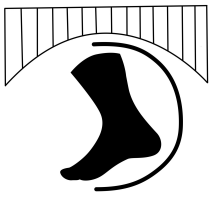


MAGIC VALLEY
FOOT AND ANKLE
SPECIALISTS

Caleb Roberts, DPM
115 Northstar Ave.
Twin Falls, ID 83301
Office: 208.734.7676
Fax: 208.736.8378

Patient Information

Name_____

Mailing Address_____

City_____State_____ Zip_____

Date of Birth_____Age_____

SSN_____-_____-_____

Phone (____)_____-_____Cell (____)_____-_____

Email_____

Sex ☐ Male ☐ Female

Employment Status

☐ Employed ☐ Not Employed ☐ Retired

Employer Name_____

Position_____

Work Number (____)____-_____ ☐ Contact you at work?

Marital Status

☐ Single
☐ Married: Spouse_____
☐ Divorced
☐ Widowed

Race

☐ Asian
☐ Black or African American
☐ Pacific Islander
☐ Hispanic or Latino
☐ American Indian
☐ White/Caucasian
☐ Other (Not listed)

Preferred Language

☐ English
☐ Spanish
☐ Other

_____

Insurance Information

Person Responsible for Account

Relationship ☐ Self ☐ Spouse ☐ Father ☐ Mother

Name of Policy Holder:_____

Insurance Co._____

ID Number_____

DOB:_____-_____-_____ Age:_____

SSN: _____-_____-_____

Phone (____)____-_____ Cell: (____)_____-_____

☐ Secondary Insurance

Insurance Co. _____

ID Number:_____

Emergency Contact

Name:_____

Relationship: _____

Address:_____

City_____ State_____ Zip_____

Phone (_____) _____-_____

Primary Care Physician

Name_____

Date last seen:_____

☐ My Doctor referred me

Referral Source

☐ Friend
☐ Relative
☐ Yellow Pages
☐ Social Media
☐ Insurance List
☐ Internet/Google Search
☐ Other _____

Messages

☐ Ok to text: appointment reminders, results and followup (including HIPPA information)

OR

☐ Please leave a voice message asking me to return your call

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I had the opportunity to receive a copy of the “Notice of Privacy Practices” and that I have read (or had the opportunity to read if I so

_____
Signature of Patient/Responsible Party

_____
Printed Name of Patient/Responsible Party

_____
Date

Please complete other side

Past Diagnosed Medical History

☐ No past diagnosed medical history

_____

_____

_____

_____

_____

Past Surgical History

☐ No past surgical history

_____

_____

_____

_____

_____

Family History

Arthritis	☐ Father ☐ Mother	Other:	**Heart Attack**	☐ Father	☐ Mother
Cancer	☐ Father ☐ Mother	_____	**Hypertension**	☐ Father	☐ Mother
Diabetes	☐ Father ☐ Mother	_____	**Kidney Failure**	☐ Father	☐ Mother
Foot Problems	☐ Father ☐ Mother	_____	**Stroke**	☐ Father	☐ Mother
Gout	☐ Father ☐ Mother	_____	**Vascular Disease**	☐ Father	☐ Mother

Medication Information

☐ No daily medications

Please fill out!! This information is very important for your care

Medication Name	Dosage	Frequency	Purpose for Medication

Allergies

☐ none

_____

_____

Preferred Pharmacy

_____

City _____

Social History

Smoker?

☐ Never smoker
☐ Current every day smoker
☐ Current some day smoker
☐ Former smoker
☐ Heavy tobacco smoker
☐ Light tobacco smoker

Do you drink alcohol? ☐ Yes ☐ No

Type of Alcohol

☐ Beer ☐ Liquor ☐ Wine

Frequency

☐ Socially ☐ Minimally ☐ Infrequently

Recreational Drug Use

☐ Yes ☐ No

Please complete other side

Please Provide A Short Narrative of Why You Are Here:

