Financial Agreement: I understand that I am responsible for deductibles, co-pays, non-covered services, coinsurance, and items considered "not medically necessary" by my insurance company. I agree to pay co-payments and coinsurances as services are rendered. I understand my insurance is a contract between myself and my insurance company and Eastern Shore Foot & Ankle Center. I understand that Eastern Shore Foot & Ankle Center will bill my insurance as a courtesy to me. The remaining balance will be taken care of within 30 days of notice from the insurance company. Although my insurance company may estimate what they may pay, it is the insurance company that makes the final determination. I agree to pay any portion of the charges not covered by insurance. If a referral and/or preauthorization are required by my insurance company, I will assist Eastern Shore Foot & Ankle Center in obtaining the referral and or preauthorization. If payment cannot be made at each visit, I will notify the front-desk staff to make other arrangements, I understand that I am ultimately responsible for any balance on my account.

Assignment of Benefits: I hereby assign to Eastern Shore Foot & Ankle Center such insurance benefits to which are entitled under my insurance plan(s).

Release of Information: I herby allow Eastern Shore Foot & Ankle Center to furnish any information pertaining to my medical treatment to my insurance carrier, worker's compensation representative, attorney, or other providers of service as necessary to obtain payment of service and provide additional care.

Consent for Treatment: I hereby authorize Eastern Shore Foot & Ankle Center to examine, treat, and perform diagnostic tests and office procedures that the physician deems necessary.

Privacy Practices: Eastern Shore Foot & Ankle Center is required by law to maintain the Privacy of a patient's protected health information. In addition we are required by law to provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. You must notify us in writing of any restrictions on the release of your protected health information I have read and agree to the above. My signature below indicated that I have also received a copy of the Eastern Shore Foot & Ankle Center Notice of Privacy Policies and I have indicated any restrictions of my Protected Health Information. Scanned signatures suffice as originals.

Patient Signature		*Date*

Authorization to Disclose Health Information

Date:_____ Re: _____

I, _____ grant permission for the following person(s) to obtain medical care, speak with provider and/or staff, and pick-up any information regarding the patient listed above.

Name	*Relationship to Patient*
_____	_____
_____	_____
_____	_____
_____	_____

Signature:_____ *Witness:*_____

Eastern Shore Foot & Ankle Center

"Helping you put your best foot forward."

Welcome to Our Office!

Last Name	First Name	Middle Initial	Birth Date	Age

Spouse's Name, Parent or Guardian Name if a Minor

Residence Address	City	State	Zip	Martial Status - if Adult
				□Single □Married

Home Phone	Cell Phone	Email Address

Name of Employer (Patient)	Occupation	Business Phone

Name of Employer (Insured)	Name of Insured

Name, Address, and Phone contact in case of emergency	Relationship

Have you had previous treatment by a Podiatrist? □Yes □No	When?	For what?

My chief foot complaint is?

Were you referred by a doctor? □Yes □No	If so, please provide doctor's name

My shoe size is:	My height is:	My weight is:

Name of Family Physician	Are you currently under you physicians care? If yes, for what? □Yes □No

Would you like a copy of your exam sent to your physician?
□Yes □No

I hereby give Dr. L. Todd Albrecht permission to examine and treat my feet. I also authorize payment of my insurance benefits to be paid directly to the attending physician. I understand that I am ultimately responsible for this account.

Patient, Parent, or Guardian signature _____

Check only those that you have or have had:

Diabetes	□Yes
Liver Disease	□Yes
Poor Circulation	□Yes
Kidney Disease	□Yes
Rheumatoid Arthritis	□Yes
Blood Clot (DVT)	□Yes
Heart Disease	□Yes
Stomach Ulcers	□Yes
Foot Ulcers	□Yes
Foot Surgery	□Yes
High Blood Pressure	□Yes

Additional Information

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Current Medications

Are you currently taking any prescription and/or nonprescription medications including vitamins, nutritional supplements, oral contraceptives, pain relievers, diuretics, laxatives, or cold medications? Yes No (please circle one). If yes, list medications below:

Name of Medication	Dose (i.e.mgs)	How often taken

Are there any medications that have caused an allergic reaction?
Yes No (please circle one). If yes, list medications below, the type of reaction, and the severity of the reaction ranging from very mild, mild, moderate to severe:

Name of Medication	Type of Reaction	Severity of Reaction
		□Mild □Moderate □Severe
		□Mild □Moderate □Severe
		□Mild □Moderate □Severe

Smoking Status

Please chose from the following:

- ☐ Never a smoker
- ☐ Previous smoker
- ☐ Current, 1-3 cigarettes per day
- ☐ Current, up to 1 pack per day
- ☐ Current 1-2 packs per day
- ☐ Current, 2 or more packs per day