



NEW PATIENT FORMS

Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip \_\_\_\_\_ Email Address \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Occupation and Employer \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone# \_\_\_\_\_

Primary Care Physician Name and Phone Number \_\_\_\_\_

Pharmacy Name, Address & Phone Number \_\_\_\_\_

Primary Language \_\_\_\_\_ Ethnicity:  Hispanic or Latino  Not Hispanic or Latino  Other

Race:  African American  Caucasian  Multi-Racial  Asian  Native American  Native Hawaiian/Pacific  Other

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(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 \_\_\_\_\_

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Insurance Information

Check here if NO health insurance Referral Needed?  Yes  No

Primary Carrier \_\_\_\_\_ Policy# \_\_\_\_\_ Group# \_\_\_\_\_

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

Employer of Policy Holder (if other than patient) \_\_\_\_\_

Secondary Carrier \_\_\_\_\_ Policy# \_\_\_\_\_ Group# \_\_\_\_\_

Secondary Carrier Policy Holder \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Is this a compensation or work-related case? Yes  No  Date of Incident: \_\_\_\_\_ Claim# \_\_\_\_\_

Worker's Compensation Company Information: \_\_\_\_\_

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

Are you interested in MLS Laser Treatment for Pain and other issues? Yes  No  Maybe

How did you hear about our office? \_\_\_\_\_

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All treatment options will be discussed prior to any service(s) being performed. Once verbal and/or written consent is given, I authorize Dr. Kelly Geoghan to administer the necessary treatment in order to diagnose and treat as needed.

Signature \_\_\_\_\_ Date \_\_\_\_\_



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Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Shoe Size: \_\_\_\_\_ Are you Pregnant? \_\_\_\_\_ Nursing? \_\_\_\_\_

What type of foot and/or ankle problem are you having?

Medications and Strength

Allergies-please list what reaction you have to each allergy too

NO MEDICATIONS: \_\_\_\_\_

NO ALLERGIES: \_\_\_\_\_

Include prescriptions, over the counter medication & and vitamins

Adhesive/Tape \_\_\_\_\_ Other \_\_\_\_\_
Anticoagulant \_\_\_\_\_ Food \_\_\_\_\_
Aspirin \_\_\_\_\_ Novocaine \_\_\_\_\_
Codeine \_\_\_\_\_ Penicillin \_\_\_\_\_
Demerol \_\_\_\_\_ Sulfa \_\_\_\_\_
Local Anesthetics \_\_\_\_\_ Iodine \_\_\_\_\_
Latex \_\_\_\_\_

Cigarette Smoking History

Current Every Day \_\_\_\_\_ Current Occasional \_\_\_\_\_ Heavy Smoker \_\_\_\_\_
Light Tobacco Smoker \_\_\_\_\_ Former Smoker \_\_\_\_\_ Never Smoker \_\_\_\_\_
Patient is a Smoker Current Status Unknown \_\_\_\_\_ Unknown if ever Smoked \_\_\_\_\_

If you currently or previously smoked: When did you start smoking? \_\_\_\_\_
If you quit, when did you stop smoking? \_\_\_\_\_ How much did/do you smoke per day? \_\_\_\_\_

Do you Vape or Chew Tobacco? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes: Started \_\_\_\_\_ Stopped \_\_\_\_\_ Amount \_\_\_\_\_

Past Medical History (please check all that applies) NO PAST MEDICAL HISTORY \_\_\_\_\_

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

Past Surgical History

Surgery \_\_\_\_\_ Date \_\_\_\_\_
Surgery \_\_\_\_\_ Date \_\_\_\_\_
Surgery \_\_\_\_\_ Date \_\_\_\_\_

Social History

Alcohol Use \_\_\_\_\_ Non-Drinker \_\_\_\_\_ Occasional \_\_\_\_\_ Social \_\_\_\_\_ Moderate \_\_\_\_\_ Heavy \_\_\_\_\_
Illegal Drug Use \_\_\_\_\_ Yes \_\_\_\_\_ No Exercise: \_\_\_\_\_ Never \_\_\_\_\_ Less than 3 times a week \_\_\_\_\_ More than 3 times a week \_\_\_\_\_
Family Medical History (diabetes, cardiac, pulmonary, cancer, other)



