THUNDERBIRD
FOOTCARE
Podiatric Medicine & Surgery

Kathleen M. Stone, D.P.M. | Teisha M. Kubala, D.P.M.
8325 W Happy Valley Rd., Unit 105, Peoria, AZ 85383
602-547-2111 | 602-547-0473 Fax | www.thunderbirdfootcare.com

To Our New Patient:

Welcome to Thunderbird Footcare! We are thrilled that you have chosen our team for your foot and ankle needs. We will do our best to provide you with the most up-to-date and comprehensive podiatric care available. We have a total commitment to keeping your feet healthy – and keeping you happy.

To maximize your time with us, we ask that you bring the following to your first visit: photo identification, medical insurance card(s), written referral (if required by your insurance company), and current medication list with dosages.

In addition, please complete and sign the New Patient Forms included with this letter. These include our Patient Registration, Comprehensive Health Review, and Consent to Treat.

Whether you have a serious foot health condition or you're just looking for added comfort, Thunderbird Footcare is your one-stop-shop for quality podiatric care. We look forward to your appointment with us!

Sincerely,

Thunderbird Footcare

*Please visit us online at **www.thunderbirdfootcare.com** for additional patient information and our Notice of Privacy Policies.

*The highest compliment we can receive is the referrals of your family, friends, and coworkers.

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PATIENT REGISTRATION

PATIENT INFORMATION

Patient's Last Name	First	Middle	❑ Mr. ❑ Mrs. ❑ Dr. ❑ Miss ❑ Ms.	Marital Status (Select One) ❑ Single ❑ Mar ❑ Div ❑ Sep ❑ Wid
Nickname (Name I preferred to be called)	Birth Date (mm/dd/yyyy)	Sex ❑ M ❑ F	Spouse's Name	
Street Address	City	State	Zip Code	Home Phone # ( )
Preferred Method of Contact: ❑ Text ❑ E-Mail ❑ Call	E-Mail			Mobile Phone # ( )
Race/Ethnicity: (Please check all that apply) ❑ Prefer not to answer ❑ Hispanic/Latino/Spanish Origin ❑ White ❑ Black/African American ❑ American Indian or Alaska Native ❑ Asian ❑ Pacific Islander/Hawaiian				Employer/Work Phone # ( )
Pharmacy Name, Phone # & Cross Streets			Primary Care Physician (PCP)	

PERSON RESPONSIBLE FOR BILL (IF DIFFERENT THAN ABOVE)

Name of Person Responsible for Bill	Birth Date (mm/dd/yyyy)	Sex ❑ M ❑ F	Relationship to Patient ❑ Self ❑ Spouse ❑ Child ❑ Other	
Street Address	City	State	Zip Code	Home Phone # ( )
Preferred Method of Contact: ❑ Text ❑ E-Mail ❑ Call	E-Mail			Mobile Phone # ( )
Employer	Employer Address			Employer/Work Phone # ( )

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD AND PHOTO ID TO RECEPTIONIST)

Primary Insurance	Subscriber Name	Birth Date (mm/dd/yyyy)			
Insurance ID #	Group #	Policy #	Effective Date	Expiration Date	Co-Payment $
Secondary Insurance	Subscriber Name	Birth Date (mm/dd/yyyy)			
Insurance ID #	Group #	Policy #	Effective Date	Expiration Date	Co-Payment $

IN CASE OF EMERGENCY

Name of Nearest Friend or Relative	Relationship to Patient	Home Phone # ( )

REFERRAL

How did you learn about us? (Please check all that apply) ❑ Dr. _____ ❑ Hospital/ER ❑ Lecture ❑ Insurance Plan
❑ Phonebook ❑ Internet ❑ Website ❑ Friend/Family: _____ ❑ Other: _____

The above information is true to the best of my knowledge. I certify that I have insurance with the insurance company(ies) disclosed and assign directly to Thunderbird Footcare all insurance benefits, if any, otherwise payable to me for service(s) rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature below on all insurance submissions. Thunderbird Footcare may use my health care information and may disclose such information to the disclosed insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

X _____
PATIENT/GUARDIAN SIGNATURE DATE

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COMPREHENSIVE HEALTH REVIEW

Patient Name: _____ Date of Birth: _____ Today's Date: _____

HISTORY OF PRESENT ILLNESS / WHAT BRINGS YOU IN?

