GREATER LAFAYETTE
Foot Care
A UNITY HEALTHCARE PARTNER

1345 Unity Place, Suite 225
Lafayette, IN 47905
PH: 765.449.2436 | FX: 765.449.1817

PATIENT'S INFORMATION

Date:_____ DOB:_____Social Security#:_____

Patient Name:_____
Last Name First Name Middle Name

Address:_____
Street City/State Zip Code

E-mail Address:_____

Phone Home:_____ Cell:_____ Work:_____

Marital Status:_____ **Sex** (Circle) M F **Gender Identity** (Circle) M F Both Neither

Race:_____ **Ethnicity** (Circle) Hispanic Not Hispanic

EMPLOYER INFORMATION

(Circle) Full Time Part Time Retired Not Employed Self-Employed Active Military Duty

Employer Name:_____ Employer's Phone:_____

Employer's Address:_____
Street/Mailing City/State Zip Code

EMERGENCY CONTACT & MISCELLANEOUS INFORMATION

Patient Permanent Mailing Address (If applicable for college students)

_____
Street City/State Zip Code

Emergency Contact Name:_____

Emergency Contact Phone:_____ Relationship:_____

REFERRAL INFORMATION

How were you referred to us (Circle) Physician Emergency Room/Urgent Care Employer Family Member/Friend

Website TV Newspaper Radio Other _____

If physician or medical facility referral, please list name:_____

INSURANCE INFORMATION

Primary Insurance Co. :_____

Subscriber's Name:_____ DOB:_____Subscriber's SS#:_____

Subscriber's Address:_____
Street City/State Zip Code

Subscriber's Relationship to the Patient:_____

Subscriber's Employer:_____

Secondary Insurance Co.:_____

Subscriber's Name:_____ DOB:_____Subscriber's SS#:_____

Subscriber's Address:_____
Street City/State Zip Code

Subscriber's Relationship to the Patient:_____

Subscriber's Employer:_____

Third Insurance Co. :_____

Subscriber's Name:_____ DOB:_____Subscriber's SS#:_____

Subscriber's Address:_____
Street City/State Zip Code

Subscriber's Relationship to the Patient:_____

Subscriber's Employer:_____

PARENT INFORMATION
(if minor child)

Father's Name:_____
Last Name First Name Middle Name

Father's Home Address:_____
Street City/State Zip Code

Father's Phone: Home:_____ Cell:_____ Work:_____

Father's Employer:_____SS#:_____

Father's Employer Address:_____
Street City/State Zip Code

Mother's Name:_____
Last Name First Name Middle Name

Mother's Home Address:_____
Street City/State Zip Code

Mother's Phone: Home:_____ Cell:_____ Work:_____

Mother's Employer:_____SS#:_____

Mother's Employer Address:_____
Street City/State Zip Code

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Medical History

Patient Name: _____ Date: _____

Height : _____ Weight : _____ Shoe Size:_____ Do you have Diabetes? □ Y □ N

Occupation:_____

What type of foot/ankle problem are you having? _____

_____

Do you smoke? □ Y □ N Packs per day: _____ Number of Yrs: _____

Do you use alcohol? □ Y □ N If yes, please circle how often? □ Rarely □ Often □ Socially

Do you exercise and/or play sports? (please list): _____

_____

Have you seen a podiatrist before? □ Y □ N Who:_____Last Visit:_____

Primary Physician:_____Referring Physician:_____Date Last Seen by Physician:_____

Preferred Pharmacy and Location:_____

Medications: □ None

Drug Name	Dose	Times Per Day	Drug Name	Dose	Times Per Day
Aspirin / Blood Thinners?					

Allergies: □ None

Drug or Medication Name	Reaction or Side Effect
Adhesives / Tapes / Latex?	
Seafood?	

Patient Name: _____ Date: _____

Surgical History: □ None

Operation	Year	Operation	Year

Personal/Family Medical History: □ None
(please mark with an (√) a history of the following with either yourself or other family member)

Medical Condition	Self	Other	Medical Condition	Self	Other
Alcohol or Chemical Dependency			High Blood Pressure		
Anemia			Injury/Fracture		
Anxiety			Kidney Disease		
Arthritis			Liver Disease		
Bleeding Disorders			Low Back Pain/Trauma		
Cancer (Skin)			Muscle Joint Pain		
Cancer (Other) List:_____			Nausea Vomitting or Diarrhea		
Chronic Chest Pain			Nervous System Problems		
Circulatory Problems			Neuropathy		
COPD			Osteoarthritis		
Depression			Osteoporosis		
Diabetes, Type I			Respiratory Disease		
Diabetes, Type 2			Rheumatoid Arthritis		
Eye Problems			Shoe Size _____		
Fibromyalgia			Stroke		
Gout			Swelling Legs or Feet		
Heart Attacks			Thyroid Disease		
Heart Disease			Tired Feet		
Heart Murmurs			Total Joint Replacement		
Hepatitis			Ulcers (feet)		
High Cholesterol			Weight Loss or Gain Unexplained		
HIV/AIDS					

UNITY HEALTHCARE, LLC
HIPAA RELEASE OF INFORMATION

Name: _____ DOB___/___/_____

Due to HIPAA rules and regulations, we are not permitted to discuss your medical information with anyone, including your family, without your consent or unless an exception to the rule applies (e.g. provider-to-provider discussions related to your treatment or to collect payment).

