LEON G. SHINGLEDECKER, DPM, FACFAS

PLEASE PRINT

PATIENT INFORMATION

IS THIS A WORK RELATED INJURY? ___ YES ___ NO
(If yes, please provide us with all WC information)

PATIENT NAME: _____

ADDRESS_____CITY _____

STATE_____ ZIP_____

MAILING ADDRESS (IF DIFFERENT): _____

GENDER____ AGE_____ DATE OF BIRTH _____ MARITAL STATUS: M S W D

TELEPHONE AT PATIENT'S RESIDENCE: _____ CELL: _____

WORK: _____

CONTACT PREFERENCES: ___ PATIENT ONLY ___ PATIENT AND/OR SPOUSE
___ ANYONE ANSWERING PHONE ___E-MAIL _____

EMERGENCY CONTACT:

NAME: _____RELATIONSHIP_____HOME_____

WORK _____ CELL _____ E-MAIL_____

PARTY RESPONSIBLE FOR ACCOUNT:
_____ SELF ____ SPOUSE _____CONSERVATOR/POA

NAME_____

ADDRESS_____ CITY _____ STATE _____ZIP_____

TELEPHONE _____ E-MAIL _____

CELL_____

FAMILY PHYSICIAN
_____TELEPHONE_____

ADDRESS _____CITY _____STATE _____

ZIP_____ DATE OF LAST VISIT _____

OTHER SPECIALIST:
_____SPECIALTY_____

TELEPHONE _____

PREFERRED PHARMACY _____

CITY _____
TELEPHONE _____

WHOM MAY WE THANK FOR REFERRING YOU TO THIS OFFICE?

_____

WHAT IS YOUR CHIEF COMPLAINT/FOOT PROBLEM?

_____

PREVIOUS
PODIATRIST _____
ADDRESS _____
_____
_____

SIGNATURE _____
___PT___ POA ___ CONSERVATOR
DATE _____

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

NAME	DOSE	TIMES PER DAY

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY)

DATE	REASON FOR HOSPITALIZATION

Social History

Use of Alcohol:

☐ Never ☐ NO longer use

History of alcohol use

☐ Current USE Type _____ ☐ Rare ☐ Occasional ☐ Moderate ☐ daily

Use of Tobacco: ☐ Never ☐ Quit- how long ago? _____

☐ Smoked ___ packs/day for ___ years

Use of Recreational Drugs:

☐ Never ☐ Quit How long ago? _____

Type _____

Current USE Type _____

☐ Rare ☐ Occasional ☐ Moderate ☐ Daily

family History

Do you have a family history of :

☐	Diabetes	___Mother	___Father
☐	Cancer	___Mother	___Father
☐	Heart Disease	___Mother	___Father
☐	High Blood Pressure	___Mother	___Father
☐	Stroke	___Mother	___Father
☐	Coronary Artery Disease	___Mother	___Father
☐	Thyroid Disease	___Mother	___Father___
☐	Rheumatoid arthritis	___Mother	___Father
☐	Other _____		

Your Medical History

Allergies:

☐ Medications _____

☐ Anesthesia _____

☐ Foods _____

☐ tape _____

☐ LATEX_____

☐ SHELLFISH _____

☐ IODINE _____

☐ OTHER _____

☐ NO KNOWN ALLERGIES_____

MY ALLERGIES

ALLERGIC TO:	ALLERGIC REACTION

Patient Signature

Date

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

PLEASE CIRCLE

ACID REFLUX	YES	NO
ARTHRITIS	YES	NO
ASTHMA	YES	NO
BACK TROUBLE	YES	NO
BLADDER INFECTIONS	YES	NO
ABNORMAL BLEEDING	YES	NO
BLOOD CLOTS	YES	NO
BLOOD TRANSFUSION	YES	NO
BRONCHITIS/EMPHYSEMA	YES	NO
CANCER	YES	NO
DIABETES	YES	NO
FIBROMYALGIA	YES	NO
GOUT	YES	NO
HEART ATTACK	YES	NO
HEART DISEASE/FAILURE	YES	NO
HEPATITIS	YES	NO
HIV+/AIDS	YES	NO
HIGH BLOOD PRESSURE	YES	NO
KIDNEY DISEASE	YES	NO
LIVER DISEASE	YES	NO
LOW BLOOD PRESSURE	YES	NO
MIGRAINE HEADACHES	YES	NO
MITRAL VALVE PROLAPSE	YES	NO
NEUROPATHY	YES	NO
OPEN SORES	YES	NO
PNEUMONIA	YES	NO
POLIO	YES	NO
RHEUMATIC FEVER	YES	NO
SICKLE CELL DISEASE	YES	NO
SKIN DISORDER	YES	NO
SLEEP APNEA	YES	NO
STOMACH ULCERS	YES	NO
STROKE	YES	NO
THYROID DISEASE	YES	NO
TUBERCULOSIS	YES	NO

