GENTLE FOOT CARE CENTER
PATIENT INFORMATION FORM

DATE: ___/____/____

(PLEASE PRINT)

PATIENT NAME: _____ _____ ___
LAST FIRST MI

HOME ADDRESS: _____ CITY/STATE: _____ ZIP: _____

MAY WE LEAVE A MESSAGE?

HOME PHONE #: (____) ____-_____ YES NO CELL PHONE #: (____) ____-_____ YES NO

WORK PHONE #: (____) ____-_____ YES NO E-MAIL: _____

Height: _____ Weight: _____ BIRTH DATE: ___/___/___ AGE: ___ SEX: M F

Race:

- ☐ Not Specified
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander

Ethnicity

- ☐ Not Specified
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ White

Social Security#_____

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO

IF YES, NAME: _____ RELATIONSHIP: _____ PHONE #: (____) ____-_____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE #: (____) ____-_____

PRIMARY CARE DOCTOR: _____ PHONE#: (____) ____-_____

PHARMACY: _____ LOCATION: _____ PHONE #: (____) ____-_____

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?

_____ YES NAME(S) _____

_____ NO

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____-_____

WHO REFERRED YOU TO US? _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____

PHONE #: (____) ____-_____ CONTRACT # _____ GROUP # _____

SECONDARY INSURANCE COMPANY NAME: _____

PHONE #: (____) ____-_____ CONTRACT # _____ GROUP # _____

INSURED NAME: _____ _____ DATE OF BIRTH _____ EMPLOYER _____

MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME DOSE HOW OFTEN DO YOU TAKE?

_____

_____

_____

_____

SURGERIES:

LIST **ALL** SURGERY DATE TYPE OF SURGERY DATE

_____ _____

_____ _____

_____ _____

_____ _____

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ ☐ SMOKE ____ PACKS/DAY FOR ____ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ TYPE _____
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

EMPLOYER: _____ OCCUPATION: _____

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? ☐ CHILDREN–AGE(S) _____ ☐ PET(S)–WHAT KIND? _____
☐ ELDERLY OR DISABLED FAMILY MEMBER ☐ OTHER _____

EXERCISE: ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY

TYPES OF EXERCISE: _____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES ☐ CANCER ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE
☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE ☐ RHEUMATOID ARTHRITIS
☐ AMPUTATION ☐ OTHER _____

YOUR MEDICAL HISTORY

ALLERGIES: ☐ MEDICATIONS _____
☐ ANESTHESIA _____ ☐ FOODS _____
☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER _____ ☐ NONE KNOW

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

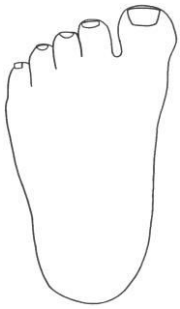
ACIDREFLUX/HEARTBURN	Y	N	EPILEPSY	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	FIBROMYALGIA	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	GERD	Y	N	PACE MAKER	Y	N
ASTHMA	Y	N	GOUT	Y	N	POLIO	Y	N
ABNORMAL BLEEDING	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ADHD	Y	N	HEART DISEASE/FAILURE	Y	N	PSYCHATRIC CARE	Y	N
BLOOD CLOTS	Y	N	HEPATITIS/LIVER DISEASE	Y	N	SICKLE CELL DISEASE	Y	N
CANCER	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER/CANCER	Y	N
CHF	Y	N	HIGH CHOLESTERAL	Y	N	SLEEP APNEA	Y	N
CONSTIPATION/DIARRHEA	Y	N	HIV POSITIVE/AIDS	Y	N	STOMACH ULCERS	Y	N
COPD/EMPHYSEMA	Y	N	KIDNEY DISEASE	Y	N	STROKE/MINI STROKE	Y	N
DEPRESSION/ANXIETY	Y	N	LUPUS	Y	N	THYROID DISEASE	Y	N
DIABETES	Y	N	MEMORY LOSS	Y	N			
DIABETIC RETINOPATHY	Y	N	MITRAL VALVE PROLAPSE	Y	N			
OTHER CONDITIONS:								

CURRENT PROBLEM

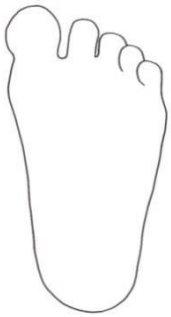
WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

LEFT FOOT



TOP OF FOOT

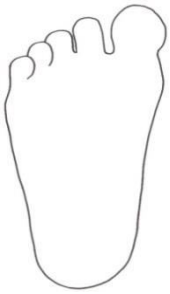


BOTTOM OF FOOT

INSIDE OF FOOT

OUTSIDE OF FOOT

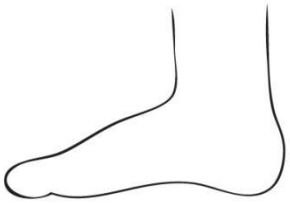
RIGHT FOOT



BOTTOM OF FOOT

TOP OF FOOT

OUTSIDE OF FOOT



INSIDE OF FOOT

HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS / WEEKS / MONTHS / YEARS
DID YOUR PAIN OR PROBLEM: ☐ BEGIN ALL OF A SUDDEN ☐ GRADUALLY DEVELOPS OVER TIME
HOW WOULD YOU DESCRIBE YOUR PAIN? ☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING
☐ RADIATING ☐ ITCHING ☐ STABBING ☐ OTHER _____
HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)
(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 *(WORST PAIN POSSIBLE)*
SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: ☐ STAYED THE SAME ☐ BECOME WORSE ☐ IMPROVED
WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? ☐ WALKING ☐ STANDING ☐ DAILY ACTIVITIES
☐ RESTING ☐ DRESS SHOES ☐ HIGH HEELS ☐ FLAT SHOES ☐ ANY CLOSED TOE SHOE
☐ RUNNING ☐ OTHER _____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? _____

