Kelly L. Geoghan DPM

New Patient Information (Please Print)

Name _____ Date of Birth _____/_____/_____
First Middle Last

Home Address _____ City _____ State _____

Zip _____ Email Address _____ Home Phone _____

Work Phone _____ Cell Phone _____ Sex: Male ☐ Female ☐

Marital Status _____ Social Security No._____ Occupation/Employer_____

Emergency Contact _____ Relationship _____ Phone _____

Primary Care Physician Name and Phone Number _____

Preferred Pharmacy Name, Address, & Phone Number _____

Primary Language _____ Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Multi-Racial
☐ Native Hawaiian or Pacific Islander ☐ White ☐ Some other Race ☐ Other _____

(If patient is a child or dependent adult, please give name of responsible party for finances and billing)

Responsible Party _____ Date of Birth _____/_____/_____

Address _____

Phone Number _____ Relationship to Patient _____

Insurance Information

☐ Check here if NO health insurance

Primary Carrier _____ Group # _____ ID No. _____

Policy Holder (if other than patient) _____ Date of Birth _____/_____/_____

Employer of policy holder (if other than patient) _____

Secondary Carrier _____ Group # _____ ID No. _____

Secondary Carrier Policy Holder _____ Date of Birth _____/_____/_____

Is this a compensation or work-related case? Yes ☐ No ☐ Date of Accident _____

Are you interested in Laser Treatment for Toenail Fungus? Yes ☐ No ☐

Are you interested in Laser Therapy for Pain Treatment? Yes ☐ No ☐

I hereby give the above named doctor permission to administer the necessary treatment in order to diagnose and treat my present foot condition, after it has been explained to me.

Signature _____ Date _____

Relationship _____

Dr. Kelly L. Geoghan • 1447 York Road • Suite 504 • Lutherville, MD 21093
(410)753-4422 • (410)753-4660(fax) • www.flawlessfeet.net • info@flawlessfeet.net

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Past Medical History- (Please Print)

Date _____ Name _____ DOB _____

Age _____ Height _____ Weight _____ Shoe Size _____

Complaint _____

Medications
Include prescriptions, over the counter medication& and vitamins

_____
_____
_____
_____
_____

Allergies/Reaction

☐ Adhesive/Tape _____
☐ Anticoagulant _____
☐ Aspirin _____
☐ Codeine _____
☐ Demerol _____
☐ Local Anesthetics_____
☐ Other _____

☐ Latex _____
☐ Food _____
☐ Novocain _____
☐ Penicillin _____
☐ Sulfa _____
☐ Iodine _____

Smoking History

☐ Current Every Day ☐ Current Some Day ☐ Heavy Smoker
☐ Light Tobacco Smoker ☐ Former Smoker ☐ Never Smoker
☐ Smoker Current Status Unknown ☐ Unknown if Ever Smoked

Tobacco User ☐ Yes ☐ No

Past Medical History *Place a check mark to indicate if you have had any of the following:*

☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Bleeding Disorder
☐ Circulation Problems
☐ Diabetes
☐ Depression
☐ Gout
☐ Heart Disease
☐ Hepatitis
☐ High Cholesterol
☐ HIV/AIDS
☐ Hypertension (High B/P)
☐ Kidney Disease
☐ Liver Disease
☐ Nervousness
☐ Rheumatic Fever
☐ Seizures/Epilepsy
☐ Sickle Cell Disease
☐ Skin Problems
☐ Stomach Ulcer
☐ Stroke
☐ Thyroid Disease
☐ Other _____

Hospitalizations _____

Past Surgical History

Surgery _____ Date _____
Surgery _____ Date _____
Surgery _____ Date _____

Social History

Alcohol Use ☐ Non-Drinker ☐ Occasional ☐ Social ☐ Moderate ☐ Heavy
Drug Use ☐ Yes ☐ No
Exercise Habits ☐ Never ☐ less than 3 times a week ☐ more than 3 times a week

Family History (Please list the family member parent, grandparent, brother, sister)

_____

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Acknowledgement of Receipt of Notice of Privacy Practice

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have reviewed, read and understand the Notice of Privacy Practices document containing a more complete description of the uses and disclosures of my health information. I understand that Kelly L. Geoghan, DPM, LLC has the right to change their Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below for a current copy of the Notice of Privacy Practice.

Patient Name: _____ Date of Birth: _____

Signature: _____ Relationship to patient: _____

Date signed: _____

Do we have your permission to?

Leave a message on your answering machine? ☐ YES ☐ NO

Confirm appointments? ☐ YES ☐ NO

Speak with household members concerning your podiatry care? ☐ YES ☐ NO

Name/relationship who we can speak with regarding your care:

_____

Name/relationship who we can speak with regarding your care:

_____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, however, acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgments

☐ Other: _____

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Financial Policies for Kelly L. Geoghan, DPM LLC

Thank you for choosing Kelly L. Geoghan, DPM LLC Podiatry as your foot care provider. We are committed to providing you with quality and affordable health care. Please read the following office payment policy and feel free to ask us any questions that you may have. Once you accept this policy, kindly sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. Non-covered services. Please be aware that some - and perhaps all - of the services you receive may be not covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit. We will not bill your insurance for non-covered services.
4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. Insurance Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.
6. Referrals. It is the patient's responsibility to ensure the office receives required referrals prior to your appointment. Failure to do so may result in your appointment being cancelled or rescheduled. Our office does not keep track of referrals. Please make sure any referral on file is valid prior to your appointment or you may be responsible for the visit.
7. Nonpayment. Invoices are sent out every 30 days. Your prompt payment will assist us in keeping the cost of healthcare down. If your account is over 90 days past due, you will receive a letter requesting immediate payment. Partial payments will not be accepted unless otherwise approved by our Billing Department. Please be aware that if a balance remains unpaid, we may refer your account to small claims court and you may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative podiatric care. During that 30-day period, our physician will only be able to treat you on an emergency basis.
8. Cancellation Policy. Our office requires at least 24 hours notice for all appointment cancellations. If you are unable to provide 24 hours' notice, you may billed a $25.00 charge for the missed appointment.
9. Requests for Medical Records. If a patient request a copy of their medical records, there is a fee of $0.75 per page plus the cost of shipping and handling.
10. Returned Checks. There is a fee of $30.00 for all returned checks.
Assignment and Release: I hereby authorize my insurance benefits to be paid directly to the physician. I am legally responsible for any amount which is not paid by my insurance even if my physician is participating with my insurance company. I also authorize the physician to release any information required to process the claim. I understand that accounts are considered past due if no payment is received within 30 days of billing. If payment is not made within that time for services rendered, I agree to pay any and all necessary cost of collections, including but not limited to attorney's fee of 35% on the balance outstanding, court cost and service of process fees.

My signature below is my acceptance of this agreement.

_____ _____

Signature and Date of Birth Date

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