Welcome to
FAYETTEVILLE PODIATRY
Dr. Lloyd Trichell & Dr. Aaron Teufel

(Updated 6.8.18)

Please Print. This form should be filled out COMPLETELY and ACCURATELY. Thank you!

Patient Name:____
Last *First* *Middle*

What name would you like to be called?_____________ Date of Birth:_______/_____/_______ Age: ______

Sex: M / F Social Security Number:___________-_______-_____________

Address:____
Street *Apt. #* *City* *State* *Zip*

Home Phone (____) ______-______Work Phone (____) ______-_____Other Phone:(____) ______ -_________

How would you like to be contacted?

Phone Call Email Preferred Cell Phone # or Email: ______________________________

Email:____

Race/Ethnicity:__________________________Primary Language:__________________________

Marital Status: S M W D Employment Status: Full-time / Part-time / Not Employed/Retired/Student

Employer:____

How did you hear about us? Phone Book Health Fair Friend/Family Internet

Insurance Doctor Referral:________________________Other:____________________

Primary Care Doctor:______________Practice City:___________Date Last Seen:____/____/______

Emergency Contact:___________________Relationship:________________Phone#:(____) ____-_____

Primary Insurance Company:__________________________

Policy Holder's Name:____
Last *First* *Middle*

SSN:____-_____-_______ DOB:____/____/____Member Id:____________________

Relationship to Patient:______________Primary Phone:(____) ______-_________Employer:__________

Secondary Insurance Company:__________________________

Policy Holder's Name:____
Last *First* *Middle*

SSN:___________-______-_____________ DOB:____/____/______Member Id:____________________

Relationship to Patient:_____________Primary Phone:(____) ______-__________Employer:_____________

I have answered these questions truthfully and to the best of my knowledge.

Signature:________________________________ **Date**:____________________

PATIENT HEALTH HISTORY (updated 6/11/18)

PATIENT NAME_________________________________ DATE_____________________________
DATE OF BIRTH______________________
HEIGHT_____________WEIGHT_____________SHOE SIZE_____________

PRESENT ILLNESS:
CHIEF COMPLAINT____
ONSET________________________________DURATION_________________________________
LOCATION_____________________________PAIN TYPE_________________________________
CHANGES_____________________________PREV. TREATMENT_________________________

ALLERGIES:
____
__NO KNOWN DRUG ALLERIES

CURRENT MEDICATIONS: (DOSE FREQUENCY)
____
____
____

Preferred Pharmacy: ____

PAST MEDICAL HISTORY: (CHECK ALL THAT APPLY)

__ABNORMAL BLEEDING	__FIBROMYALGIA	__NEUROPATHY
__ACID REFLUX	__GOUT	__OPEN SORES
__ANEMIA	__HEART ATTACK	__PNEUMONIA
__ARTHRITIS	__HEART DISEASE/FAILURE	__POLIO
__ASTHMA	__HEPATITIS	__RHEUMATIC FEVER
__BACK TROUBLE	__HIV/AIDS	__SICKLE CELL DISEASE
__BLADDER INFECTIONS	__HIGH BLOOD PRESSURE	__SKIN DISORDER
__BLOOD CLOTS	__KIDNEY DISEASE	__SLEEP APNEA
__BLOOD TRANSFUSION	__LIVER DISEASE	__STOMACH ULCERS
__BRONCHITIS/EMPHYSEMA	__LOW BLOOD PRESSURE	__STROKE
__CANCER	__MIGRAINE HEADACHES	__THYROID DISEASE
__DIABETES	__MITRAL VALVE PROLAPSE	__TUBERCULOSIS

FAMILY MEDICAL HISTORY: (CHECK ALL THAT APPLY FOR MOM OR DAD)

__ASTHMA (M / D)	__DIABETES (M / D)	__MENTAL ILLNESS (M / D)
__ALCOHOLISM (M / D)	__EPILEPSY (M / D)	__STROKE (M / D)
__ARTHRITIS (M / D)	__GOUT (M / D)	__TUBERCULOSIS (M / D)
__BLOOD DISORDERS (M / D)	__HEART DISEASE (M / D)	__OTHER (M/D)__________
__CANCER (M / D)	__HIGH BLOOD PRESSURE (M / D)	

PLEASE LIST ALL PRIOR SURGERIES
TYPE OF SURGERY DATE:
____
____
____
PLEASE LIST ALL PRIOR BONE FRACTURES OR JOINT DISLOCATIONS:
____
____
____
FOR MEDICAL STAFF USE ONLY:
FOOT EXAM: ____________________________ BLOOD PRESSURE: _______________

Fayetteville Podiatry
Dr. Lloyd Trichell and Dr. Aaron Teufel
Review of Symptoms

Please Check all that apply:

1. **Constitutional Symptoms:**
   - _ Chills
   - _ Fever
   - _ Headache

2. **Cardio-Vascular:**
   - _ Ankle Swelling
   - _ Leg Swelling
   - _ Leg Cramping
   - _ Calf Cramping
   - _ Color Change in extremity
   - _ Cold Feet/Hands
   - _ Loss of Sensation
   - _ Shortness of Breath
   - _ Water Retention

3. **Endocrine:**
   - _ Cuts Slow to heal
   - _ Excess Hair Growth
   - _ Hyperglycemia
   - _ Hypoglycemia
   - _ Recent Hair Loss
   - _ Unusual Extra Energy
   - _ Unusual Fatigue/Sluggishness

