R. Curtis Arnold, DPM

417 D Street, South Charleston, WV 25303

Ph: 304-744-8951 Fax: 304-744-0165

Email: DrFoot00@gmail.com

Website: www.FootDoctorWV.com

Appointment Day_____ Date_____ Time_____ Arrival time_____

Dear New Patient,

I and my staff would like to take this opportunity to welcome you to our office. We will make every effort to make your visits as pleasant as possible. Enclosed are our patient data sheets. (They are also available on the internet for printing or you can also access them on the portal by calling our office to obtain the access code). We would appreciate you taking a few minutes prior to your appointment and filling them out. If there is time before your appointment, please complete and mail them to us or drop them off. If you do not mail them or drop them off please bring them with you along with any X-ray, MRI disk or labs that may be beneficial to your visit. You will need to have your insurance cards, driver's license/identification card, and a list of all medications so that we may make copies of them if necessary and to avoid any delays for you and other patients, please plan to arrive 15 minutes before your appointment time to complete any other necessary paperwork as our office strives to maintain our daily scheduled appointments.

If you are unable to keep your scheduled appointment or have any questions regarding our office, please do not hesitate to give my staff a call. Again, welcome to our office.

Sincerely,

R.C Arnold, D.P.M. and Staff

DIRECTIONS...

If approaching from the East on I 64, take the Montrose Drive exit. Turn right and follow the 2nd Ave signs to the right. Go to the 4th stop sign and turn right onto D Street. On D Street, go through the second stop sign. The office is near the end of the block on the left (directly across from the Post Office).

If approaching from Charleston, go west on MacCorkle Ave to 7th Avenue. At the Indian Mound make a left; 1 block turn left onto D Street. Our office is on the third block on the right.

If approaching on I-64 from the west, take the MacCorkle Ave exit. Turn right and follow the directions for MacCorkle Ave. At the Indian Mound make a right; 1 block turn left onto D Street. Our office is on the third block on the right.

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PATIENT INFORMATION

Please Print

Full Name_____ Preferred_____ Date of Birth_____

Male_____ Female_____ Single_____ Married_____ Widowed_____ Divorced/separated_____ SS#_____

Home Address_____ Apt #_____ Race_____

City_____ State _____ Zip Code_____ Ethnicity_____

Home Phone_____ Work Phone_____ Cell Phone_____ Preferred Number_____

Work Status - Employed: Full_____ Part-time_____ Other: Retired_____ Domestic_____ Disabled_____ Student_____

Employer_____ Address_____ Phone _____

Email Address_____ Primary Language_____ How did you hear about us_____

If the patient is a child or dependent adult, please give the name of the responsible party for billing patient care and/or questions.

Responsible Party_____ Date of Birth_____ Relationship to patient_____

Address_____ Apt # ____ City_____ State_____ Zip-code_____

Employer _____ Address_____ City_____ State____ Zip-code_____

EMERGENCY INFORMATION

Emergency Contact_____ Relationship_____ Phone Number_____

Allowed Contacts: Anyone Answering Phone_____ Patient only_____ Spouse_____ Children_____ Other_____

Do you have a care plan or surrogate decision maker: Yes_____ No_____ (If yes complete questions below)

Decision Maker_____ Relationship_____ Phone Number_____

INSURANCE INFORMATION

( ) Check here if you have **NO** health insurance ( ) Copies of current Insurance Cards and Drivers License must be attached

Primary Carrier_____ ID#_____ Group#_____

Policy Holder (if other than patient)_____ SS#_____ Date of Birth_____

Secondary Carrier_____ ID# _____Group#_____

Policy Holder (if other than patient)_____ SS#_____ Date of Birth_____

Assignment of Benefits

I understand that I am responsible for payment of my account and insurance billed by this office is a courtesy. I am responsible for follow-up of my insurance. Any amount not paid by my insurance company in 90 days is my responsibility to pay. All co pays and deductibles are due at the time of service. If we are unable to check eligibility and the insurance card doesn't have the amount of co pay. There will be a 40.00 co pay hold charge. There is also a 3% fee for the convenience of using your credit card/debit card. Cash and checks are accepted without this fee. The above information that I have provided is true and accurate. I hereby authorize payment of any claims billed by this office to be made directly to R. Curtis Arnold, D.P.M.

