MATTHEW MCQUAID, DPM, INC.

Patient Name:_____ **Date of Birth:**_____ **Age:**_____

Mailing Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Phone Number:_____ **Work Phone:**_____ **Cell Phone:**_____ **SSN**:____-____-_____

Employer Name:_____ **Occupation:**_____

Email:_____ **Patient's Gender:**_____ **Marital Status:**_____

Emergency Contact Person (Name and Phone #):_____

Primary Care Physician:_____

Who may we thank for referring you? (Please Circle One):

Internet/Google Friend/Family Insurance list Facebook

Dr. Referral- Please list Dr's Name:_____ Other:_____

If Married, Please fill in this information:

Spouse's Name:_____ **Spouse's Occupation:**_____

Spouse's Employer Name:_____ **Spouse's Work Phone:**_____

If Patient is a Minor, Please fill in this information:

Guardian or Name of Person responsible for payment:_____

Their Date of birth:_____ **Their SSN:**_____

Their Employer: _____ **Their Occupation**_____

INSURANCE INFORMATION:

Primary Insurance Name	Name of Insured	Date of Birth	ID/Policy Number
Secondary Insurance Name	Name of Insured	Date of Birth	ID/Policy Number

FINANCIAL ARRANGEMENTS, HEALTH INSURANCE AND ASSIGNMENT OF BENEFITS

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.
Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff.
An APR of 12% or 1% per month for balances over 30 days old may be charged.
We will gladly discuss your proposed treatment and answer any questions we can relating to your insurance. As a courtesy to you, we will bill your insurance company for you. You must realize, however, the following:

1) Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2) Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
3) We must emphasize that as health care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

I acknowledge the above and authorize payment of medical benefits to Matthew McQuaid, DPM, INC. for services rendered. My signature below authorizes the release of medical information to my insurance carrier to process claims. In the case of medical insurance assigned claims, the provider agrees to accept the charge determined by the medical insurance carrier as the full charge. I understand that I am responsible for the deductible, coinsurance, and non-covered services.

PATIENT / RESPONSIBLE PARTY'S SIGNATURE: **DATE:**

X

PATIENT'S MEDICAL HISTORY/REVIEW OF SYMPTOMS

PATIENT NAME: _____

Welcome to our office. Please complete the following information to help us become better acquainted. Thank You.

Have you had any previous foot care by specialist? _____

Current Medications: (you may attach a list if needed) _____

What pharmacy do you use? _____

Medication Allergies: _____

Do you suffer from any medical illnesses? Please check all that apply.

( ) Diabetes
( ) Stomach Ulcer/Gastritis
( ) Hepatitis
( ) Headaches
( ) Liver Disease
( ) Kidney Disease
( ) Cancer
( ) Gout
( ) Arthritis
( ) Heart Disease
( ) Bleeding Disorder
( ) Psychiatric Disorder
( ) Depression
( ) Anxiety
( ) Cataracts
( ) Glaucoma
( ) Stroke
( ) Fibromyalgia
( ) High Blood Pressure
( ) Venereal Disease
( ) Tuberculosis
( ) Seizures
( ) Thyroid Disorder
( ) Chest Pain
( ) Asthma
( ) Anemia
( ) Other_____

Have you ever had an operation? If yes, please list the surgery/surgeries you have had. _____

_____

_____

Do you smoke? _____ _____ **If you've smoked in the past, approximately when did you quit?**_____
Yes **No**

Do you drink alcohol? _____ _____
Yes **No**

Height _____**Weight** _____ **Shoe Size:** _____

Diabetes and Heart Disease runs in families. Is there any history of these problems in your family?

_____

Are you pregnant at this time? _____ _____ _____
Yes **No** **Does not apply to me.**

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for professional services rendered. I give my permission to Dr. Matthew McQuaid to render medical care on my feet.

PATIENT/ GUARDIAN'S SIGNATURE: _____
Date

Doctor's Review:
Doctor's Signature: _____ **Date:** _____

MATTHEW MCQUAID, DPM, INC.

PATIENT RESPONSIBILITIES

We have entered an age of extreme complexity in regards to the various insurance benefits that each insurance company provides. Because of this, it has become necessary for our office to place the responsibility of understanding the requirements of your particular insurance policy on you. We request that you review your insurance coverage booklet and individual policy prior to your appointment.

The patient is responsible for co-payments, deductibles, non-covered services and/or amounts that insurance denies. If you have an HMO insurance, we ask that you obtain a referral/authorization from your primary care physician before your appointment with our office. You will be held financially responsible if a referral/authorization is not obtained prior to your visit.

We will gladly bill your insurance for you, but not all services are a covered benefit. Our office will help you to the best of our ability, though ultimately, it is your responsibility to understand what provisions and/or restrictions are included or excluded in your specific insurance policy.

By your signature below, you are acknowledging that you have read this notice and are aware of these issues.

_____ _____

Signature of patient or guarantor Date

Dear Patient:

We strive to make your experience in this office as pleasant and time saving as possible. In order to achieve this goal we implement our billing and charting systems in the treatment rooms. After Dr. McQuaid examines you, his assistant will enter the room and enter any data necessary. This method ensures your visit here will proceed smoothly and efficiently.

Thank you for your consideration in this matter.

