Welcome to our office!

In order to provide you with the best possible health care, we have enclosed the necessary documents for you to review and complete before your visit. Please plan to arrive **15 minutes early** for your appointment and bring your completed forms so that our staff can prepare your chart. Also, please make sure to bring the following information with you for your appointment:

1. **Please fill out each form** included with this letter and bring the documents to your first appointment.

2. Your **insurance cards** to make a copy for our records.

3. The **referral** from your primary care physician, if required by your insurance company.

4. Any **co-payment** required by your insurance carrier. Co-payments are due at the time of your visit and may be paid by cash, check, or credit card.

5. **Photo identification**, such as a driver's license.

We appreciate the confidence you have placed in our office, and we look forward to providing you with the best possible health care in the future.

Please call our office if you have any questions or need additional information.

Sincerely,

Podiatry Associates of the Lehigh Valley
Patient Payment Policy

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care.

For your convenience, we have answered a variety of commonly-asked financial policy questions below. If you need further information about any of these policies, please ask to speak with a Billing Specialist or the Practice Manager.

How May I Pay?
We accept payment by cash, check, VISA, Mastercard, and Discover.

Do I Need A Referral?
If you have an HMO plan with which we are contracted, you need a referral authorization from your primary care physician. If we have not received an authorization prior to your arrival at the office, we have a telephone available for you to call your primary care physician to obtain it. If you are unable to obtain the referral at that time, you will be rescheduled.

Your financial responsibility depends on a variety of factors, depending on your specific insurance plan. Our staff will file an insurance claim as a courtesy to you. The Patient is responsible for payment of all applicable deductible, co-pays and non-covered services.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility.

Patient Signed: ___________________________ Date: ___________________________

Patient's Name Printed: ___________________________

Parent / Guarantor Signed: ___________________________ Date: ___________________________

If Patient is a minor

Credentials: • Certified in Foot Surgery, American Board of Podiatric Surgery • Board Certified in Peripheral Nerve Surgery • Chief of Podiatry & Director of Podiatric Residency Program, St. Luke’s Hospital • Board Qualified in Foot Surgery, American Board of Podiatric Surgery • Specializing in Reconstruction & Diabetic Foot Conditions

Podiatry Associates of the Lehigh Valley is an independent practice and not employed by St. Luke’s.
Please answer all questions fully

<table>
<thead>
<tr>
<th>Patient</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name (Last, First, Mi)</td>
<td>Social Security #</td>
</tr>
<tr>
<td>Age</td>
<td>Birthdate</td>
</tr>
<tr>
<td>Home Phone</td>
<td>Email</td>
</tr>
<tr>
<td>Mailing Address</td>
<td>City</td>
</tr>
<tr>
<td>Employer</td>
<td>City</td>
</tr>
<tr>
<td>Marital Status</td>
<td>M</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Responsible Party</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name (Last, First, Mi)</td>
<td>Social Security #</td>
</tr>
<tr>
<td>Birthdate</td>
<td>Sex</td>
</tr>
<tr>
<td>Mailing Address</td>
<td>City</td>
</tr>
<tr>
<td>Employer</td>
<td>City</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family Doctor</th>
<th>Who Referred You To Our Office?</th>
<th>Pharmacy &amp; Location</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Insurance Information</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Insurance Company</td>
<td>Subscriber's Name</td>
</tr>
<tr>
<td>Relationship</td>
<td>Policy #</td>
</tr>
<tr>
<td>Birthdate</td>
<td>SSN #</td>
</tr>
<tr>
<td>Second Insurance Company</td>
<td>Subscriber's Name</td>
</tr>
<tr>
<td>Policy #</td>
<td>Copay</td>
</tr>
<tr>
<td>Birthdate</td>
<td>SSN #</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Past Medical History (please check):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
</tr>
<tr>
<td>Anemia</td>
</tr>
<tr>
<td>Arthritis</td>
</tr>
<tr>
<td>Gout</td>
</tr>
<tr>
<td>Kidney problems</td>
</tr>
<tr>
<td>Tuberculosis</td>
</tr>
</tbody>
</table>

Please check any of the following diseases that run in your family.
| Diabetes | High blood pressure | Cancer | Arthritis | Heart disease |  |  |
Do you have any ALLERGIES to MEDICATIONS?  ☐ Yes  ☐ No

If yes what are they?

What medications do you regularly take prescribed by a physician?

SOCIAL HISTORY:

☐ Alcohol _______ drinks/day  ☐ Smoking _______ packs/day  ☐ Non-prescription, illicit drugs

PAST SURGICAL HISTORY:

☐ Appendix _______  ☐ Hysterectomy _______  ☐ Gallbladder _______

☐ Hip or Knee Surgery _______  ☐ Abdominal/Bowel _______  ☐ Heart _______

☐ Foot Surgery _______  ☐ Tonsils _______  ☐ Veins or Arteries _______

☐ Other: _______

Do you have any of the following problems on a regular basis:

☐ Recent weight loss  ☐ Headaches  ☐ Skin rashes

☐ Fainting  ☐ Abnormal bleeding  ☐ Back pain

☐ Shortness of breath  ☐ Chest pain  ☐ Shoulder pain

☐ Difficulty in breathing  ☐ Muscle weakness  ☐ Hip pain

☐ Nausea or vomiting  ☐ Memory loss  ☐ Knee pain

☐ Persistent cough  ☐ Painful urination  ☐ Neck, arm or hand pain

☐ Swelling ankles  ☐ Frequent urination  ☐ Stomach pain

FOR INSURANCE CLAIMS: I authorize the release of any medical information needed to process my claim and request claim assignment to be made directly to Podiatry Associates of the Lehigh Valley, LLC

Signed: ____________________________  Date: ____________________________

FOR MINORS: I as parent or guardian of the above named patient give my permission for Podiatry Associates of the Lehigh Valley, LLC to render medical and surgical treatment and will assume full financial obligation.

Signed: ____________________________  Date: ____________________________

I hereby give my permission to Podiatry Associates of the Lehigh Valley, LLC to administer treatment; and to perform such minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of my foot condition. I consent to the photographing of my foot condition.

Signed: ____________________________  Date: ____________________________
REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Name of Patient: ___________________________ Date of Birth: ____________

(please print)

I request that all communications to me (by telephone, mail or otherwise) by Podiatry Associates of the Lehigh Valley, LLC and/or their staff be handled in the following manner:

For written communications:
Address to: ____________________________________________________________

For oral communications:
Call: _________________________________________________________________

May we leave a message on your answering machine? Yes □ No □

May we leave a message with a family member? Yes □ No □

ACKNOWLEDGEMENT 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.

Patient Name (please print) __________________________ Date __________________________

Parent or Authorized Representative (if applicable) __________________________

Signature __________________________