I further authorize the release of any medical information needed to process claims. I understand that I am financially responsible for any charges not covered by this assignment. **Initials**_____

I further authorize any physician, hospital, medical attending, or others to furnish R. Curtis Arnold, or any representative thereof, information to assist in payment of any claims billed. **Initials**_____

Acknowledgement of Privacy Practices and Patient Bill of Rights

I acknowledge that I could receive a copy of the Notice of Privacy Practices to take home, or read in the office if I so chose. I also understand that if I have any questions regarding this notice I can ask the staff so that I can fully understand. **Initials**_____

I acknowledge that I have received a copy of The Patient's Bill of Rights. I also understand that if I have any questions regarding this notice I can ask the staff so that I can fully understand. **Initials**_____

********** STATEMENT OF ACCURACY - SIGNATURE REQUIRED **********

I acknowledge that the above information is true and accurate. I understand that it is my responsibility to inform this office if there is any change to the information.

_____	_____	_____
Patient/Parent/GuardianPrintedName	**Signature**	**Date**

Medicare Notification

If a Medicare Patients or Medicare Advantage Patient

I request that payment of Medicare benefits be made to R. Curtis Arnold, D.P.M. for any service furnished by him. I authorize release to the Health Care Financing Administration and it's agents any medical information about me needed to determine if these benefits are payable for related services.

I hereby agree that I am responsible for all non-covered services and any deductibles or co-payments on covered services. **Initials**_____

ROUTINE FOOT CARE: Medicare does not cover "routine foot Care" which is trimming of nails, corns, or calluses, unless the patient has diabetes or severe circulation problems. If you are diabetic and/or have severe circulatory problems, in order for Medicare to pay for your visit, we must document on your claim the name of the doctor you see for that condition and the date you last saw him/her. You will be required to give us this information each time you visit our office. You understand that without this information we can't bill Medicare and that the visit will be your responsibility. **Initials**_____

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Patient Bill of Rights and Responsibilities

We want to encourage you, as a patient at R. Curtis Arnold, D.P.M., to speak openly with your health care team, take part in your treatment choices, and promote your own safety by being well informed and involved in your care. Because we want you to think of yourself as a partner in your care, we want you to know your rights as well as your responsibilities. We invite you and your family to join us as active members of your care team.

Our Responsibilities to You as Our Patient:

- You have the right to receive detailed information about your charges.
- You have the right to be treated with respect.
- You can expect that all communication and records about your care are confidential, unless disclosure is permitted by law. You have the right to request a list of people to whom your personal health information was disclosed.
- You have the right to see or get a copy of your medical records. You may add information to your medical record by informing the Front Desk of personal changes and the Medical Assistants for health changes.
- You have the right to give or refuse consent for recordings, photographs, films, or other images to be produced or used for internal or external purposes other than identification, diagnosis, or treatment. You have the right to withdraw consent up until a 24 hours before the item is used
- If you or a family member needs to discuss an ethical issue related to your care, please feel free to speak with the Chief Health Officer of the Continuous Quality Improvement Committee.
- You have the right to voice your concerns about the care you receive. If you have a problem or complaint, you may talk with your doctor or the office manager

Your Responsibility to Us as Our Patient:

