

BLUEGRASS FOOT CENTER

DR. STEVEN BLOCK

1901 Leitchfield Rd, Suite B

Owensboro, KY 42303

270-684-5252

Things to bring to your appointment.

****Please arrive 20 Minutes prior to your appointment****

****All Services rendered in the office at the time of service will be expected to be paid for that day*****

1. Photo ID
2. Insurance Card(s)
3. New Patient paperwork
4. Updated medication list

MEDICAL HISTORY

Your Name: _____
(Last) (First) (M.I.)

Height _____ Weight _____

Family Physician: _____ Phone: _____

Physician's Address: _____ City: _____ State: _____

Specialist _____ For what condition? _____

Are you currently working? YES / NO / Retired (Employer _____ Type of job _____)

What type of foot/ankle problem are you having? _____ (use back of page if necessary)

Have you ever been diagnosed with: (please circle) In blank please specify type where indicated

Anemia	Degenerative arthritis	Hepatitis	Osteoporosis
Asthma	Diabetes	HIV	Rheumatic fever
Autoimmune dz _____	Emphysema (COPD)	Hypothyroid	Rheumatoid arthritis
Bladder Probs _____	Fibromyalgia	Jaundice	Scoliosis
Brain/nervous dz _____	Gout	Joint Replacement Surg	Seizure (most recent)
Breathing Prob _____	Heart Attack	Kidney Prob _____	Stomach Prob _____
Cancer (type _____)	Heart Probs/Chest Pain	Liver dz _____	Stroke
Circulation problems	Hypertension	Low Blood Sugar	NONE OF THE ABOVE
Coronary artery disease	High Cholesterol	Lung Dz _____	

Do you smoke? YES / NO If no, have you ever smoked? YES / NO
If yes, how much per day? Estimated _____ (#) packs per day for _____ (#) years Quit _____ (year)

Do you have a chronic cough? YES / NO

Are you a menstruating female? YES / NO
Are you currently nursing? YES / NO Is there any possibility that you may be pregnant? YES / NO

Are you a Diabetic? YES / NO If yes, for how long? _____
If yes, are you or have you ever been on insulin? YES / NO If yes, for how long? _____

Do you currently receive Homehealth Care or Skilled Nursing YES / NO Facility Name _____

Please list the most recent glucose level and the date it was taken: _____

Please list the range of your average glucose level: _____

Are you currently taking a blood thinner such as aspirin, coumadin, xarelto, plavix or ticlid? YES / NO

Do you have any allergies to iodine or shellfish? YES / NO

Please list all medications that you are currently taking. (use back of page if necessary)

Are you allergic to any medication? (If yes- please specify) _____

Have you ever been [or] are you currently disabled? YES / NO

If yes, For what condition (be specific)? _____

How long have you been disabled? _____

MEDICAL HISTORY, CONTINUED.

Name

Please list your Family Medical History:

(mother, father, brothers, sisters, aunts, uncles, grandparents)

diabetes, heart disease, hypertension, cancer, arthritis, depression, liver disease, gout, etc.

Have you ever had an injury/fracture/sprain/break? YES / NO
If yes, please provide location/date/duration of above:

Have you ever had surgery? YES / NO An overnight hospital stay? YES / NO
If yes, please list your surgeries/hospital Stays: [please provide dates if possible]

Have you ever had an addiction to drugs or alcohol? YES / NO
If yes, please provide specifics:

Have you ever been a patient in a pain treatment program? YES/ NO
If yes, please provide specifics:

REVIEW OF SYMPTOMS

The following is a list of symptoms. Please check the symptoms which you experience on a frequent basis or have experienced at least once in the past three (3) months.

Neurologic ☐ None

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Headache | <input type="checkbox"/> Numb face/mouth |
| <input type="checkbox"/> Appetite changes | <input type="checkbox"/> Difficulty swallow | <input type="checkbox"/> History of abuse | <input type="checkbox"/> Numbness/burnig (feet/hands) |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Dischargefromears | <input type="checkbox"/> Intolerance to temp changes | <input type="checkbox"/> Panic attacks |
| <input type="checkbox"/> Chills/fever | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Legally blind | <input type="checkbox"/> Ringing of ears |
| <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Drowsiness | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Seizure |
| <input type="checkbox"/> Cold feet | <input type="checkbox"/> Dryness of eyes | <input type="checkbox"/> Lossofcoordination | <input type="checkbox"/> Weight change |
| <input type="checkbox"/> Dehydration | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Manic episodes | |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Fainting | <input type="checkbox"/> Memory loss | |
| <input type="checkbox"/> Difficulty chewing | <input type="checkbox"/> Falling frequently | <input type="checkbox"/> Muscle weakness | |
| <input type="checkbox"/> Difficulty hearing | <input type="checkbox"/> Fatigue | | |

