Nathaniel Hamm, DPM, LLC.
PATIENT INFORMATION FORM

(PLEASE PRINT)
DATE: ___/___/___
PATIENT NAME: _____ _____ ___ DATE OF BIRTH: ___/___/___ AGE: ___ SEX: M F
LAST FIRST MI
HOME ADDRESS: _____ CITY/STATE: _____ ZIP: _____

Social Security # _____

MAY WE LEAVE A MESSAGE?
HOME PHONE #: (___) ___-_____ YES NO

ALTERNATE PHONE #: (___) ___-_____ YES NO
E-MAIL: _____ YES NO
PRIMARY LANGUAGE: _____

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO
IF YES, NAME: _____ RELATIONSHIP: _____ PHONE #: (___) ___-_____
EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE #: (___) ___-_____

PRIMARY CARE DOCTOR: _____ WHO REFERRED YOU TO US? _____
PHARMACY: _____ LOCATION: _____ PHONE #: (___) ___-_____
IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?
_____ YES NAME(S) _____
_____ NO
WHO IS RESPONSIBLE FOR PAYMENT? _____ RELATIONSHIP TO PATIENT? _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (___) ___-_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____
ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (___) ___-_____

INSURED NAME: _____ DATE OF BIRTH _____ EMPLOYER _____

CONTRACT # _____ GROUP # _____

SECONDARY INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (___) ___-_____

INSURED NAME: _____ DATE OF BIRTH _____ EMPLOYER _____

CONTRACT # _____ GROUP # _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME DOSE HOW OFTEN DO YOU TAKE?

_____

_____

_____

_____

_____

_____

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY DATE TYPE OF SURGERY DATE

_____ _____

_____ _____

_____ _____

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION DATE REASON FOR HOSPITALIZATION DATE

_____ _____

_____ _____

_____ _____

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO:
☐ NEVER ☐ QUIT – HOW LONG AGO? _____ ☐ SMOKE ___ PACKS/DAY FOR ___ YEARS

USE OF RECREATIONAL DRUGS:
☐ NEVER ☐ QUIT – HOW LONG AGO? _____ TYPE _____
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

EMPLOYER: _____ OCCUPATION: _____
HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%
DO OTHERS DEPEND UPON YOU FOR THEIR CARE? ☐ CHILDREN–AGE(S) _____
☐ PET(S)–WHAT KIND? _____ ☐ ELDERLY OR DISABLED FAMILY MEMBER
☐ OTHER _____
EXERCISE: ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY
TYPES OF EXERCISE: _____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES ☐ CANCER ☐ HEART DISEASE
☐ HIGH BLOOD PRESSURE ☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE
☐ RHEUMATOID ARTHRITIS ☐ OTHER _____

YOUR MEDICAL HISTORY

ALLERGIES: ☐ NONE KNOWN ☐ MEDICATIONS _____

☐ ANESTHESIA _____ ☐ FOODS _____

☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y N	FIBROMYALGIA	Y N	NEUROPATHY	Y N
ANEMIA	Y N	GOUT	Y N	OPEN SORES	Y N
ARTHRITIS	Y N	HEART ATTACK	Y N	PNEUMONIA	Y N
ASTHMA	Y N	HEART DISEASE/FAILURE	Y N	POLIO	Y N
BACK TROUBLE	Y N	HEPATITIS	Y N	RHEUMATIC FEVER	Y N
BLADDER INFECTIONS	Y N	HIV+/AIDS	Y N	SICKLE CELL DISEASE	Y N
ABNORMAL BLEEDING	Y N	HIGH BLOOD PRESSURE	Y N	SKIN DISORDER	Y N
BLOOD CLOTS	Y N	KIDNEY DISEASE	Y N	SLEEP APNEA	Y N
BLOOD TRANSFUSION	Y N	LIVER DISEASE	Y N	STOMACH ULCERS	Y N
BRONCHITIS/EMPHYSEMA	Y N	LOW BLOOD PRESSURE	Y N	STROKE	Y N
CANCER	Y N	MIGRAINE HEADACHES	Y N	THYROID DISEASE	Y N
DIABETES	Y N	MITRAL VALVE PROLAPSE	Y N	TUBERCULOSIS	Y N

