

More Than Just Podiatry

Office of Dr. James Sills-Powell

1776 Crosswinds Drive
Wentzville, MO 63385

3701 N. St. Peters Pky Ste C
St. Peters, MO 63376

Tel: (314) 735-5197 | Fax: (314) 338-3495

Please fill out completely or mark areas "n/a" if they do not apply

PATIENT INFORMATION:

Name _____ Birth Date _____ Sex: _____

Social Security Number _____ Marital Status: _____

Race: _____ Ethnicity: _____

Address:

Street

City/State

Zip

PRIMARY Phone (____) ____-____ Email: _____

Are you employed? _____ Name of Employer: _____

Emergency Contact _____ Relationship _____

Home Phone (____) ____-____ Cell Phone (____) ____-____ Other (____) ____-____

PRIMARY CARE DOCTOR:

NAME OF PCP Phone: (____) ____-____ DATE LAST SEEN

INSURANCE: Please give **ALL** cards to the receptionist so we may copy them to your patient chart.

Primary Insurance Company Name _____

Secondary Insurance Company Name _____

RESPONSIBLE PARTY: The person who supplies the patient's insurance or who is responsible for payment if uninsured

Name _____ Social Security Number _____ DOB _____

Relation to Patient _____ Phone (____) ____-____ Other (____) ____-____

PHARMACY INFORMATION:

NAME OF PHARMACY CITY/ZIP CODE Phone (____) ____-____

I certify that the above insurance information is current and accurate; I authorize assignment of insurance to More Than Just Podiatry. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. More Than Just Podiatry and its representatives may use my health care information and may disclose such information to the above-named insurance company for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services received. This consent will end when my current treatment plan is completed or one year from the date signed below.

PATIENT NAME (PRINT)

PATIENT SIGNATURE

DATE

All information provided on this form will remain confidential in compliance with our HIPAA guidelines

Medical History

Have you ever been treated for (select all that applies):

Corns/Calluses	Warts	Athlete's Foot
Fungal Nails	Ingrown Nails	Neuroma
Leg/Foot Ulcers	Foot Numbness	Bunions
Broken Foot/Bone	Broken Ankle	Ankle Sprain
Hammer/Mallet Toe	Leg/Foot Cramp	Flat Feet
Arch pain	High Arch Feet	Knee Pain
Lower Back Pain	Heel Pain	Rash
In-Toeing	Toe Walking	Gait Problems
Childhood Foot Problems		

Do you get leg cramps after activity?

Does foot pain limit your desired activities?

Do you have any difficult walking?

Any pain in the calves or buttocks when walking?

Is the pain relieved by stopping & standing still?

List the sports and other activities in which you are involved:

Patient Medical History: Have you ever been treated for:

Stroke	Heart Attack	High Blood Pressure
Phlebitis	Vascular Disease	Heart Condition
Anemia	Poor Circulation	Eyes: Glaucoma
Diabetes	Kidney Disease	Keloid/Thick Scar
Gout	Osteoporosis	Alzheimer's
Sciatica	Lyme's Disease	Rheumatic Fever
Arthritis	Headaches	Hearing/Ear Disorder
Epilepsy	Nerve Disorder	Psychiatric Disorder
Asthma	Lung Disease	Tuberculosis
Hepatitis	Liver Disease	Thyroid Problem
Dark Urine	Chronic Light Stool	Weight Loss
Cancer	Stomach Ulcer	None of the above
Other: _____		

Surgical History: Surgical procedures and complications:

Past Family & Social History

List immediate family members who have had:

Diabetes _____ Foot Problems _____
 Arthritis _____ Heart Attack _____
 Stroke _____ High Blood Pressure _____
 Cancer _____ Birth Defects _____
 # of Childbirths ____ Are you currently pregnant?
 Are you slow to heal after cuts
 Any abnormal bruising, bleeding or scarring?
 Do you smoke now?
 Did you ever smoke?
 If you quit, what year did you do so? _____
 Alcohol use? None Rarely Moderately Daily Quit
 Recreational Drugs?
 Are you currently taking any medications?
 Are you taking Insulin?
 List medications, dose & purpose below:

Are you taking your medications as prescribed?

Allergies: Is there a history of skin reaction or other outward reaction or sickness following an injection, oral or topical administration of:

Latex, Adhesive tape	Penicillin
Other antibiotics	Empirin, Tylenol
Aspirin, Advil, Aleve, Motrin	Celebrex
Other pain remedies	Morphine
Codeine	Other narcotics
Novocaine	Other anesthetics
Sulfa drugs	Shrimp, Iodine or Merthiolate

Clearly list additional medication, drugs, foods, etc.