- You are expected to provide complete and accurate information, including your full name, address, home and/or cell telephone number, date of birth, Social Security number, insurance carrier and employer when it is required.
- You should provide this office with a copy of your advance directive if you have one.
- You are expected to provide complete and accurate information about your health and medical history, including present condition, past illnesses, hospital stays, medicines, vitamins, herbal products, and any other matters that pertain to your health, including perceived safety risks.
- You have the right to make a treatment choice or to refuse treatments. You are expected to ask questions when you do not understand information or instructions. If you believe you cannot follow through with your treatment plan, you are responsible for telling your doctor. You are responsible for outcomes if you do not follow the care, treatment, and service plan.
- You are expected to treat the staff, other patients, and visitors with courtesy and respect; abide by all rules and safety regulations; and be mindful of noise levels, privacy, and number of visitors.
- You are expected to provide complete and accurate information about your health insurance coverage and to pay your bills in a timely manner.
- You have the responsibility to keep appointments, be on time, and call this office if you cannot keep your appointments.

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Patient Name_____ Date of Birth_____ Age_____

Primary Physician_____ Phone Number_____ Date Last Seen_____

Referring Physician_____ Phone Number_____ Date Last Seen_____

Height_____ Weight_____ Shoe size_____

PODIATRIC HISTORY

What is the chief foot/ankle complaint for which you came to be treated?

_____

_____

_____

Have you ever been to a Podiatrist before? Yes or No
If yes , please list:

Name_____

Last Visit_____

Do you have diabetes?	☐	Yes	☐	No
Family history of diabetes?	☐	Yes	☐	No
Do you use tobacco?	☐	Yes	☐	No
Cigarettes	☐	Yes	☐	No
E Cigarettes	☐	Yes	☐	No
Cigars	☐	Yes	☐	No
Snuff	☐	Yes	☐	No
Chewing tobacco	☐	Yes	☐	No
Do you drink alcohol?	☐	Yes	☐	No

How often?_____ How much?_____

Do you drink caffeine?	☐	Yes	☐	No

How often?_____ How much?_____

Athletic Activities in which you participate (please list and indicate frequency

_____

_____

Please mark Yes or No to indicate if you have had any of the following:

Chronic foot pain	☐	Yes	☐	No
Bunion	☐	Yes	☐	No
Cramps feet/legs	☐	Yes	☐	No
Numbness feet/legs	☐	Yes	☐	No
Ingrown toenail	☐	Yes	☐	No
Infections feet/legs	☐	Yes	☐	No
Amputations	☐	Yes	☐	No

Other_____

Athlete's foot	☐	Yes	☐	No
Corns & Calluses	☐	Yes	☐	No
Fracture	☐	Yes	☐	No
Heel Pain	☐	Yes	☐	No
Plantar Warts	☐	Yes	☐	No
Neuroma	☐	Yes	☐	No
Swelling feet/legs	☐	Yes	☐	No

Patient Name_____ **Date of Birth**_____ **Age**_____

MEDICAL HISTORY

Medication: Include prescriptions, over-the-counter medications, vitamins, and herbal medicines:

_____

_____

Pharmacy_____ Address _____ Phone_____

Vaccinations: FLU Yes☐ Date_____ No☐ COVID Yes☐ Date_____ No☐ PNEMONIA Yes☐ Date _____ No☐

Prior Surgeries:

_____

_____

Check all that apply for you, mother, and father

	You	Mother	Father
AIDS/HIV			
Angina			
Anxiety			
Arthritis			
Asthma			
Artificial heart valve			
Back Problems			
Bleeding disorders			
Cancer			

If yes, where _____ When _____

Chemical dependency			

If yes, what type_____

Chest Pain			
Circulatory problems			
Depression			
Diabetes			
Fainting			
Glaucoma			
Gout			

	You	Mother	Father
Heart Attack			
Heart Disease			
Hepatitis/Jaundice			
High blood pressure			
High cholesterol			
Hyperthyroidism			
Hypothyroidism			
Joint pain			
Kidney problems			
Liver disease			
Low blood pressure			
Phlebitis			
Radiation treatment			
Respiratory disease			
Rheumatic fever			
Sinus problems			
Shortness of Breath			
Stroke			
Tuberculosis			

I certify that the above information is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient Name_____ **Patient Signature**_____ **Date**_____