_____

_____

_____

_____

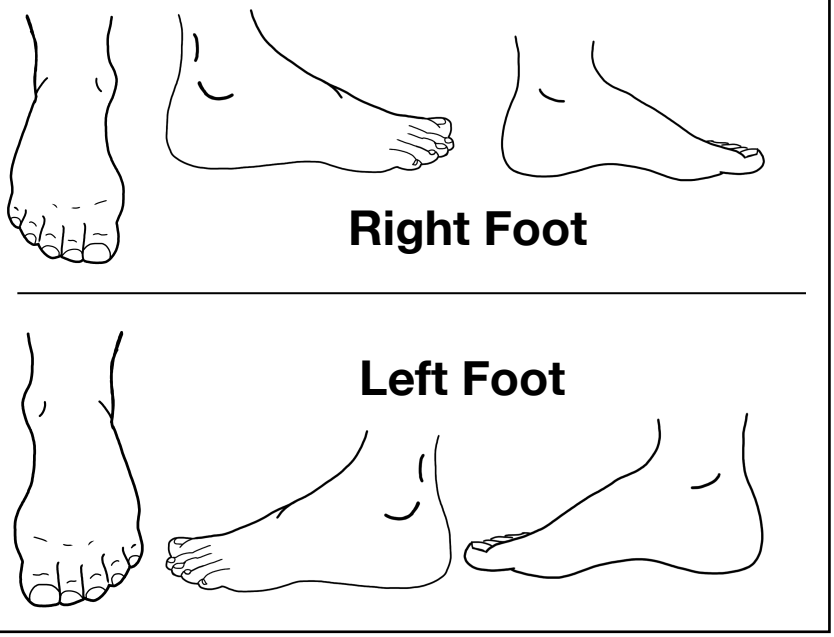
DURATION OF PROBLEM

- ☐ _____ Days
- ☐ _____ Weeks
- ☐ _____ Months
- ☐ _____ Years

SEVERITY OF PAIN

- ☐ 1-3
- ☐ 4-6
- ☐ 7-9
- ☐ 10

Please mark on the diagram where you have a problem



FEELS LIKE?

- ☐ Burning
- ☐ Tingling
- ☐ Throbbing
- ☐ Radiating
- ☐ Shooting
- ☐ Numbness
- ☐ Itchiness
- ☐ Sharp
- ☐ Dull
- ☐ Ache

Have you ever worn orthotics before?

- ☐ Yes, over the counter type insole
- ☐ Yes, custom made from a podiatrist
- ☐ Never
- ☐ I don't know what orthotics are?

How often do you wear the following shoes?

- ☐ Sneakers/tennis shoes _____% of time
- ☐ Casual shoes _____% of time
- ☐ Pumps or low heel shoes _____% of time
- ☐ High heels shoes >2 inches _____% of time
- ☐ Flip flops or sandals _____% of time
- ☐ Work or other boots _____% of time
- ☐ Lace up dress shoes _____% of time
- ☐ Loafers or deck shoes _____% of time

SHOE SIZE? _____

ARE YOU *CURRENTLY* EXPERIENCING ANY OF THE FOLLOWING

GENERAL
- ☐ Fatigue
- ☐ Excess weight loss or gain
- ☐ Fever
- ☐ Chills

EYES
- ☐ Itching
- ☐ Burning
- ☐ Discharge
- ☐ Blurring
- ☐ Irritation

EAR/NOSE/THROAT
- ☐ Ringing in ears
- ☐ Ear infection
- ☐ Nose bleeds
- ☐ Sinus infections
- ☐ Difficulty swallowing

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Palpitations
- ☐ CHF
- ☐ Circulation issues
- ☐ Leg pain at rest

RESPIRATORY
- ☐ Asthma
- ☐ Wheezing
- ☐ Cough
- ☐ Difficulty breathing
- ☐ Oxygen

GASTROINTESTINAL
- ☐ Abdominal pain
- ☐ Stomach ulcers
- ☐ Constipation
- ☐ Diarrhea
- ☐ Liver problems

GENITOURINARY
- ☐ Frequent/Painful urination
- ☐ Blood and/or discolored urine
- ☐ Urinary tract

MUSCULOSKELETAL
- ☐ Joint pain
- ☐ Rheumatoid arthritis
- ☐ Gout
- ☐ Muscle pain
- ☐ Back pain

SKIN
- ☐ Rash
- ☐ Itching
- ☐ Ulcers
- ☐ Dryness
- ☐ Suspicious

NEUROLOGICAL
- ☐ Stroke
- ☐ Balance issues
- ☐ Abnormal sensations in feet
- ☐ Sciatica
- ☐ Weakness

PSYCHIATRIC
- ☐ Depression
- ☐ Anxiety
- ☐ Insomnia
- ☐ Mood disorders
- ☐ Mental illness
- ☐ Paranoia

ENDOCRINE
- ☐ Diabetes
- ☐ heat/cold intolerance
- ☐ Thyroid issues
- ☐ Increased sweating

LYMPHATIC
- ☐ Abnormal bruising
- ☐ Bleeding
- ☐ Enlarged Lymph Nodes
- ☐ Other (list

IMMUNOLOGIC
- ☐ Uticaria
- ☐ Hay fever
- ☐ Persistent Infections
- ☐ HIV exposure
- ☐ Other (list

Other From Above:

_____

_____

_____

FOR THOSE WITH DIABETES ONLY

ROUGHLY, HOW LONG HAVE YOU BEEN DIAGNOSED?

