ ]**No** Do you think you may be pregnant at this time?
[ ]**Yes** [ ]**No** Have you, or any member of your family, had a problem with anesthesia?
[ ]**Yes** [ ]**No** Do you take any blood thinners? (Including aspirin)
[ ]**Yes** [ ]**No** Have you ever had a blood transfusion?
[ ]**Yes** [ ]**No** Do you currently use a Wheelchair, Cane, or Walker? (Circle One)
Any other problem or condition not listed above:_____

_____

Current Medication and Allergies:

[ ] I am not currently taking any medications including Aspirin.

Medication	Dosage/Use

Do you have any Allergies to **LATEX** or **TAPE**? [ ]**Yes** [ ]**No**

Do you have any Allergies to Medications? [ ]**Yes** [ ]**No** If **YES**, please list below:

Medication	Reaction

FAMILY HISTORY: Please indicate if any of these diseases occur in your family members and which side of the family they occur on:

Disease	Mother	Father
Bleeding Disorder		
Stroke		
Gout		
Diabetes		
Heart Disease		
Cancer (TYPE?)		
High Blood Pressure		
Other (Specify)		

Patient Signature:_____ **Date:**_____

PLEASE DO NO WRITE BELOW THIS LINE

Dr. Signature:_____ Date:_____
History Reviewed:

[ ] No Changes [ ] Changes Noted Above

Nurse Reviewed:_____Date:_____

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Brandon D. Wilde, DPM

Thank you for choosing Valley Foot & Ankle. We look forward to your upcoming visit and creating an exceptional experience for you at our clinic.

In order to provide you with the best possible care, please take a few minutes to complete this form. Please tell us about your health and what you would like to accomplish during your visit. The information provided will help your care team get to know you and ensure that all of your questions and concerns are addressed.

First Name: **Last Name:** **Preferred Name:**

Preferred Pharmacy:

Have you seen a Podiatrist before? Yes No Doctors Name:____________________ Date:______________

- **Please describe your current foot or ankle problem(s). (Please specify left, right or both sides.)**
- **How long have you had this problem?**
- **What do you think caused the problem? Was there an injury? (If so, When?)**
- **Please circle any of the items below that describe your current problem.**

Numbness Intermittent Radiating localized Rapid Onset Disabling

Weakness Constant Worsening Swelling Slow Onset Recurrent

Other ____

- **Please circle treatments that you have tried:**

Ice New Shoes Surgery Decreased Activity Physical Therapy

Stretching Injection Prescription arch supports Store bought inserts Heat

No past treatments Other ________________________________

Please rate your pain on a scale of 0-10 (0 is no pain and 10 is the worst)

Have you had recent x'rays, and MRI or other imaging tests related to your foot or ankle condition?

Do you smoke or use tobacco? (if so, what and how much?)

What type of activities do you enjoy?

Running Gardening Snow skiing Water skiing basketball/volleyball/softball Golf

Aerobics Walking Hiking Crossfit Other high intensity sport

Swimming

Other (Please explain)_______________________________________

PLEASE TURN OVER TO COMPLETE >>

6. Please circle if you are experiencing any of the following:

Fever	Rash	Chest pain with activity	Excess thirst	Swelling of Ankles
Chills	Open Wound	Leg pain when walking	Fatigue	Back Pain
Joint Stiffness	Numbness	Shortness of breath with activity	Depression	Painful Urination
Limping	Weakness	Chronic Cough	Anxiety	Joint or muscle pain
Heart Burn	Blood in Stool	Easy bleeding/bruising	Other_____	

7. Have you ever been diagnosed with the following conditions? (Please circle all that apply)

Diabetes	Hepatitis	Heart Disease	HIV Infection	Gout
Heart Attack	Arthritis	Stroke	Stomach Ulcer	Cancer
Blood Clots	Chronic Pain	Bleeding Disorder	Osteopenia	Alcoholism
Liver Disease	Kidney Disease	High Blood Pressure	Osteoporosis	Mental Health problems
Substance abuse or addiction		Other medical problems_____		
I have no medical conditions				

8. Please circle if family members have any of the following medical conditions:

Blood clot on the legs or lungs	Diabetes	Heart Disease	Gout	Bleeding Disorders
Osteoporosis	Arthritis	Foot Problems		
Other Family Medical History _____		I have no related family medical history		

9. Please circle your current employment status:

Full time Part time Unemployed Homemaker Student Retired Work Comp

On Disabilty (please list the reason)_____

What is or was your occupation? _____

10. What would you like to accomplish today or what would you like to get out of the office visit? Feel free to list any questions that you would like answered.