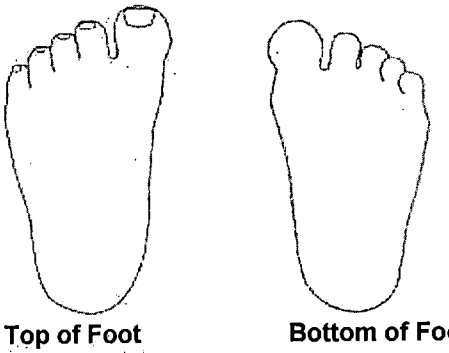
OTHER CONDITIONS: _____

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

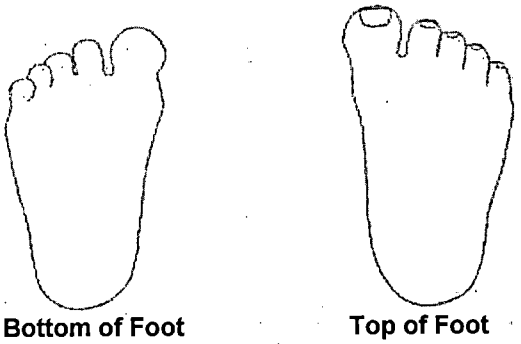
WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

LEFT FOOT



Top of Foot Bottom of Foot

RIGHT FOOT



Bottom of Foot Top of Foot

Inside of Foot Outside of Foot Outside of foot Inside of Foot

HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: ☐ BEGIN ALL OF A SUDDEN ☐ GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? ☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING
☐ RADIATING ☐ ITCHING ☐ STABBING ☐ OTHER _____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)

(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 *(WORST PAIN POSSIBLE)*

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: ☐ STAYED THE SAME ☐ BECOME WORSE ☐ IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? ☐ WALKING ☐ STANDING ☐ DAILY ACTIVITIES
☐ RESTING ☐ DRESS SHOES ☐ HIGH HEELS ☐ FLAT SHOES ☐ ANY CLOSED TOE SHOE
☐ RUNNING ☐ OTHER _____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? _____

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? _____

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ YES (DESCRIBE) _____ ☐ NO

IF YES, WAS IT A WORK-RELATED INJURY? ☐ YES ☐ NO

AUTHORIZATIONS ********YOU MUST COMPLETE THIS SECTION ******** **

Yes	No	I hereby authorize benefits directly to the physician of the surgical and/or medical benefits
Yes	No	I understand I am responsible for any portion of my bill not covered by my insurance company
Yes	No	I hereby authorize release of information and/or medical records of myself to any treating physician or insurance company.
Yes	No	The information authorized for release may include information which may be considered a communicable or venereal disease including hepatitis, syphilis, gonorrhea, HIV or AIDS.
Yes	No	I voluntarily request Dr. Hamm as my podiatric physician and such associates, assistants and Other health care providers as they deem necessary to treat my condition.

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

_____ _____
PRINT NAME OF PATIENT, PARENT OR GUARDIAN SIGNATURE OF DOCTOR

_____ _____
IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT DATE

_____
SIGNATURE DATE

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 front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- 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, Discover, cash or check.
- 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.
- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- 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.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.
- 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 this office.
- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party _____ Date: _____

Witness Signature: _____ Date: _____

Printed Name of Witness: _____

_____ Patient initials to indicate copy received.

Reviewed April 2008

Nathaniel Hamm, DPM LLC

Berea
429 Front Street
Berea, OH 44017
440-243-6660

Brunswick
3487 Center Road
Brunswick, OH 44212
330-225-7520

Parma
5500 Ridge Rd Ste 140
Parma, OH 44129

NOTICE OF PRIVACY PRACTICES

A. CONSENT TO GENERAL CARE

I hereby consent to general care, including routine diagnostic care, treatment procedures (such as x-ray examination and laboratory procedures), and drugs and supplies ordered by the physician in charge. I acknowledge that no guarantee or assurance has been made to me regarding the result of any examination or treatment.

B. TEACHING PROGRAMS

I am aware that Nathaniel Hamm, D.P.M. participates in programs for training of health care personnel. Some services may be provided to me by persons in training under the supervision and instruction of doctors or hospital employees. These persons may also observe care provided to me by doctors and hospital employees.

C. AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION AND NOTICE OF PRIVACY PRACTICES

I hereby authorize Nathaniel Hamm, D.P.M. to disclose all or any part of my medical information to (A) any person or entity that may be liable for payment of charges associated with my medical care, including but not limited to, hospitals, insurance companies, governmental payers such as Medicare or Medicaid, workers' compensation carriers, and welfare funds; (B) any person or facility that is currently involved in my care, such as a nursing home to which I am being transferred, a home health agency, or a durable medical equipment provider; (C) my employer if my injury is work-related; (D) any person or entity that may process or collect a claim for payment, such as a billing company or collection agency; (E) Nathaniel Hamm, D.P.M.'s legal counsel in any matter to which such information is relevant and necessary; (F) persons, committees, or entities performing audits or analyzing patient medical information for quality of care, peer review, financial or compliance purposes; (G) researchers for medical research purposes; (H) family members or relatives involved in my care; (I) clergy; (K) Nathaniel Hamm, D.P.M.'s risk manager and compliance officer; (L) companies that provide services for Nathaniel Hamm, D.P.M. and, in doing so, will have access to patient health information; and (M) an attorney or law enforcement personnel pursuant to a subpoena.

I acknowledge that Nathaniel Hamm,, D.P.M. has provided me with a copy of his Notice of Privacy Practices.

Signature of Patient/Legal Representative: _____

Date: _____ **The Patient was unable to sign due to medical reasons.**

Nathaniel Hamm, D.P.M Representative please initial: _____

D. USE OF PHOTOGRAPHY AND OTHER ELECTRONIC RECORDING MEDIA

I authorize the use of photographs when necessary and/or recommended by my physician to record and measure the progress of certain treatment. I understand that photographs or recordings will not be undertaken without any knowledge, but to the extent that such media benefits me by its use in the course and scope of my treatment I consent to its use. In addition the use of such photographs or other recorded information for purposes of education, training and research by my physician.

E. LEGAL RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIAN

I understand that, unless I am specifically otherwise informed in writing, all physicians furnishing services to me, including pathologists, anesthesiologists, radiologists, emergency room physicians and the like, are independent contractors and are not employees or agents of Nathaniel Hamm, D.P.M. Nathaniel Hamm, D.P.M. is not responsible for any acts or omissions of physicians that are not directed or controlled by Nathaniel Hamm, D.P.M. (Section R.C. 2307.48 of the Ohio Revised Code).

F. RELEASE FROM RESPONSIBILITY OF PERSONAL EFFECTS

I understand that Nathaniel Hamm, D.P.M. will not be responsible for any loss or damage of items such as glasses, hearing aids, dentures/partials, wallets, purses, watches, clothing, jewelry, etc. unless deposited with Nathaniel Hamm, D.P.M. for safekeeping.

G. ASSIGNMENTS OF INSURANCE BENEFITS

I hereby assign to Nathaniel Hamm, D.P.M. and/or physician who accepts assignments, any and all benefits, including major medical, that are payable to the patient or to the undersigned for payment of medical care and treatment during this hospitalization. The patient or the undersigned insured is responsible for charges not covered by the assignment. Should the account be referred to an attorney or collection agency for collection, the undersigned shall be responsible for any reasonable attorney's fees and collection expense in addition to the amount being collected.

H. PRICE DISCLOSURE

Pursuant to Section 3727.12 of the Ohio Revised Code, you are entitled, upon request, to a list of the usual and customary charges for Room and Board, and the usual and customary charges for a selected number of X-ray, Laboratory, Emergency Room, Operating Room, Physical Therapy, Occupational Therapy, and Respiratory Therapy Services.

I CERTIFY THAT I HAVE RECEIVED A COPY OF THE PAMPHLET ENTITLED "YOUR PATIENT RIGHTS AND RESPONSIBILITIES."

IMPORTANT MESSAGE FOR MEDICARE INPATIENTS ONLY: I have received a copy of the letter "An Important Message from Medicare."

_____	_____	_____
Witness	**Patient or Legal Representative**	**Date**

_____

(Relationship if other than Patient)

In the event that you have an outstanding balance on your account that is 90 days past due and you have not attempted to settle this (despite multiple received invoices, phone calls and notifications from our office), the credit card number that you have provided at your initial appointment will be charged for the past due amount.

Please provide a credit card that may be held in your file in the event of a 90 day past due outstanding balance on your account. This card will NOT be charged for any other instance without your consent.

Name on Card: _____ Billing Zip Code _____

Card # _____

Exp. Date: _____ Security Code (on back of card): _____

Signature of Patient/Responsible Party:_____

Printed Name of Patient/Responsible Party _____

Date: _____

_____ Patient initials to indicate copy received if requested