Review of Systems: Are you currently experiencing any of the following:

General:	Decreased Strength	Weight change	Decreased exercise tolerance
Head:	Headaches	Vertigo	Injury
Eyes:	Abnormal vision	Double vision	Diminished vision Increased drainage Pain
Ears:	Change in hearing	Tinnitus	Bleeding Vertigo
Nose:	Nose bleed	Obstruction	Discharge Inflammation of mucous membrane
Mouth:	Dental difficulties	Gum bleeding	Use of dentures
Neck:	Stiffness	Pain	Tenderness Noted masses
Chest:	Shortness of breath	Wheezing	Cough Spitting up blood
Heart:	Chest pains	Palpitations	Fainting Breathlessness
Abdomen:	Difficulty Swallowing	Appetite change	Vomiting Bowel habit changes Tarry Stool Pain
Neurologic:	Weakness	Tremor	Seizures Changes in mentation Lack of muscle control
Psychiatric:	Depressive symptoms	Change in sleep habits	Changes in thought content

Patient's Current Chief Complaints (CC)/History of Present Illness (HOPI)

LEFT FOOT



RIGHT FOOT



Indicate the location of your problem or pain on the diagrams above.

Does the pain radiate anywhere else on the foot/leg?

Yes

No

Indicate the severity of pain/discomfort

None

Light

Moderate

Strong

Severe

How long ago did pain/discomfort start?

Years

Months

Weeks

Days

Hours

Pain occurs while

Walking

Standing

Running

Wearing Shoes

Does pain/discomfort cause difficulty with daily activity?

Yes

No

Pain discomfort is

Aching

Burning

Dull

Sharp

Tender

Throbbing

Tingling

Is this problem work related? Date of injury: _____

Yes

No

Date of report to employer: _____

Physician's notes:

FOR STAFF USE ONLY

Patient's Vitals: BP:

SPo2:

Pulse:

Temp:

Patient's Height & Weight: Patient's Shoe Size:

Are you diabetic?

Name of Physician managing diabetes?

Date last seen?

Covid Vaccines?

Flu Vaccine?

James D. Sills-Powell, DPM

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Email: info@mttinc.biz • Website: www.mttinc.biz

AUTHORIZATION OF MEDICAL INFORMATION

Please read the following questions carefully and sign at the bottom of the page. You have the right to review our privacy practices at any time.

Please refer to our HIPAA notice located in our reception area.

I have read and understand the HIPAA notice.

I decline reading the HIPAA notice but, am fully aware that it is always available to me.

Please **CHECK** where we may leave a message if necessary:

HOME

ANSWERING

WORK

CELL PHONE

May we discuss your medical condition with members of your family or friends? YES___ NO___

If **YES**, please list the name of that person and their relationship to the patient.

NAME: _____

RELATIONSHIP TO PATIENT: _____

PHONE NUMBER: _____

Please list ANY information from your medical record you would **NOT** like More Than Just Podiatry to disclose:

I give permission to More Than Just Podiatry to release information, either verbal or written regarding my medical condition only, for the purpose of medical management.

Patient Name (print)

Signature of Patient/Legal Guardian

Date

This release may be rescinded at any time in writing from the patient/legal guardian.

Please note: More Than Just Podiatry's HIPAA policy is in effect for the entire time you are a patient of ours not just for the date that you sign the policy. If we have any changes we will have you fill out a new form at that time.

FINANCIAL INFORMATION

Traditional Medicare Insurance:

Our office participates with Medicare. This means that we will send your claim to Medicare and we will adhere to Medicare's allowable fee schedule. Medicare sets an allowable fee for each service that they cover. Once you have met your annual deductible Medicare will pay us 80% of the allowable fee and you will be responsible for the remaining 20%. If you have a secondary insurance this amount will then be sent on to them and you will be billed for any remaining balance after their payment.

Medicare has strict guidelines concerning their coverage of routine foot care such as trimming nails, or paring corns and calluses. The doctor will be able to determine if your routine foot care is or is NOT covered by Medicare. **Should you have a non-covered service such as this performed, you will be asked to pay for that service at the time of your appointment. We will also ask you to sign Medicare's Advanced Beneficiary Notice (ABN) indicating you were informed that Medicare will not be paying for that particular service.** The ABN will be provided at the time of visit.