What is your specific foot/ankle problem? _____

Which foot/ankle is involved? ❑ Right ❑ Left ❑ Both

Have you seen another doctor for this problem? ❑ Yes ❑ No

Doctor's name? _____

When did the problem begin? _____

Have you had a similar problem in the past? ❑ Yes ❑ No

How was the problem onset? ❑ Sudden ❑ Gradual

The problem is: ❑ Improving ❑ Worsening ❑ Unchanged

The problem is worst: ❑ AM ❑ PM ❑ At Rest ❑ With Activity

What aggravates the problem? _____

What improves the problem? _____

Is the problem painful? ❑ Yes ❑ No If so, rate your current pain: (none) 0 1 2 3 4 5 6 7 8 9 10 (worst)

Describe the pain: ❑ Sharp ❑ Dull ❑ Aching ❑ Throbbing ❑ Cramping ❑ Itching ❑ Popping

❑ Burning ❑ Tingling ❑ Clicking ❑ Shooting ❑ Stabbing ❑ Other: _____

Describe previous treatments: _____

Is this from an injury? ❑ Yes ❑ No If so, is it work-related? ❑ Yes ❑ No _____

PAST MEDICAL HISTORY

❑ Diabetes Type 1 2 Duration ____ years Last Blood Sugar _____ HbA1c ____

❑ Acid Reflux
❑ Anemia
❑ Anesthesia Complications
❑ Arthritis (❑ Osteo / ❑ Rheum)
❑ Asthma
❑ Back Problems/Sciatica
❑ Blood Clot/DVT
❑ Cancer: _____
❑ Cellulitis/Skin Infection (❑ MRSA?)
❑ Circulation Problem
❑ Dementia/Alzheimer's
❑ Excessive/Easy Bleeding
❑ Fibromyalgia
❑ Foot/Leg Ulcer
❑ Gout
❑ Healing Problems/Keloids
❑ Heart Disease/Heart Attack
❑ High Blood Pressure (❑ Low BP?)
❑ High Cholesterol
❑ Hormone Therapy
❑ Immune Disorder/HIV
❑ Kidney Disease (❑ Dialysis)
❑ Liver Disease (❑ Hepatitis)
❑ Leg Cramps/Leg Pain at Rest
❑ Lung Condition: _____
❑ Mitral Valve Prolapse/Murmur
❑ Multiple Sclerosis
❑ Nervous Disorder/Depression
❑ Neuropathy
❑ Osteomyelitis/Bone Infection
❑ Parkinson's Disease
❑ Previous Addiction to: _____
❑ Pulmonary Embolism
❑ Rashes/Skin Condition
❑ Raynauds Disease/Phenomena
❑ Seizure Disorder/Epilepsy
❑ Sickle Cell Disease/Trait
❑ Sleep Apnea
❑ Stomach Ulcers
❑ Stroke ❑ Rt ❑ Lt (year _____)
❑ Thyroid Condition (❑ Hi ❑ Lo)
❑ Varicose Veins
❑ Women – Are You Pregnant or Breast Feeding?
❑ Other problems not listed: _____

PAST SURGERIES

❑ Foot/Ankle Surgery: _____
❑ Joint Replacement: _____
❑ Open Heart/Bypass Surgery
❑ Hysterectomy ❑ Tubal ligation ❑ C-Section
❑ Stent Placement: Heart Leg
❑ Cosmetic Surgery: _____
❑ Appendix ❑ Gallbladder ❑ Tonsils/Add
❑ Leg Bypass ❑ Open Fracture Repair
❑ Carotid Surgery ❑ Vein Surgery
❑ Hernia repair ❑ Thyroid ❑ Back surgery
❑ Other: _____

FAMILY HISTORY (circle relative)

Mother **F**ather **S**ister **B**rother **G**rand**M**a **G**rand**P**a

❑ Cancer	M F S B GM GP
❑ Diabetes	M F S B GM GP
❑ Gout	M F S B GM GP
❑ Heart Disease	M F S B GM GP
❑ High Blood Pressure	M F S B GM GP
❑ Severe Arthritis	M F S B GM GP
❑ Anesthesia Complications	M F S B GM GP
❑ Foot Problems	M F S B GM GP
❑ Other: _____	M F S B GM GP

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COMPREHENSIVE HEALTH REVIEW

Patient Name: _____

MEDICATIONS (include RX meds, OTC meds, and vitamins)

❑ **List Given to Office Staff**

Medication	*Dosage*	*Medication*	*Dosage*

MEDICATION ALLERGIES

❑ **None**
❑ Adhesives/Tape
❑ Aspirin
❑ Codeine
❑ Cortisone
❑ Iodine
❑ Latex
❑ Local Anesthetics
❑ Penicillin
❑ Seafood/Shellfish
❑ Sulfa Drugs
❑ _____