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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: SELF: \_\_\_\_\_

Date signed: \_\_\_\_\_ PARENT: \_\_\_\_\_

**Do we have your permission to?** GUARDIAN: \_\_\_\_\_

Leave a message on your answering machine/voicemail? \_\_\_\_\_ YES \_\_\_\_\_ NO

Leave a message to confirm appointments? \_\_\_\_\_ YES \_\_\_\_\_ NO

Send you an email? \_\_\_\_\_ YES \_\_\_\_\_ NO

Speak with any household members, guardians or whoever is listed below regarding your care: \_\_\_\_\_ YES \_\_\_\_\_ NO

Name and relationship who we can specifically speak with:

\_\_\_\_\_  
\_\_\_\_\_

**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



## NEW PATIENT FORMS

### Office Policies for Kelly L. Geoghan, DPM LLC

- 1. Insurance.** We participate in most insurance plans but it is the patient's responsibility to verify participation. If you are not insured by an insurance plan that we participate with, payment in full is due at the time of service. If you are insured by a plan we participate with but you do not have a valid insurance card present, payment in full is required. If your insurance changes, please notify us before your next visit so we can update your records. We will need to copy your updated insurance card too. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your benefits.
  - 2. Co-payments and deductibles.** In accordance with your insurance guidelines, all co-payments and deductibles must be paid at the time of service. Most follow up visits are a billed service and are subject to a copay/deductible according to your insurance guidelines including orthotic fittings/follow up appointments and minor office procedures.
  - 3. Non-covered services.** Please be aware that some, and perhaps all, of the services you receive may be not covered or considered medically necessary by your insurance carrier. You must pay for these services in full at the time of service. We will not bill your insurance or supply any correspondence for any non-covered services.
  - 4. Forms.** All patients must complete all forms provided before seeing the doctor. We require you to provide a current/valid photo ID and current valid insurance to provide proof of insurance. We will make a copy of this information for our records. Periodically, we may need you to update your forms. We will get a copy of your insurance card yearly.
  - 5. Claims.** A claim will be sent to your insurance carrier for all covered services. Your insurance company may need you to supply 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 processes your claim. Your insurance benefit is a contract between you and your insurance company. We follow insurance guidelines.
  - 6. Referrals.** It is the patient's responsibility to ensure the office receives valid referrals prior to your appointment. Failure to do so may result in your appointment being 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. Overdue balance.** If your account is over 90 days past due, you will receive a letter requesting immediate payment. Partial payments will not be accepted unless approved by our Billing Department. Please be aware that if a balance remains unpaid, your account may be sent to a Collection Agency and/or Small Claims Court. If you have a balance that is 90 days overdue or more, we will only treat you for emergency care until your bill is paid in full. You will not be seen for any non-emergency services until your balance is paid in full.
  - 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 be charged \$25.00 for the missed appointment. We will work with you for emergencies.
  - 9. Requests for Medical Records.** If a patient requests a copy of their medical records, there may be a fee. Also, we require a signed medical release before sending the records.
  - 10. Returned Checks.** There is a fee of \$30.00 for all returned checks which will be added to your balance.
  11. Treatment of Minor:
  - 12. HSA and Flex Spending payment:** We accept this form of payment but it is your responsibility to know and follow their guidelines. We do not know the details about your Health Savings Account or Flex Spending benefits. We cannot refund any payment type to then apply to an HSA or Flex Spending Card after the date of service.
  - 13. Benefits.** As a courtesy, we may check your benefits for a specific service. Please be advised that benefits given are a quote and not a guarantee of payment. Your insurance carrier may not inform us that some services are diagnosis driven, need pre-certification and are only covered if considered medically necessary. We provide you with the information they relay to our office. If your claim is denied, even after a quote is given, you will be responsible for the services. We advise you to verify your coverage and can supply you with any codes necessary to check your benefits.
- 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 90 days from the time services are rendered, I agree to pay any and all necessary cost of collections, including but not limited to attorney's fees of 35% on the balance outstanding, court cost and service of processing fees.

My signature below is my acceptance of this agreement.

Signature: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_