Heart/Lungs ☐ None

- | | |
|--|---|
| <input type="checkbox"/> Blacking out or fainting after standing quickly | <input type="checkbox"/> Pain/numbness in arm(s) |
| <input type="checkbox"/> Bruising of skin very easily | <input type="checkbox"/> Palpitations (feeling like your heart is pounding very hard) |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Chronic sinusitis/allergies | <input type="checkbox"/> Swelling of feet/legs |
| <input type="checkbox"/> Chronic swelling of legs/feet | <input type="checkbox"/> Tightness of chest |
| <input type="checkbox"/> Difficulty breathing only a night | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Frequent cough | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Increase heart rate | |
| <input type="checkbox"/> Pain with breathing | |

Abdomen ☐ None

- | | |
|---|--|
| <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Pain in abdomen |
| <input type="checkbox"/> Burning of stomach | <input type="checkbox"/> Rectal bleeding |
| <input type="checkbox"/> Chronic gas | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Chronic hunger | <input type="checkbox"/> Vomiting of blood |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Yellow discoloration of fingernails/skin/eyes |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Difficulty or pain urinating |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Urinary retention |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Urinary urgency (always feeling like you have to urinate) |
| <input type="checkbox"/> Intolerance to foods | <input type="checkbox"/> Urinating excessively |
| <input type="checkbox"/> Irritable bowel syndrome | |

Orthopedic ☐ None

- | | |
|--|--|
| <input type="checkbox"/> Ankle pain | <input type="checkbox"/> Knee pain |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Cramping in calf with walking | <input type="checkbox"/> Pain in feet/legs when I first get out of bed |
| <input type="checkbox"/> Difficulty in keeping up with similar age peers | <input type="checkbox"/> Pain in fingers/hands |
| <input type="checkbox"/> Difficulty walking > 20min | <input type="checkbox"/> Pain with bending of back |
| <input type="checkbox"/> Frequent ankle sprains | <input type="checkbox"/> Pain with sitting |
| <input type="checkbox"/> Hip pain | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Shoulder pain |

Integument ☐ None

- | | | | |
|---|---|--|--------------------------------------|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Hypertrophic scar | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Blisters/boils | <input type="checkbox"/> Dry skin/eczema | <input type="checkbox"/> Itching of skin | <input type="checkbox"/> Sores/ulcer |
| <input type="checkbox"/> Cracking of skin | <input type="checkbox"/> Excessive sweating | <input type="checkbox"/> Moles | |
| <input type="checkbox"/> Color changes-skin | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Odor | |

Hematologic ☐ None

- | | | |
|--|--|--|
| <input type="checkbox"/> anemia | <input type="checkbox"/> fever | <input type="checkbox"/> severe menstrual cramps |
| <input type="checkbox"/> bleeding tendency | <input type="checkbox"/> night sweats | <input type="checkbox"/> swelling of hands or face |
| <input type="checkbox"/> bruise easily | <input type="checkbox"/> nose bleeds | <input type="checkbox"/> swollen groin lymph nodes |
| <input type="checkbox"/> calf pain | <input type="checkbox"/> recent sickle cell crisis | <input type="checkbox"/> swollen neck lymph nodes |
| <input type="checkbox"/> chills | <input type="checkbox"/> recent transfusion | <input type="checkbox"/> water retention |

NEW PATIENT INFORMATION

(Last) _____ (First) _____ (M) _____
(Address) _____ (City) _____ (State) _____ (Zip) _____
Date of Birth _____ Age _____ SS# _____ - _____ - _____ Phone: _____ Cell: _____
Email: _____ May we contact you via email? YES / NO
Preferred Method of Contact for Reminders: Call Text Email For Statements: Email US Mail
(CIRCLE ONE) Male / Female Married: Yes / No Student: Yes / No

