

HISTORY & PHYSICAL of PATIENT

Name _____

Date _____

Past Medical Conditions: (Circle Yes Or No)

AIDS/HIV	Yes	No	Kidney Problems	Yes	No
Diabetes	Yes	No	Bleeding Problems	Yes	No
Heart Disease	Yes	No	Lung Disease	Yes	No
Gout	Yes	No	Liver Disease	Yes	No
Hypertension	Yes	No	Ulcers	Yes	No
Arthritis	Yes	No	Type _____	How Long _____	

Any Other Medical Problems: (Please List) _____

Family History: _____

Allergies:

Iodine: Yes No Local Anesthesia: Yes No Athletic Tape: Yes No

Any Allergies to Medications: (Please List) _____

Do you Smoke? Yes No How Much? _____

Are You Pregnant? Yes No

Current Medications: (Please List)

Past Surgeries/Hospitalizations: (List most recent first)

Previous Podiatric Examinations: (List reason for visit – ie: Bunions, Foot Pain etc.)

CACTUS FOOT & ANKLE, LLC

Myron H. Hansen, DPM, PLC
1880 W. Frye Rd., Bldg. F, Suite 3
Chandler, AZ 85224

To Our Patients:

The privacy of your medical records and information is important to us. Medical information is personal and we are committed to protecting it. Documentation of your medical treatment and services rendered are created to provide you with quality care and to comply with certain legal requirements. This notice will provide you with a brief statement of our privacy practices.

Our Legal Duty:

1. To keep your medical information private.
2. To provide upon your request a complete Notice of the Privacy Practices as required by HIPAA.
3. To comply with the terms and conditions of the current notice.

Notice of Change to the Privacy Practice:

Our office will update any new notice if/and when any important changes are made.

Use and Disclosure of your Medical Information:

We may disclose information for treatment, payment or to health care operators for the purpose of the quality of your care, for payment and to obtain any authorizations, pre-certifications, etc. Any information you do not wish to disclose must be specified in writing. Any specific written information you authorize for non-disclosure may be revoked at any time in writing.

For a complete Notice of the Privacy Practices as required by HIPAA, please ask the receptionist for a copy.

I have read the above Notice of Privacy Practices and fully understand said Notice.

Signature of Patient or Responsible Party

Printed Name

Date

Myron H. Hansen, DPM, PLC
1880 W. Frye Rd., Bldg F, Suite 3, Chandler, AZ 85224
(480) 889-2905

Financial Responsibility

Patient Name: _____

I HEREBY AUTHORIZE MY INSURANCE COMPANY TO MAKE PAYMENTS DIRECTLY TO:

Myron H. Hansen, DPM, PLC

I understand I am financially responsible for any co-payments, deductibles, co-insurance and all charges which are not covered by my insurance. I understand that there will be a **\$25.00** service charge on all returned checks. **I understand that verification of benefits is not a guarantee of payment. Insurance benefits are determined by your insurance company when the claim is received. I understand I will be responsible for any portion of the claim that is not covered by my insurance company.** Initial: _____ With the exception of Medicare, I understand if I have secondary insurance, I am responsible for payment of my co-insurance at the time service is rendered and upon request I will be provided with all required documentation to collect reimbursement myself.

I understand that I am responsible for all charges if it is determined that the insurance information I have provided is not correct.

Delinquent accounts will be turned over to a collection agency without notice. **Accounts will be considered delinquent if unpaid after 60 days.** In the event my account is turned over for collection, I will pay all reasonable collection, court and attorney costs at the time the account is considered delinquent. Appointments **not** cancelled with a 24 hour notice will be subject to a **\$30.00** fee.

Signature of Patient or Responsible Party

Printed Name

Date

Release of Information:

I hereby authorize Myron H. Hansen, DPM, PLC to release any medical information or incidental information to my referring physician or any other physicians who have been or may become involved with my care. I also authorize the release of information that may be necessary in the processing of any insurance claims.

Signature of Patient or Responsible Party

Printed Name

Date

A photostatic copy of this authorization shall be considered as effective and valid as the original.

PATIENT INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____ AGE: _____

ADDRESS: _____

PHONE NUMBER: (____) _____ CELL PHONE: (____) _____

PATIENT'S SSN: _____ - _____ - _____ MARITAL STATUS: _____

HEIGHT: _____ WEIGHT: _____ SHOE SIZE: _____ SEX: MALE FEMALE

PATIENT'S EMPLOYER: _____ PHONE NUMBER: (____) _____

EMPLOYER'S ADDRESS: _____

POLICY HOLDER'S NAME: _____ DATE OF BIRTH: _____

SSN: _____ - _____ - _____ RELATIONSHIP TO PATIENT: _____

EMPLOYER: _____ PHONE NUMBER: (____) _____

EMPLOYER'S ADDRESS: _____

FAMILY PHYSICIAN: _____ PHONE NUMBER: (____) _____

PHARMACY: _____ PHONE NUMBER: (____) _____

MYRON H. HANSEN, DPM

1880 W. FRYE RD., STE F-3

CHANDLER, AZ 85224

ASSIGNMENT: I hereby assign my insurance benefits to be paid directly to the supplier of services rendered.

SIGNED: _____ DATE: _____

RELEASE: I authorize the release to my insurance carrier(s) any information necessary to process this claim.

SIGNED: _____ DATE: _____