OTHER CONDITIONS: _____

_____

_____

_____

_____

_____

_____

GUARANTOR INFORMATION – Must be completed (Patient &/or Responsible Party):

Responsible Party / Guarantor Name: _____ Guarantor Birthdate: _____

Employer Name: _____ Occupation: _____

Employer's Address: _____ Phone: ( ) _____

City, State & Zip: _____

SS#: _____ Driver's License # and State: _____

INSURANCE INFORMATION: (A valid insurance card is required in order to bill your insurance)

Insurance Carrier: _____ Insurance Group Number: _____

Guarantor on Policy: _____
Relationship to Patient: __Self __Spouse __Dependent __Other
Insured's Employer: _____
Address: _____

Insured's SS#: _____ Insured's Birthdate: _____

Plan Unique ID #: _____ Plan Effective Date: _____

Annual Deductible Amount: _____ Co-Pay Amount: $_____
Has patient's deductible been met for this year? ___ Yes ___ No

Type of Plan: ___ PPO ___HMO ___EPO ___Indemnity ___Other

_____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

_____

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

_____ _____

SIGNATURE DATE

We are dedicated to providing you with the best possible care and service to you. An essential element of your care and treatment is understanding your financial responsibilities. If you have any questions about our policies, please discuss them with one of our staff members.

HEALTH INSURANCE

We are contracted with most insurance plans. Our office will file your visit with your insurance company, and will only collect your co-pay and or deductible or co-insurance when it applies. Please note: Our contract with your insurance carrier requires us to collect your co-pay and any deductible at each visit. Please make arrangements for payment when you sign in, before your appointment with the doctor.

If you have insurance coverage with a plan that we do not have a contractual agreement with, the charges for your care and treatment are due at the time of services. In the event that your health plan determines a service to be "non-covered", you will be responsible for the complete charge. Effective January 01, 2015 all outstanding balances that are "patient responsibility" will begin to accrue interest at the rate of 3% monthly if over 60 days past due.

AUTHORIZATION FOR CLAIMS AND PAYMENTS

I, hereby authorize Dr. Leon Shingledecker to apply for benefits on my behalf. I request that payment for covered services is made directly to Dr. Shingledecker unless it would indicate otherwise. I certify that the information I have reported about my insurance coverage is correct and further authorize the release of information, medical and other, as necessary in processing of claims. I acknowledge and understand that I am responsible for the payment of all services rendered to me or any member of my family.

Should any employee or other individual be exposed to my blood or bodily fluids, I hereby consent to testing my blood for Hepatitis virus and AIDS (HIV) virus as necessary.

REFERRALS

It is your responsibility to obtain a valid referral from your primary care physician when required by your insurance company.

DISABILITY/INSURANCE FORMS/COPY OF X-RAYS

There is a $25.00 per form charge to fill out disability and insurance forms. Please mail or leave them with the front desk along with your payment. Forms will not be completed until payment is received. Please allow at least 30-45 working days for processing. We will call you once we have completed your request to arrange for you to pick them up. There is a $3.00 per film fee for copying x-rays.

MEDICATION REFILLS

Refills for medication prescribed by this office should be obtained by calling your pharmacy to request the refill. Please do not call the office. Refills are not approved after normal business hours, weekends, or holidays, so please call in your refill in time for the pharmacy to contact our office.

CANCELLATION POLICY

Our office will make every effort to confirm your scheduled appointment, but it is ultimately your responsibility to cancel or reschedule when necessary. APPOINTMENTS MUST BE CANCELLED WITHIN 24 HOURS OR THERE WILL BE A $65.00 CHARGE TO THE PATIENT ACCOUNT. The cancellation fee is the responsibility of the patient and will not be billed to your insurance company.

I hereby certify that the information is true and correct to the best of my ability.

YOUR SIGNATURE below constitutes that you fully understand, acknowledge, and agree with the above policies of this office.

Signature: _____ Date: _____

LEON G. SHINGLEDECKER, D.P.M.

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided with a copy of the Notice of Privacy Practices and that I read (or had the opportunity to read if I choose) and understood the notice.

Patient Name: _____ Date: _____
(Please Print)

Parent or Authorized Representative:

_____
(If applicable)

Signature: _____

Thank you for choosing Dr. Shingledecker as your podiatric care provider. We are committed to providing you with the best care when diagnosing and treating your podiatric needs.

The following explanation is intended to promote a better understanding of how our office works in conjunction with your health insurance carrier with regards to "Routine Foot Care" and cutting and or trimming of the toenails.

Before treatment is rendered, it is necessary that you have been to see either your PCP or Dr. Shingledecker within the past 6 months, (to the day) for the service to be paid for by your carrier. If you have not had a visit within the past 6 months, the services will not be paid by your carrier and will be your financial responsibility ($75.00). That $75.00 will be collected before services are rendered. If by chance your carrier does pay, you will be refunded promptly.