Referrals Primary Physician: _____ Date Last Seen: _____

REFERRING PHYSICIAN (IF ONE): _____

Employment

Employer: _____ Phone: _____ Full Time / Part Time

Address: _____ Occupation: _____

Guarantor Information (person who carries insurance/Guardian to a minor)

Name: _____ DOB: _____ Phone: _____

Address: _____ Relationship to patient _____

Guarantor's Employer: _____ Guarantor's SS#: _____

How Did You Hear About Us?? Please circle
Google/Websearch Provider Office My Doctor Church Bulletin My Insurance Company Emergency Room
Newspaper Phone Book Sign Coworker Friend One of our Patients Email Advertisement

Insurance

Please provide us with a copy of your current insurance card. It is also your responsibility to inform us of any changes in your coverage.

→ PLEASE READ AND SIGN:

I authorize the Bluegrass Foot Center and its doctor, to examine and treat me, and for them to bill my insurance company. Payment should be made directly to the Bluegrass Foot Center.

I understand that my insurance may require certain referrals or that a physician be within a certain provider network, and that any non-compliance of these restrictions may result in reduced or eliminated benefits.

I realize that I am responsible for payment of all fees incurred for my care although I may have insurance that may cover all or part of the cost of such care. I understand that I am responsible for any charges that may be applied to my insurance deductible, coinsurance, or services not covered by my policy. I agree to pay for any collection fee, court costs, attorney and legal fees if it becomes necessary in collecting any outstanding balance.

I authorize the Bluegrass Foot Center to release any information or records acquired in the course of my examination or treatment to my insurance company or other medical professionals as necessary for my treatment.

This authorization shall remain in effect until it is revoked by me.

Signature _____ Date _____

Medicare / MediGap Authorization (Signature on File) *only sign if you have Medicare*

If I qualify for Medicare or MediGap (Medicare Supplement), I request that the payment of authorized benefits be made to Bluegrass Foot Center for any services furnished. I authorize any holder of medical information about me to release to the HCFA and it's agents any information to determine those benefits payable to related services.

I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature _____ Date _____



STEVEN M. BLOCK, DPM, AACFAS

Financial Policy

Without hesitation, the ultimate concern to this office is your medical care. However, due to the complicated manner in which medical care costs are covered, we must present a financial policy to all patients to avoid confusion with regards to payment for your medical care.

We will file insurance forms for all services rendered, however, we remind you, that you as the patient, are ultimately responsible for the bill, regardless of insurance coverage. We are proud that our basic fees are comparable to others in our community. We encourage you to ask questions about them. In order to keep fees to a minimum, we ask that, whenever possible, you pay at the time of service, which includes all copayments and deductibles, so that we do not have to send bills. A statement of your account is provided containing information needed for insurance purposes. The primary way to avoid many problems is to ensure your insurance coverage is accurate, up to date, and includes podiatry services as a benefit.

By reducing billing costs, we can keep medical costs down and use personnel on the most important task: quality patient medical care.

Your Medical Record

The medical records (including all x-rays) always and legally remain the property of the doctor – not the patient. The patient can request, free of charge, one copy of their personal record. The physician may wish to review the record before release to clarify technical issues. Should the physician elect to send you to another physician for any reason, your original x-rays may be sent either with you or through the mail to the referred physician. This will be done only after the patient has signed a waiver authorizing the transfer of the x-rays. Your original x-rays will be given out only when the patient's care is directed from this office to another.

Patients wishing to obtain x-rays for their own use can obtain them on disc at a cost of \$10.

Referrals

Patients requiring a referral can not be seen until the referral has been received by our office.

Missed Appointment Policy

A 24-hour notice is required for all appointment cancellations. Your time is valuable, and so is ours. The office will charge \$25 billed to the patient for missed appointments that were not cancelled 24 hours in advance.

Disability and Family Medical Leave Act Forms

Should you require surgery and need forms filled out indicating the time needed off work, our office will supply a standard form with all pertinent information regarding your diagnosis, procedures, time needed off, and level of mobility for work to your employer and/or insurance company. All additional information requested above and beyond what is included in our standardized form will be charged at a rate of \$10 per page and \$.50 per copy for medical records information.

Returned Check Policy

There will be a \$35 charge for all returned checks.