SOCIAL HISTORY

Employer: _____

Occupation: _____

❑ I Drink Alcoholic Beverages ❑ Beer ❑ Wine ❑ Hard Alcohol
How much/often? _____

I Exercise Each Week: ❑ 0 days ❑ 1-2 days ❑ 3+ days

List Sports/Activities: _____

Do you smoke? ❑ Yes ❑ No ❑ Former

❑ I Use or Have Used Drugs that are Illegal _____

❑ My foot/ankle problem limits my activities

I Live With: ❑ No One ❑ Spouse ❑ Children ❑ Parents ❑ Other

I Stand _____ % of My Day

REVIEW OF SYSTEMS

CONSTITUTIONAL
❑ Recent Weight Changes
❑ Fever/Chills
❑ Nausea or Vomiting
❑ Fatigue

CARDIOVASCULAR
❑ Chest Pain
❑ Palpitations
❑ Arrhythmia/Irregular Heart Beat
❑ Leg Pain when Walking
❑ Swelling of Hands/Feet

MUSCULOSKELETAL
❑ Muscle Pain or Cramps
❑ Joint Pain
❑ Stiffness/Swelling Joints
❑ Low Back Pain
❑ Trouble Walking

GASTROINTESTINAL
❑ Indigestion/Heartburn
❑ Diarrhea
❑ Blood in Stools
❑ Stomach Pains

RESPIRATORY
❑ Shortness of Breath
❑ Chronic/Frequent Cough
❑ Wheezing

GENITOURINARY
❑ Frequent Urination
❑ Painful Urination
❑ Kidney Stones
❑ Blood in Urine

INTEGUMENTARY
❑ Rash or Itching
❑ Dry Skin
❑ Change in Hair/Nails

HEMATOLOGICAL
❑ Bruise Easily
❑ Slow to Heal

NEUROLOGICAL
❑ Migraines
❑ Frequent Headaches
❑ Numbness/Tingling
❑ Dizzy Spells
❑ Paralysis/Tremors

PSYCHIATRIC
❑ Anxiety
❑ Depression
❑ Nervousness
❑ Insomnia
❑ Confusion/Memory Loss

STATS

Age _____ Height _____ Weight _____ Shoe Size _____

Type of Shoes Worn (check all that apply):

❑ Tennis ❑ Sandals ❑ Dress Shoes ❑ Flats ❑ Loafers
❑ Work Boots ❑ Boots ❑ Flip Flops ❑ Heels ❑ Slippers

The information I have provided is true to the best of my knowledge. I recognize that the information I have provided will help me receive better care.

X _____ _____

PATIENT/GUARDIAN SIGNATURE DATE

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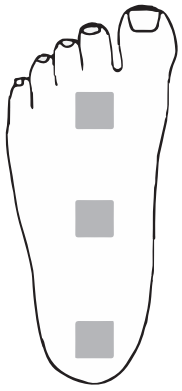
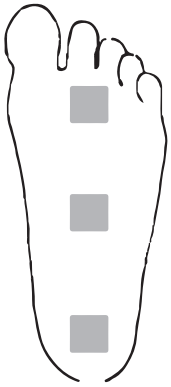
COMPREHENSIVE HEALTH REVIEW

Where is the Pain/Problem Located? **Please Mark on the Pictures Below:**

Left Foot

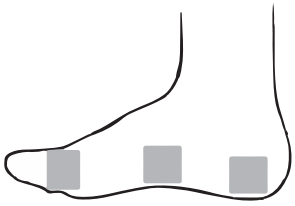


Top of Foot



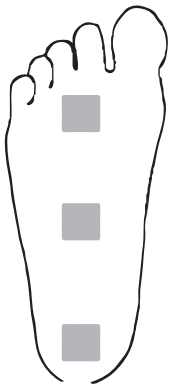
Bottom of Foot

Inside of Foot

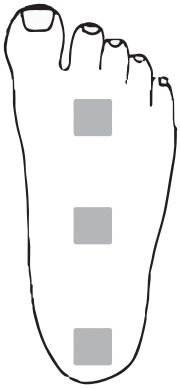


Outside of Foot

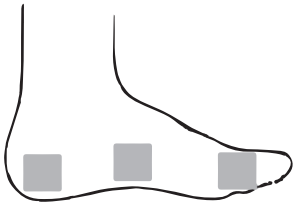
Right Foot



Bottom of Foot



Top of Foot



Outside of Foot

Inside of Foot

HIPPA PERMISSION AND FINANCIAL POLICY

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this acknowledgement. By signing this form, you acknowledge that you had the opportunity to review the Thunderbird Footcare, Notice of Privacy Practices, describing the use and disclosure of protected health information about you regarding treatment, payment, health care operations and other uses and disclosures as stated in our Notice.

I GIVE MY PERMISSION TO DISCLOSE MEDICAL INFORMATION, INCLUDING FINANCIAL INFORMATION TO THE FOLLOWING PEOPLE:

Family or Friend Name:_____

Family or Friend Name:_____

Patient Signature: _____ Date: _____

E-Mail Address: _____

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FINANCIAL POLICY

1. All co-payments are due at the time of visit. 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 a violation of the contract you have with your insurance company. Our office accepts cash, checks (post-dated checks are not accepted), credit and debit cards.