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? _____

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ YES (DESCRIBE) _____ ☐ NO

IF YES, WAS IT A WORK-RELATED INJURY? ☐ YES ☐ NO

OLGA GARCIA LUEPSCHEN, DPM PA

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

_____ _____

PRINT NAME OF PATIENT, PARENT OR GUARDIAN SIGNATURE

_____ _____

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT DATE

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

_____ _____

PRINT NAME OF PATIENT, PARENT OR GUARDIAN DATE

_____

SIGNATURE

Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, cash or check.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If your insurer sends the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.
- There is a service fee of ***$25.00*** for all ***returned checks***. Your insurance company does not cover this fee.
- There is a service fee of ***$25.00*** for any ***missed appointments***. Your insurance company does not cover this fee.
- There is a service fee of ***$10.00*** for a ***second time billing statement mailed***. Your insurance company does not cover this fee.

Signature of Patient/Responsible Party: _____Date: _____

Printed Name of Patient/Responsible Party _____ Date: _____

ASSIGNMENT OF BENEFITS

I have read the above policy regarding my financial responsibility to Olga Garcia Luepschen, DPM, PA for providing medical services to me or the below named patient. I agree to pay Olga Garcia Luepschen, DPM, PA any amount due after insurance payment has been made by my carrier and any contractual adjustments have been credited or full amount of all bills incurred by me or the below named is no health insurance coverage.

I, the undersigned certify that (or my dependant) have coverage with my insurance as presented and assign directly to Olga Garcia Luepschen, DPM,PA insurance benefits, payable to me for service rendered. I understand that I am responsible for payment of Deductibles, co-payment, and/or non-covered service and/or non-covered foot care products. I hereby authorize the doctor to release all necessary information to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance Carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information.

Patient Full Name (PRINT) _____Patient Signature_____ Date_____

Gentle Foot Care Center 2 Ryant Blvd Sebring, Fl 33870

863-314-9255

863-314-0055 fax

Informed Consent for Telehealth Services

Patient Name: Location of the Patient:	Date of Birth:
Provider Name: Olga Garcia Luepschen, DPM Site/Location: Gentle Foot Care Center	Date Consent Obtained:

Introduction:

Telehealth involves the use of medical information exchanged from one site to another via electronic communications. Providers provide services using an interactive audio and video telecommunication system that permits real-time communication to persons who are at some distance from the provider.

Purpose: The purpose of this telehealth service is to enable patients to receive medical care by a provider.

Privacy and Security: I understand that for this encounter, electronic systems used will incorporate network and software security protocols as approved by Federal and State regulations, to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. I understand and acknowledge that security protocols could fail, causing a breach of privacy of personal medical information.

Nature of Telehealth Consultation: I consent to Dr. Luepschen who explained to me how the video and conferencing technology will be used for the purposes outlined below:

1. Discuss and monitor examination/procedure/treatment
2. Diagnosis, follow-up and educational purposes
3. Photo recordings may be taken during the encounter
4. Non-medical technical personnel may be present in the telehealth area to aid in video transmission
5. Other _____

Medical Records: I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth, and that no information obtained in the use of telehealth, which identifies me, will be disclosed to researchers or other entities without my consent.

Alternatives: I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My Provider has explained the alternatives to my satisfaction.

Risks and Consequences: The telehealth consultation will be similar to a routine medical office visit, except interactive video technology will allow you to communicate with a Provider at a distance. At first, you may find it difficult or uncomfortable to communicate using video images. The use of video technology to deliver healthcare and educational services is a new technology and may not be equivalent to direct patient to Provider contact. Following the telehealth consultation, your Provider may recommend a visit to **a local** Hospital for further evaluation.

Gentle Foot Care Center
Olga Garcia Luepschen, DPM
2 Ryant Blvd.
Sebring, FL 33870
863-314-9255
863-314-0055 fax

Rights: I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment. I understand that I have the right to inspect all information obtained and recorded in the course of a telehealth interaction, and may receive copies of this information for a reasonable fee. I understand that it is my duty to inform my Provider of electronic interactions regarding my care that I may have with other healthcare providers.

I have had a direct conversation with the above doctor, during which I had the opportunity to ask questions concerning telehealth service. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand. All blanks or statements that required completion were completed before I signed this form.

I hereby consent to participation in a telehealth consultation.

Date: _____

_____ _____
Signature of Patient Witness

_____ _____
Signature of Authorized Representative Relationship to Patient