Payment of Your Account

In cases of financial difficulty, we do offer the option of a payment plan. All patients needing to establish a payment plan can do so by requesting a financing form, which includes a \$25 financing administrative fee (to cover costs of producing numerous billing statements/postage/etc). A Collections fee of 30% will be added to your account (with a maximum charge of \$30) for all balances sent to a collection agency. For this reason, it is best to arrange a payment schedule with our office to avoid being sent to collections.

Orthotics

Patients needing custom orthotics (shoe inserts) are billed at \$357 per pair, to be paid by the patient. We do not bill insurance for orthotics. For those desiring a second pair of orthotics, a 25% discount will be applied to orthotics ordered within 30 days of receiving the first pair.

Should you have any questions regarding our financial policies, please do not hesitate to ask any member of our staff.

Patient/Guarantor

Date

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal healthcare information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosure of health information about the patient to carry out treatment, payment, and/or healthcare operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When appropriate, we provide the minimum necessary information to only those we feel are in the need of your health care information. This includes information about treatment, payment, and/or health care operations in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients) and may have to disclose personal health information for purposes of treatment, payment, or health care operations).

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, **if you refuse to disclose your Personal Health Information, we have the right to refuse to treat you.** If you chose to give consent in this document at some future time you may request to refuse all or part of your PHI. You may not revoke actions that may have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak to our HIPAA Compliance Office. You have the right to review our privacy notice, to request restrictions, and revoke consent in writing.

Signature

Name (Printed)

Date

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

The misuse of PERSONAL HEALTH INFORMATION (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers, and doctors continually undergo training to understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest of standards of ethics and integrity in performing services for our patients. It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws, and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As a part of this plan, we have implanted a Compliance Program that we believe will help us prevent any inappropriate use of PHI. We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem, so that we may remedy the situation promptly.

ERISA INSURANCE PLANS

I assign the right to payment for all medical benefits directly to Steven M. Block, D.P.M. in consideration for medical services and supplies provided to me pursuant to my health insurance plan.

In the event my health insurance plan refuses to pay for provided, medically reasonable and necessary services, I also assign all my ERISA* rights to Steven M. Block, D.P.M. for a full and fair review of any and all denied claims, including any penalties that may be assessed against the insurance company for claims processing violations. This ERISA assignment is in consideration for the unpaid services provided, in consideration for my insurance plan's reduced fee schedule, and in consideration for the continued willingness of Steven M. Block, D.P.M. to see patients, including me, on an insurance assignment basis. **I understand that if my treating doctor prevails in any payment dispute, I may be liable for any applicable co-payment for any contested services.**

*ERISA is an acronym for the Employee Retirement Income Security Act. The Employee Retirement Income Security Act includes federal laws requiring insurance companies to process submitted insurance claims and appealed (denied) insurance claims according to ERISA regulations. The failure to process submitted insurance claims and appealed insurance claims according to ERISA regulations may result in fines charged to the insurance company in amounts up to \$110 a day for each fraction.

Signature

Name (printed)

Date

Bluegrass Professional Center
1901 Leitchfield Rd, Suite B
Owensboro, KY 42303
(270) 684-5252



Effective July 28, 2012, Kentucky Law now requires ALL medical offices to advise ALL patients as to the potential addiction associated with narcotic pain medications.

Patient Name: _____ Date: _____

1. I have been made aware of certain risks and consequences that are associated with the taking narcotic pain medications. They are described in Paragraph 2 such as but not limited to risk of addiction and dependence. I hereby acknowledge that I understand the information he has given me.
2. I understand that the explanation of the risks and consequences that I have received is not exhaustive and that other, more remote, risks and consequences may arise. I have been advised that these more remote risks and consequences will be explained to me upon request. I acknowledge that I have been given the opportunity to ask questions concerning this procedure and its risks and consequences, and my questions, if any, have been answered to my satisfaction.
3. I acknowledge that I have read this document in its entirety and that I fully understand it and that all blank spaces have either been completed or crossed off prior to my signing.

Possible Complications (all or many may apply):

Addiction	Intolerance to pain
Constipation	Nausea
Vomiting	Dizziness
Need for additional pain medications	
Decrease protective sensation	

I hereby state I have read and understand the above and any questions have been answered to my satisfaction prior to my signature.

Patient's signature (parent/legal guardian) Date

Witness Date