

Tri-State Foot and Ankle Center, LLC

5936 Limestone Rd ~ Suite 202 ~ Hockessin, DE 19707

2018 Naamans Rd ~ Suite 1 ~ Wilmington, DE 19810

Dr. Harold Gruber, DPM • Dr. Sandra Hudak, DPM

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

Address: _____ City: _____ State: _____ Zip: _____

Telephone: Home _____ Work _____ Cell _____

Date of Birth: _____ Age: _____ Male Female S.S.N. _____

Who referred you to our office? _____

Employer of Patient: _____ Address: _____

Telephone Number: _____ Occupation: _____

Insurance company: _____ Subscribers Name: _____

Subscribers D.O.B: _____ ID number: _____

Group Number: _____ Secondary Insurance: _____

ID number: _____ Group Number: _____

Emergency Contact: _____ Telephone: _____

Family Physician: _____ Telephone: _____

Person Responsible for Payment:(who pays your bills) Self Other: _____

Responsible Persons Address: _____

Release and Assignment:

I hereby authorize the FOOT AND ANKLE CENTER to release to my insurance company information concerning my illness and treatment and hereby sign to the above all payments for medical services rendered to my dependent or myself. I understand that I am responsible for any amount not covered by insurance. I consent to treatment of my condition as indicated by my medical history and the doctor's diagnosis.

(Patient or Guardian Signature)

(Date)

Request For Signature On File:

Below is a request to put your signature on file permanently in our office. This means that by signing below, you will not have to sign the release of medical information or release of payment directly to the doctor each time you come into our office. By doing this you will be helping us process your insurance claims faster and more efficiently. If you have any further questions about this, please ask our receptionist.

Please initial all below:

I authorize use of this form on all my insurance submissions

I authorize release of information to all my insurance companies

I understand that I am responsible for my bill

I understand that I have made an agreement with my insurance company and that it is my duty, and not the physicians, to resolve issues of non-payment. I also understand that my insurance company may not cover medications, medical services, or medical goods that may be prescribed by my doctor. Once again, issues of payment are based on an agreement between myself and my insurance company, and not the doctor.

I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies

I authorize payment directly to my doctor

I permit a copy of this authorization to be used in place of the original

I authorize the sending of lab specimens to the laboratory

(Patient Signature)

(Date)

(Patients Name: Please Print)

Medical History

Patient Name: _____ Date: _____

Describe the problem you are currently having:

How is your general health? Excellent Good Fair Poor

Have you seen a physician within the last year? Yes No

Reason: _____ Are you still being treated: Yes No

Do you smoke? Yes No How much? _____ For how long? _____

Do you drink Alcohol? Yes No How many drinks per day? _____

Do you have any known allergies? (Ex. Medications, Adhesives, Latex, Shellfish, ect.?) Yes No

Please list: _____

Do you use, or have you used IV/ other recreational drugs? Yes No

Females: Are you pregnant? Yes No How many months? _____

Please check all that apply: If you have or have had any of the following:

- | | |
|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Bursitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Stomach Trouble | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Blood Disorder |
| <input type="checkbox"/> Skin Disorder | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Kidney or Bladder Disorder | <input type="checkbox"/> Foot Ulcers |
| <input type="checkbox"/> Vascular Problem (hardening of arteries, etc) | <input type="checkbox"/> Difficulty Healing |
| <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> HIV / AIDS |
| <input type="checkbox"/> Bleeding Tendencies | <input type="checkbox"/> High Cholestrol |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ |

Family History: (Parents, Brothers, Sisters, and/or Children)

- | | |
|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Other |

Father: Age:_____ Alive Deceased Mother: Age_____ Alive Deceased

Current Medications: (Including Dosage)

Please include any information not requested that you feel important: (Example Surgeries, etc.) :

Signature: _____

Acknowledgment of Receipt of Notice of Privacy Practices (HIPPA)

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 choose) and understand the notice.

Patient Name (please print)

Date

Parent or Authorized Representative (if applicable)

Signature

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Office Policies:

1. When appointments are cancelled within 24 hours of the appointment time, patients will incur a \$20.00 no show fee.
2. Refills may require up to 72 hours notice in order to be processed correctly. Also, if you have not been in to see the doctor in over one month, an appointment may be required.
3. Patients are required to have referrals completed before seeing the doctor. For questions about whether a referral is need or not, please contact your insurance provider.
4. Patients with Medicare: Routine foot care may or may not be covered by Medicare. A waiver must be signed before seeing the doctor. If routine foot care is not covered, payment is due at the time of service.
5. Services or products which are not covered by your insurance company are to be paid for at the time of the service / dispensing of the item.
6. The doctor reserves the right to bill patients directly if his/her insurance company has not paid the doctor in a timely fashion (after 30 days). Patients are expected to call their insurance company to resolve issues of non-payment, before the service or item will be rebilled.

Patient Signature: _____ Date: _____