2. Co-insurance and unmet deductibles are due prior to scheduled surgeries and procedures. Once benefits are verified and your financial responsibility calculated, you will be notified of the payment amount and due date.

3. You are ultimately responsible for payment of charges for services you receive from our office.

4. In accordance with your insurance member handbook, it is your responsibility to provide accurate insurance information and to present your insurance ID card at the time of your visit. If you do not have insurance or do not present a valid insurance card, you will be responsible for payment at the time of service. We will provide you with a copy of our billing form so that you can obtain reimbursement from your insurance company.

5. It is your responsibility to ensure that our physicians are in your insurance network.

6. If your plan requires a referral, it is your responsibility to obtain this prior to being seen by our provider.

7. Payment is due for rendered services 10 days from receipt of your billing statement. Outstanding balances must be paid in full prior to any additional visit unless arrangements have been made with our billing department.

8. There is a service fee of $35 for each time a check is returned. The bank may return your check up to three times before considering it nonnegotiable. Your insurance company does not cover this fee.

9. A scheduled appointment means that time has been reserved for you. Cancellations for appointments must be received at least 24 hours prior to the scheduled appointment. Cancellations for scheduled surgery and in-office procedures must be received at least 5 days prior to the scheduled surgery date and time.

10. Patients who fail to keep or fail to cancel a scheduled appointment may be charged a $50.00 No Show Fee. There is a $50.00 cancellation fee for scheduled surgeries or in-office procedures that are cancelled less than 5 business days from the date and time of surgery unless cancellation is due to insurance denial or medical necessity.

11. Medical records requests must be received in writing at least 72 hours prior to the date needed. Fees for medical records are set in accordance with allowable amounts as defined by the State of Arizona. Fees must be received prior to record delivery.

12. Administrative Services: There is a $25.00 charge for each required Administrative Service, payable prior to service completion. This Administrative Service Fee covers specific administrative services such as forms completion for family medical leave and disability, letters for insurance authorizations for brand or non-formulary drugs, letters for employers, school, health clubs, and any other administrative items not covered by insurance.

13. In the event your insurance company should happen to send payment to you (the patient), you agree to forward said payment to our office to be applied to your account.

14. SELF-PAY: Payment in full is due at the time of service if you do not have health insurance coverage.

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CONSENT TO TREATMENT

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Thunderbird Footcare Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

Patient Initials: _____

AUTHORIZATION REGARDING PRIVACY POLICY

Due to the recent implementation of the Patient Privacy Act (HIPPA), I hereby authorize Thunderbird Footcare to leave messages at my home with family members and/or answering machines regarding the following: (1) Confirm or Change Appointment, (2) Results of testing ordered by the physician, and/or (3) Any pertinent information that may be relative to my care.

Patient Initials: _____

ACKNOWLEDGMENT OF RECEIPT OF FINANCIAL POLICY

I acknowledge that I was provided a copy of the Thunderbird Footcare Financial Policy and that I have read (or had the opportunity to read if I so chose), understand and will comply by the policies stated.

Patient Initials: _____

CONSENT TO VIEW EXTERNAL PRESCRIPTION HISTORY

I authorize Thunderbird Footcare to view my external prescription history via electronic prescribing services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies and pharmacy benefit managers may be viewable by my provider and staff at Thunderbird Footcare and it may include prescriptions back in time for several years.

Patient Initials: _____

PATIENT CONSENT

I hereby voluntarily consent to care by a Thunderbird Footcare Podiatrist, encompassing routine care, diagnostic procedures, examination and medical treatment including, but not limited to, minor surgical procedures, routine laboratory work, x-rays, ultrasound, photographs and administration of medications and injections prescribed by the Thunderbird Footcare Podiatrist. I agree to ask questions to clarify treatment should I not understand the treatment plan.

Patient Initials: _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance with the insurance company(ies) disclosed and assign directly to Thunderbird Footcare and its Podiatrists, all insurance benefits, if any, otherwise payable to me for service(s) rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I agree that should my account become delinquent and is referred to an attorney or collection agency for collection, I will be charged an additional 50% of any unpaid balance at the time of referral for all costs of collection and attorney's fees. I authorize the use of my signature below on all insurance submissions.

Thunderbird Footcare may use my health care information and may disclose such information to the disclosed insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Patient Initials: _____

I have read and fully understand this Consent to Treatment. This authorization is valid as of the date I have signed below and will remain in effect as long as I am a Thunderbird Footcare patient. I have read this complete page and agree to all of its contents.

Name of Individual/Legal Representative (Print)	Signature of Individual/Legal Representative	Date