The Foot Doctor, P.C.
Michael P. Wilkinson, DPM
Daniel T. Jones, DPM
2233 E. 2nd St.
Casper, WY 82609
P: 307-237-3668
F: 307-237-1180
Email: tanisb@wyfootdoc.com

Thank you for your interest in The Foot Doctor. We look forward to handling all of your foot care needs. Please take a minute to read an overview of our office policies and procedures.

Payment is expected at the time of your visit, unless other arrangements have been made prior to your appointment. We realize that some of our patients carry Medicare insurance and though they do cover many procedures, there are some charges they do not cover. If you have any questions feel free to call the office and ask if your procedures are covered in full.

As a courtesy to our patients, we do bill primary insurance, but not secondary. It is the patient's responsibility to follow up with their insurance company to identify any reimbursement problems. While we will gladly help resolve insurance reimbursement issues, this does not mean payment is not required until your insurance pays.

We are providers for Cigna, Medicare, Blue Cross Blue Shield, and Blue Cross Blue Shield Kid Care CHIP ONLY. If your primary insurance is Medicaid (Title 19), the state of Wyoming does not cover podiatry services provided by a specialist. If you have Medicaid as your primary, we can treat you, but on a cash basis and you will be responsible for any and all charges. Medicaid will pay for charges if they are secondary to your primary Medicare insurance.

For cash patients only, we offer a 10% discount if the charges for that day are paid in full at the time of check out. A payment agreement will be provided for any patient that cannot pay their bill in full. This agreement must be signed and satisfactory monthly payments must be received in a timely manner. Failure to comply with the financial agreement will result in a **10-day notice to pay your account in full or be turned over to collections.**

We accept cash, checks, MasterCard, Visa, American Express, and Discover.

Tardiness makes the whole office fall behind. Please be respectful, and be timely for your appointment.

We require a 24 hour notice of cancellation. Because we call the day before your appointment to remind you of your appointment, failure to give notice will result in a $25.00 "No Show" fee.

Patients coming from out of town, please bring 3-5 pairs of shoes that you frequently wear to your first visit.

Please feel free to call us if you have any questions regarding this or other information.

Thank you!

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Dear New Patient,

Please complete the following for our records. Thank you!

Where did you hear about the Foot Doctor? (PLEASE CHECK ALL THAT APPLY)

Doctor _____ Who? _____

Friend _____

Family Member _____

Internet _____

Newspaper _____

Phonebook _____

Billboard _____

Health Fair _____

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PATIENT INFORMATION

Name_____ Gender: ☐ Male ☐ Female
Last First Middle Initial

S.S.N. _____ Date of Birth _____ Age_____

Mailing Address_____City/State/ZIP_____

Home Phone_____ Cell Phone_____

E-mail Address:_____

Employer_____Address_____Phone_____

Marital Status: Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐

Race: Am.Indian/Alaskan Native ☐ Asian ☐ Black ☐ Caucasian ☐ Pacific Islander ☐ Other ☐ Declined ☐

Ethnicity: Hispanic ☐ Non-Hispanic ☐ Declined ☐

Emergency Contact: _____Relationship:_____Phone:_____

Primary Care Physician: _____ **Referring Physician(if different from Primary Care):**_____

Pharmacy:_____

RESPONSIBLE PARTY (if different from patient)

Name_____ Relation to Patient _____

Mailing Address_____City/State/ZIP_____

S.S.N. _____Date of Birth _____ Home Phone_____ Cell Phone_____

Employer_____ Work Phone_____

INSURANCE INFORMATION

Primary Insurance _____ID Number_____ Group Number_____

Secondary Insurance _____ID Number_____ Group Number_____

Policy Holder Name_____ Relation to Patient_____

Policy Holder S.S.N. _____ Policy Holder Date of Birth _____

Policy Holder Employer_____ Work Phone _____

Communication/Release of Information:

I wish to be contacted in the following manner (check all that apply):

_____ Telephone numbers: _____
_____You may leave detailed messages. OR _____You may leave a call-back number only.

_____ Written communication to the above mailing address.
_____You may fax to _____.

_____ Email to the above mailing address (Used for Secure Messaging)

You may speak to and release information to the following individuals regarding my healthcare (name and relation):

_____

I understand that I am legally and financially responsible for all charges **whether or not** they are paid by the stated insurance. I authorize the release of any information necessary to determine liability for payment. I also authorize release of information to my primary doctor, spouse, other family members stated above, as well as my insurance company. (If there is anyone you do not wish information to be released to, please state below.) I request that payment of benefits be made to the provider on my behalf. This assignment will remain in effect until revoked by me in writing. If this account is assigned to an attorney for collection and/or suit, the practice shall be entitled to reasonable attorney's fees and cost of collection. I give my permission to Dr. Wilkinson or Dr. Jones to administer and perform such procedures deemed necessary, by me, in the diagnosis and/or treatment of my (or my child's or my parent's) feet. If I am a Medicare patient, I understand that there are certain charges that are **Non-Covered** by Medicare and am willing to continue with the procedure.

_____ _____ _____
Patient or Guardian Signature **Relationship** **Date**

Do you currently **smoke**? Yes ☐ No ☐ Did you ever smoke? Yes ☐ No ☐
(Please indicate type of tobacco, amount per day, number of years, and quit date.)
_____

Do you currently **drink alcohol**? Yes ☐ No ☐ How many drinks per week? _____

Shoe Size: _____ Shoe Width: N ☐ M ☐ W ☐ WW ☐
Athletic Activities: _____

Do you have any **ALLERGIES** to MEDICATIONS? Yes ☐ No ☐
If yes, please list medications and reactions: _____
_____

MEDICATIONS AND SUPLEMENTS

Please list ALL of your CURRENT medications and supplements below
(if you need more room, please use the back of page):

Medication Name	**Amount**	**Take**	**Frequency Taken** (daily, every 6hrs, etc.)
Example: metoprolol	*25 mg*	*1 TAB*	*Once daily*

PAST MEDICAL HISTORY

Do **you** personally have a history of:

Issue	YES	NO	Issue	YES	NO
Diabetes **Type I? or Type II?**			Heart Disease		
Gout			Hepatitis		
Aids/HIV			High Blood Pressure		
Anemia			High Cholesterol		
Arthritis **Rheumatoid or Osteo?**			Hyper Thyroidism		
Artificial Heart Valve			Hypo Thyroidism		
Artificial Joints			Jaundice		
Back Problems			Kidney Disease		
Bleeding Disorders			MRSA		
Cancer - **What Kind?**			Respiratory Disease		
Circulatory Problems			Stroke		
Dementia			Unexplained Weight Loss		
GERD (G.I.Reflux)			Other		

PAST SURGICAL HISTORY

Type of Surgery	Date/Hospital/Physician

NON-SURGICAL HOSPITALIZATIONS

Reason	Date

FAMILY MEDICAL HISTORY

Place an "X" in the appropriate boxes to identify all illnesses/conditions in your **blood relatives**:

ILLNESS/CONDITION	FAMILY MEMBER					
	Mother	**Father**	**Brother**	**Sister**	**Grandparent**	**Other**
Alcohol/drug abuse						
Cancer **(please list type**)						
Depression/psychiatric illness						
Diabetes						
Genetic (inherited) disorder						
Heart Disease						
High blood pressure						
High cholesterol						
Liver disease						
Stroke						
Other **(specify)**						

Why are we seeing you today? _____

_____

I certify that the above answers are true and correctly recorded and give permission for the examination

Signed: _____ Date: _____