If you have any other service such as a new patient office visit or a visit for a new problem performed on the same day as routine nail care or another non-covered service, Medicare will be billed for the covered service and we will collect the uncovered service fee from you that day as well.

All Other Insurances including Medicare Replacement Plans:

More Than Just Podiatry (MTT POD) will submit your claims to all other insurance companies providing:

- At each visit we receive a copy of all current insurance identification cards.
- Our Patient Information Form is current and correctly completed.
- Our Financial Policy is signed.

If we have not heard from your secondary insurance within 60 days, you will be billed directly. In that event you must contact the insurance company directly to find out why your claim has not been paid. **It is the patient's responsibility to give us their current insurance information.** If we do not have a copy of your current insurance card, or have received incorrect or old insurance information, all charges will become the patient's responsibility. **All uncollected co-pays and co-insurances from prior visits will be due at the time of your next appointment,** as specified in your insurance contract and mandated by your carrier in our participating provider agreement.

For your convenience MTT POD accepts cash, all major credit cards, debit cards, and personal checks. Payment is expected at each visit.

You will receive a billing statement for all personal balances due. If we have not received a response from you by phone or received a payment or letter regarding your unpaid balance within 90 days, your account will be sent to our collections department.

No Insurance:

If you do not have health insurance, charges for the day's medical service are due at the time of service unless other arrangements have been made with the office in advance. In many cases a cash payment discount may be given to patients without health insurance.

Care Credit:

This is offered as a payment option for patients who qualify. Please speak to the office staff if you would like more information.

There is a \$35.00 fee assessed for returned checks. MTT POD understands that unexpected financial problems do arise. We encourage you to contact the office at (314) 735-5197 immediately for assistance in managing your account.

Referrals/Authorizations:

It is the patient’s responsibility to obtain all referrals if your insurance requires one. We will do all we can to assist you, but it is ultimately your responsibility. If a required referral is NOT in place PRIOR to your appointment, we may reschedule the appointment until it is received.

FMLA/Disability Forms:

The doctor at MTT POD will complete your first insurance disability form for you at no charge. **You will be charged a fee of \$25.00 for every disability form to be completed thereafter. The fee is payable upon presentation of the forms. The forms will NOT be completed until the \$25.00 fee is received.**

I understand that there is a \$10.00 fee for copies of medical records. Please call office to request medical records if necessary.

Missed Appointment Policy:

MTT POD reserves the right to charge a patient for a missed appointment. If you cannot make your scheduled appointment, you should give us 24 hours notice. A charge for a missed appointment is NOT a charge for the service itself. One missed appointment, or severe weather problems will NOT result in a patient being charged. **Consecutive missed appointments or repeated missed appointments will be assessed at a fee of \$30.00 for each missed appointment.** Habitually missed appointments could lead to a patient being discharged from the practice.

Collections:

MTT POD will attempt to make payment terms that meet your needs. If we do not hear from you by phone, mail or partial payment within 90 days of a statement being sent, you may be referred to a collection agency. In the event your account is assigned to collection, the patient agrees to be responsible for a 25% collection fee, as well as all court costs and attorney fees.

I understand that if a custom DME product is ordered for me, such as orthotics or special shoes, or I receive an air cast, night splint, surgical shoe, and ankle brace, Dyna-Flex Plate or Powersteps, that they are non-refundable and non-returnable. If my insurance denies them for any reason, I understand it is ultimately my responsibility and I will pay for the product(s) I have received.

I understand that More Than Just Podiatry’s financial policy is in effect for the entire time I am a patient not just for the date that I sign the policy. If More Than Just Podiatry has any changes, our office will have you fill out a new form at that time.

I authorize MTT POD/Dr. James D. Sills-Powell, to release information regarding my medical history and treatments to my insurance company in order for them to be paid. I also authorize payments for services to be paid directly to MTT POD/Dr. James D. Sills-Powell from my insurance company.

I understand that unpaid balances have to be paid prior to making a follow up appointment. I understand that I will speak with an office staff to initiate a payment plan if my balance is unmanageable.

I acknowledge by signing my name below, as the patient or guardian of the patient, that I have read and initialed all of the above financial disclosures and understand and will comply. I have asked questions, if necessary, and I have had those questions answered and I understand.

Print: _____ Date: _____

Signature: _____ Date: _____