Dr. McQuaid & Staff

Please turn page over

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

PATIENT NAME _____

RELATIONSHIP TO PATIENT: _____

SIGNATURE: _____

DATE: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:_____Initials:_____Reason:_____

_____

The office of Matthew McQuaid, DPM

Welcomes You!

Dear_____,

We have scheduled your appointment with Dr. McQuaid on _____ at _____.

Please arrive 15 minutes early at _____.

Please bring the following items: (Use checklist below)

☐ **Enclosed forms, completed**

☐ **Photo Id**

☐ **Insurance cards**

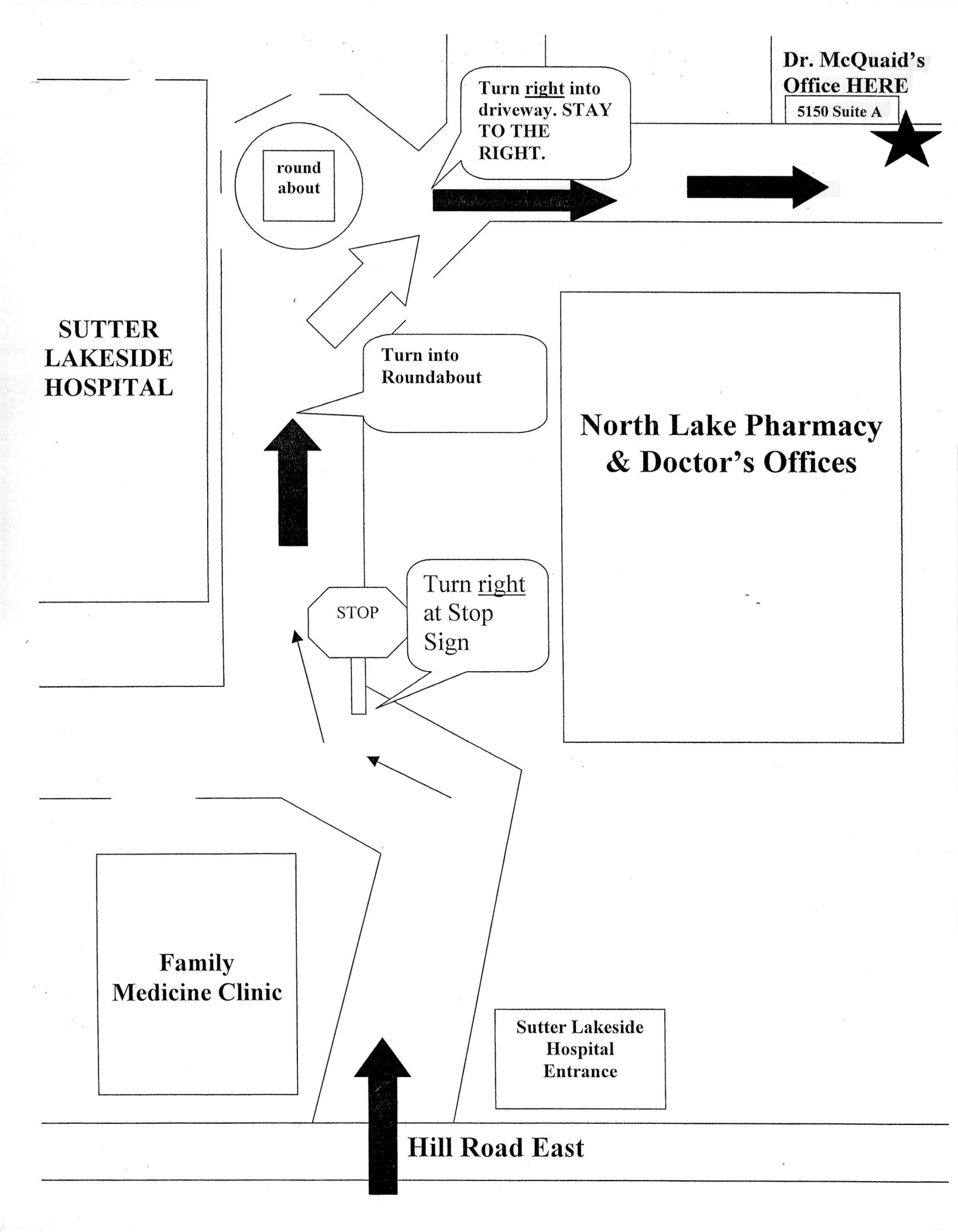
☐ **Medication list**

The previous requirements are meant to protect you from identity theft. **If you are unable to supply this information we may need to reschedule your appointment**. Please note that Governmental regulations require that we obtain these items.

As a courtesy, we are happy to bill most insurance companies for you. However, office visit co-pays, deductibles and private pay fees are due at the time of the visit.

Our address is:
5150 Hill Road East, Suite A, Lakeport, CA 95453.
Phone: 707 263-3727 Fax: 707 263-5236

We are located in the North Lake Medical building on the grounds of Sutter Lakeside Hospital. A map is provided on the back. Thank You.


Dr. McQuaid's Office HERE
5150 Suite A
Turn right into driveway. STAY TO THE RIGHT.
round about
SUTTER LAKESIDE HOSPITAL
Turn into Roundabout
North Lake Pharmacy & Doctor's Offices
STOP
Turn right at Stop Sign
Family Medicine Clinic
Sutter Lakeside Hospital Entrance
Hill Road East