_____ _____

Patient Signature Date

CONSENT TO TREAT, INSURANCE ASSIGNMENTS, FINANCIAL AGREEMENT, AUTHORIZATION TO RELEASE INFORMATION, AND PRIVACY NOTICE ACKNOWLEDGEMENT

1. **CONSENT TO MEDICAL AND SURGICAL PROCEDURES** The undersigned consents to the medical and surgical care and treatment, as may be deemed necessary or advisable in the judgment of my physician or other provider. Which may include but are not limited to laboratory procedures, x-ray examination, medical or surgical treatment or procedures, anesthesia, or other services rendered the patient under the general and special instructions of the patient's physician. (initials)

2. **ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION** In consideration of services rendered, I hereby transfer and assign to Health First Physicians all rights, title and interest in any payment due to me for services described herein as provided in the above-mentioned policy or policies of insurance. The clinic may disclose all or any part of the patient's record (including psychiatric, alcohol and drug abuse, family member or employer of the patient for all or part of the clinic's charge, including but not limited to medical service companies, insurance companies, workman's compensation carriers, welfare funds or the patient's employer.___(initials)

3. **FINANCIAL AGREEMENT** The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she obligates himself/herself to pay the account of the clinic in accordance with the regular rates and terms of the clinic. Should the account be referred to an attorney for collections, the undersigned should pay reasonable attorney's fees and collection expense. The undersigned certifies that he/she has read the foregoing receiving a copy thereof and is the patient or is duly authorized by the patient as patient's general agent to execute the above and accepts its terms._____(initials)

4. **MEDICARE / MEDICAID** Patient's certification authorization to release information and payment request. I certify that the information given to me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize that any holder of medical or other information about me to release to Social Security Administration/Division of Family Services or its intermediaries or carries any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the clinic treating me._____(initials)

5. **USE OF COPIES** I permit a copy of these authorizations and assignments to be used in place of the original, which is on file at the clinic._____(initials)

6. **PAYMENT RESPONSIBILITY** I understand that certain insurance claims may be filed as a courtesy. However, if a claim is denied for any reason, I am responsible for payment. Insurance is considered a method of reimbursing the physician for services rendered to the patient. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charges. I understand it is my responsibility to pay any CO-PAY, DEDUCTIBLE, CO-INSURANCE, OR ANY OTHER BALANCE NOT PAID FOR BY MY INSURANCE OR THIRD PARTY PAYOR WITHIN A REASONABLE PERIOD OF TIME NOT TO EXCEED 60 DAYS.
_____(initials)

_____ _____

SIGNATURE OF PATIENT DATE

_____ _____

SIGNATURE OF SUBSCRIBER, IF NOT PATIENT DATE

Leon G. Shingledecker, DPM, FACFAS

Permission to Photograph

I agree that Leon G. Shingledecker, DPM, FACFAS may take a digital photo of me.

I understand that:

- The photo will be stored permanently in my medical record.
- The photo will be used to identify me when I come here for care.
- The photo will be stored securely to protect my privacy.
- The photo will **NOT** be used outside of this office, unless I (or my legal representative) give my permission in writing.
- Dr. Shingledecker will own the photo. I can look at the photo, or get copies, if I (or my legal representatives) sign a release form

gnature of the patient (or person authorized to sign for patient) _____

lationship to Patient _____ Date _____

decline _____ Date _____

Leon G. Shingledecker, D.P.M., FACFAS

Board Certified Podiatric Surgeon
Board Certified Wound Care Specialist
www.drshingledecker.com

Please be advised, that if you are being treated for an ingrown toe nail, nail fungus, infection or any type of related procedure, IT IS STANDARD AND NECESSARY to send a culture out for pathology. Your insurance company will receive a bill from the laboratory. THIS IS NOT OPTIONAL.

Thank you for your understanding in this matter.

_____ _____

Patient's Signature Date

Leon G. Shingledecker, D.P.M., FACFAS

Board Certified Podiatric Surgeon
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www.drshingledecker.com

MEDICATION REFILL POLICY

All prescriptions will be electronically sent to your pharmacy or through a mail order pharmacy. You will receive a paper prescription for pain medication or other prescriptions that require a doctor's signature.

No prescriptions will be approved if it has been more than 2 months since your last office visit.

Pain medications and other scheduled drugs will not be filled on weekends.

Per the state statue, pain medication and other scheduled drugs will not exceed 1 refill.

By signing this form I acknowledge I have reviewed and understand the above medication refill policy.

_____ _____

Patient Name Date

_____

Patient Signature

3901 Houma Blvd., Suite 204
Metairie, LA 70006
Phone: (504) 888-9403
Fax: (504) 888-2895