11. Is there anything else that you would like the doctor to know about you?

Thank you for completing this form. Our goal as your Foot & Ankle team is to make you comfortable, keep you active and minimize future problems.

Valley Foot & Ankle Financial Policy

(Update 9/2017)

Thank you for choosing **Valley Foot & Ankle** for your foot health needs.

The following is a statement of FINANCIAL POLICY:

IF YOU HAVE HEALTH INSURANCE COVERAGE:

- You are responsible to supply us with correct and current financial information.
- Please notify us of any changes in your address, phone number, or email address.
- Referrals are your responsibility and must be current prior to your visit.
- Your estimated portion, including any copays and deductibles, will be expected at the time of service.
- You may not take advantage of a self-pay discount and then ask us to file your insurance at a later time.
- You are ultimately responsible for payment of all charges whether or not such charges are covered and paid (either in full or partially) by your insurance company.

IF YOU DO NOT HAVE HEALTH INSURANCE or IF YOU REQUEST A PROCEDURE THAT IS NOT COVERED by insurance:

- Payment in full is due at time of service.
- We accept cash, check, VISA, MC, Discover and American Express. There will be a returned check fee of $25.
- Payment plans are available.
    - All balances must be paid with in 6 months
    - We recommend that in order to pay over time you use either a credit card or Care Credit. This will allow you to avoid or eliminate interest charges.
- We charge 5% APR on all balances over 90 days. All balances over 90 days may be subject to collections.
- Payment for all over the counter medical equipment that is not part of the insurance plan is due at time of service.

Our business office is available from 8:30 am to 5:00 pm Monday thru Thursday and 8:30 am to 1:00 pm Friday to answer any questions or address any concerns you have. If you receive a statement from our office, then we expect payment from you. If you disagree with any payment made by your insurance, please contact them directly. If you disagree with your balance please contact our business office immediately at 208-232-0006.

We will no longer carry account balances over 90 days past insurance payment. These accounts will be subject to collections and all subsequent collections fees. The patient may also be dismissed from the practice.

A parent/guardian who brings a minor to our office for medical care is responsible for payment of all the child's charges.

I understand that I am responsible for all charges at the time of service. My health care provider may submit insurance information to my insurance company for processing but does so only as a courtesy for me. I am responsible to pay all charges before my insurance company pays or determines the amount I owe after insurance regardless of any billing mistakes or disputes.

I hereby guarantee payment of all charges for medical treatment and services provided to me (or my dependant) by **Valley Foot & Ankle**. I understand and agree that if the office places my account with an agency or attorney for collection, the office shall be paid by me for all collection costs to the extent allowed by the law.

I HAVE READ AND AGREE TO THIS FINANCIAL POLICY:

_____ Date: _____

Signature of Patient or Responsible Party

PLEASE TURN OVER TO COMPLETE>>

CREDIT – DEBIT – ACH POLICY

Patient Name:_____ DOB: _____

I understand it is the policy of Valley Foot & Ankle (collectively "the office") to secure my credit or debit card information at the time of my visit. The office acknowledges that we must comply with the provisions of the U.S. Law.

If, after a claim has been submitted to my insurance carrier:

1) The claim is denied or any reason OR
2) There is Patient Liability (i.e. Deductible, Co-Insurance, etc.)
   a. The office will send a statement notifying me of the balance due.
   b. **If the balance is not paid within 30 days**, then my credit/debit card will be charged for the entire balance owed for treatment of services provided to me or my dependent.

I understand my insurance company will also provide notification of these charges with an explanation of benefits. In the event this amount exceeds $250. The office will provide a courtesy call to my home or mobile number.

I understand in the event my credit or debit card has been charged for medical treatment or services, and then my insurance carrier subsequently makes payment to the office for those charges, the office will issue a credit to my credit or debit card.

Please circle one of the following:

VISA MC Discover American Express Checking HSA

Debit/Credit Card / Account Number: _ _ _ _ - _ _ _ _ - _ _ _ _ - _ _ _ _

Expiration Date: _ _/ _ _ _ _

Name of Card Holder (as it appears on card) _____

I hereby authorize Valley Foot & Ankle and its designated employees to charge my credit/debit card or account as designated above, the patient responsibility and/or denied amount for medical treatment and services provided by the office. The charge will be based on the medical treatment rendered to me (or my dependent) and the usual and customary charges made by the office for treatment and service. If payment is denied by my credit/debit card company or banking institution, I will pay the entire amount within 30 (thirty) days.

_____ Date: _____

Cardholder's Signature