Please list individuals (other than providers) we may speak with regarding your care:

Name:	Relationship:
1._____	_____
2._____	_____
3._____	_____

Email address: _____

A photocopy of this authorization shall be considered as valid as the original. **This Release of Information will remain in effect until terminated by the patient in writing.**

Patient Signature:_____ **Date___/___/_____**

UNITY HEALTHCARE, LLC
DISCLOSURE AND RELEASE AUTHORIZATION FORM

CONSENT TO TREAT: I request and give consent to my Unity Healthcare, LLC ("Unity") physician to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as my physician, in his/her professional judgment, deems necessary or beneficial. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

_____ **Initials**

OWNERSHIP DISCLOSURE: I acknowledge that Unity and indirectly, Unity's physicians, have an ownership interest in Unity Surgical Center ("USC"), and InnerVision Advanced Medical Imaging Center ("InnerVision"). I understand that I am free to determine which facility to utilize for health care services and neither Unity nor my physician shall discriminate in the care provided to me should I desire to use a facility other than USC and InnerVision. I have been informed of the information in writing by my physician's office in advance of the date of my procedure.

_____ **Initials**

RELEASE OF MEDICAL INFO AND AUTHORIZATION TO PAY INSURANCE BENEFITS: I authorize Unity and my physician to release information from my medical records to my insurance carrier(s), governmental agency, or my employer in the case of work-related injuries, for the purpose of processing claims for medical/workers compensation benefits and state on such claims that my signature is on file. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my physician, on my behalf.

_____ **Initials**

FINANCIAL AGREEMENT: I understand and agree to all of the following:

a. All accounts are the full responsibility of the patient and/or the patient's responsible party guarantor.
b. Unity will assist me in obtaining insurance benefits when those benefits are assigned to my/the patient's provider, and I have provided complete information regarding my/the patient's primary and secondary health insurance, as applicable.
c. I am responsible to make sure insurance payments are processed and paid promptly to my physician, and for my prompt payment of any amounts owed to Unity that are deemed "Patient Responsibility" under my insurance contract, or otherwise my responsibility in the event my insurance does not cover such services.
d. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts. I agree that reasonable attorney fees shall be interpreted as 40% of any balance due at the time the account is sent to an attorney or collection agency for collection, or $300.00, whichever is greater.
e. Tippecanoe County, Indiana, shall be the preferred venue for any legal action related to this financial agreement and I agree to waive my right to a trial by jury.
f. This financial agreement is being entered into individually and as an authorized agent for my spouse, if any. This financial agreement may be assigned by Unity to an attorney who purchases Unity's delinquent accounts and the terms of this agreement shall remain binding.

_____ **Initials**

TELEPHONE CONTACTS: I authorize Unity and its affiliates and agents to contact me at the phone numbers I have provided (whether such is a cell phone or a land line), including providing me with automated appointment reminders and other automated calls related to the services provided to me. If a machine or voice mail is reached I understand a message may be left for me. (If you are receiving treatment from multiple Unity providers, it may result in multiple calls.)

_____ **Initials**

NOTICE OF PRIVACY PRACTICES: I acknowledge that I have been offered a copy of the Unity Notice of Privacy Practices and understand that my protected health information ("PHI") may be used by Unity as described in such Notice.

_____ **Initials**

INDIANA LAW AND JURISDICTION: I understand that I am being provided treatment in the State of Indiana and I agree that if I should have any claim with regard to my care or treatment, such will be decided in accordance with Indiana law and such action will be brought and decided in a Court in the State of Indiana.

_____ **Initials**

NOTICE OF NONDISCRIMINATION: Unity complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex or gender identity.

_____ **Initials**

OTHER PROVIDERS: I understand in addition to the attending physician, other physicians, such as radiologists and pathologists, and other providers such as laboratories and other medical professionals, may be involved in my care, and may separately bill me for their services.

_____ **Initials**

PHOTO CONSENT: I consent to have my photographs taken by the provider or designated associate if required, and permit use of photographs for medical records, education, and lectures.

_____ **Initials**

CANCELLATIONS OR MISSED APPOINTMENTS: A fee may be charged for any appointments not cancelled at least twenty-four (24) hours in advance or missed for any other reason. These are generally not payable by insurance.

_____ **Initials**

MEDICARE CERTIFICATION: (IF APPLICABLE) I certify that the information given by me, or by Unity on my behalf, in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my treating physician to release information from my medical record to the Social Security Administration and/or Medicare program or its intermediaries or carriers, or the Professional Standards Review Organizations for the purpose of processing of claims for medical benefits and state on such claims that my signature is on file. I request that payment of such authorized benefits be made directly to Unity or my treating physician on my behalf.

_____ **Initials**

Patient Name/Signature: _____ Date: _____
Parent/Guardian Signature: _____ Date: _____