☐ <1year ☐ <5 years ☐ <10 years ☐ >10 years

HOW WOULD YOU RATE YOUR CONTROL?

Poor Fair Good

ARE YOU ON INSULIN?

Yes No

WHAT WAS YOUR LAST HEMOGLOBIN A1C?_____

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 Patient Financial Coordinator.

- **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, American Express, Discover, Care Credit, cash or check for payment.

- 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.

- 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 in this office. For all balances over 60 days from the date your insurance processes your claim, our office will begin to apply a monthly interest fee, on an 18% annual interest rate if regular monthly payments are not made.

- We want to stay in touch with you regarding your account and its collection status regarding balances due. In order for us to contact you regarding all past due accounts and any collection status you may have, you expressly authorize us to contact you either by telephone or sending text messages or emails at any number or email you have listed. You acknowledge that such contact could result in charges to you by telephone carrier. Methods of contact may include the use of pre-recorded/ artificial voice messages and/or the use of an automatic telephone dialing system, as applicable. You acknowledge and agree that this authorization shall extend to any billing or collection company or companies which may be assigned.

- **FEES: A 4% processing fee will be charged on all credit and debit card transactions. Our office will charge a $20 no show fee per missed appointment or a $20 no cancelation fee for patients who do not give 24 hours notice of cancelation without reasonable cause. Our office will charge the highest fee allowed for all returned checks. Your insurance company WILL NOT cover any additional fees as stated above.**

- At the election of either you or us, any claim, dispute or controversy (Claim) by either you or us against the other, or against the employees, agents or assigns of the other, arising from or relating in any way to this Agreement or your account, or any transaction on your account shall be submitted to binding arbitration. You further agree that no class actions, joinder or consolidation of any Claim, with a Claim of any other person or entity shall be allowable in arbitration, without the written consents of both you and us.

Signature of Patient/ Responsible Party:_____

Print Name:_____ Date:_____

Assignment of Benefit Agreement

I hereby authorize my insurance company, including Medicare if I am a Medicare Beneficiary, to make payments to **Magic Valley Foot & Ankle** for medical or surgical services or items rendered to me or my dependent by **Magic Valley Foot & Ankle**. Should my insurance carrier deny Magic Valley Foot & Ankle payment, I understand that I am financially responsible for the charges. I authorize **Magic Valley Foot & Ankle** to release any and all of my records to my insurer, or any other third party payer, legally responsible for the payment of medical expenses. I certify that the information provided or to be provided by me is correct and complete to the best of my knowledge. It is my responsibility to update any and all personal, insurance and health information. I am also acknowledging that I had the opportunity to receive a copy of the "Notice of Privacy Practices" and that I have read (or had the opportunity to read if I so choose) and understand the notice

Please sign below that you read/understand the above statement.

Signature Date

Patient Name (please print) Authorized Representative (If Applicable)

CONSENT FORM FOR ePRESCRIBE PROGRAM

ePrescribe Program. ePrescribing is way for doctors to send electronically an accurate, error free, and understandable prescription from the doctor's office to the pharmacy. The ePrescribe Program also includes:

• Formulary and benefit transactions - Gives the health care provider information about which drugs are covered by your drug benefit plan.

• Fill status notification - Allows the health care provider to receive an electronic notice from the pharmacy telling them if your prescription has been picked up, not picked up, or partially filled.

• Medication history transactions - Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug- allergy interactions; adverse drug reactions; and duplicative therapy. The medication history information would include medications prescribed by other health care providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions, venereal diseases/sexually transmitted diseases, abortion(s), rape/sexual assault, substance (drug and alcohol) abuse, genetic diseases, and HIV/AIDS. As part of this Consent Form, you specifically consent to the release of this and other sensitive health information. By signing this consent form you are agreeing that your provider at the practice may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes. You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or to deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it. This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent to the practice to enroll me in this ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Signature Date

Patient Name (please print) Authorized Representative (If Applicable)