4. **Integumenary/Dermatologic:**
   - _ Athletes Foot
   - _ Blisters
   - _ Burning of skin
   - _ Contact Dermatitis
   - _ Dermatitis
   - _ Eczema
   - _ Dry Scaly Skin
   - _ Excessive Scar Tissue
   - _ Hypersensitivity of skin
   - _ Itchy Skin
   - _ Non-Healing Wound
   - _ Psoriasis
   - _ Rash
   - _ Tingling
   - _ Ulcers

5. **Musco-Skeletal:**
   - _ Back Pain
   - _ Heel Pain
   - _ Hip Pain
   - _ Joint Pain/Joint Redness
   - _ Joint Swelling
   - _ Morning Stiffness
   - _ Muscle Tenderness
   - _ Scoliosis
   - _ Stiffness
   - _ Weakness

6. **Neurological:**
   - _ Burning Sensation
   - _ Increased Skin Sensitivity
   - _ Numbness
   - _ Paralysis
   - _ Parenthesia
   - _ Seizure
   - _ Stocking and Glove Numbness
   - _ Tingling
   - _ Tremors
   - _ Uncontrolled Movements

Patient Signature:________________________Date:____________________________

Social History

Please circle all that Apply

Marital Status:

Single Married Divorced Widowed Separated

Who do you live with?

Husband Wife Children Alone Significant Other Parents Rooms

How many children do you have? ___________________

Employment Status:

Employed Unemployed Student Disabled Retired

Occupation: ____

Are you a tobacco user?

Current Smoker Non-Smoker Former Smoker Chewing Tobacco

How many packs per day do/did you smoke? _______________________________________

How many cans per day do/did you dip? ____

How much caffeine do you drink in a day? (Coke/Tea/Coffee)? _______________________________

Dr. Aaron Teufel
Fayetteville Podiatry
509 E. Millsap, Suite 101
Fayetteville, AR 72703

Dr. Lloyd Trichell &

THIS IS OUR OFFICE FINANCIAL POLICY- PLEASE SIGN BELOW

We at Fayetteville Podiatry are committed to providing you with the best possible care. If you have Medical Insurance, we are eager 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.

Unless **INSURANCE AGREEMENTS** have been approved in advance by our staff, payment for services is due at the time services are rendered. We accept payment in the form of cash, check, MasterCard, Visa, Discover, or American Express. We will be happy to help you process your insurance claim at each visit.

Returned checks and balances older than 30 days are subject to additional collection fees. We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

You must realize, however, that:

1. Insurance is a contract between **YOU** and your **INSURANCE COMPANY.**

2. Our fees generally fall within the acceptable range by most insurance companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of U.C.R.. "U.C.R." is defined as Usual, Customary, and Reasonable fees for this region. This does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard of fees and cost of care in this area.

3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily refuse to cover certain services. We have no control over this.

4. **MEDICARE PATIENTS:** We would like you to understand that taking **ASSIGNMENT** means that **YOU** are responsible for the **YEARLY DEDUCTIBLE** of

$183.00 and for the **20% (CO-INSURANCE)** of what Medicare allows. You are also responsible for services that your co-insurance does not cover. **IF** your co-insurance does not pay this amount, **YOU** are responsible for it.

5. **ALL PATIENTS:** Any balance owed will be collected on your next appointment.

Unlike some offices, the **FILING OF INSURANCE CLAIMS** is a **COURTESY** that we have always extended to our patients. However, all charges are **YOUR** responsibility, **NOT** your Insurance Company's. We will make our **BEST EFFORT** to collect from them, but if, despite our best efforts, we are **NOT SUCCESSFUL**, **YOU** are responsible for the unpaid balance.

We realize that temporary financial problems may affect timely payment of your account. We don't want any financial problems to get in the way of our good relationship with you. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, **PLEASE** don't hesitate to ask us. We really are here to help you.

____

Your Signature   Date

PLEASE SIGN THE INSURANCE and/or MEDICARE ASSIGNMENT BELOW:

I authorize payment of **MEDICAL BENEFITS** be made on my behalf to Dr. Lloyd Trichell or Dr. Aaron Teufel, for any services furnished to me. I authorize the release of any medical information held by Dr. Lloyd Trichell or Dr. Aaron Teufel to the health care financing administration and its agents, to process my claims.

____

Your Signature   Date

SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding
The Notice of Privacy Practices

The attached Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information

Uses and Disclosures of Health information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose you health information for certain quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization.

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/ or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our Privacy Practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to the attached Notice of Privacy Practices for person or persons whom you may contact.

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

____
Patient Name (please print)

____
Parent or Authorized Representative (if applicable)

____
Signature

____
Date

Medical Information Release Form
(HIPPA Release Form)

Name: ______________________________ Date of Birth: ________________________

Release of Information

( )I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to the following:

Spouse: ___________________________ Number:_______________________

Child(ren):1.)_________________________ Number:_______________________

2.)________________________ Number:_______________________

Other:____________________________ Number:_________________________

( )I **do not** authorize the release of information including the diagnosis, records, examination rendered to me and claims information.

This release of medical records information will remain in effect until terminated by me in writing.

Messages

Please call:

( ) My Home ( ) My Work ( ) Me Cell Phone

If Unable to reach me:
( ) You may leave a detailed message
( ) Please leave a message asking me to return your call
( ) Other:____

The best time to reach me is:
( ) Day_______________ Between the hours of: _____________ and ____________
OR
( ) Night______________ Between the hours of: ______________ and ___________

Print Name:_________________________________

Signature:__________________________________ Date:_____________________