Head to Toe Healthcare, PLC®
Advanced Eye and Foot Care
Optometrist & Podiatrist

7406 N. La Cholla Blvd. Tucson, Arizona 85741
p: (520) 545-0202 f: (520) 545-0201
www.headtotoehealthcare.org

Orthotics/ Durable Medical Equipment Policy

H2T is NEVER able to guarantee payment by medical insurance carriers for Orthotics and/or Durable Medical Equipment. H2T will bill your medical insurance as a courtesy, if claims are denied; patient is responsible for payment in full. Self-pay patients are responsible for payment at the time services are rendered.

Due to sanitary reasons and professional health care standards, we do not accept returns on ANY purchased or dispensed products, even if patient states product has not been used.

X-rays Policy

Certain medical conditions require X-rays for proper diagnosis. X-rays are a separate charge from physician exam fees and not included in the office visit fee. X-rays are billed separately to either your medical insurance company or directly to the patient. Self-pay patients are responsible for payment at the time services are rendered.

Pregnant or suspected pregnant patients MUST inform H2T staff regarding their condition. Additionally, if patient has any other medical conditions or concerns regarding X-rays, inform H2T staff immediately so we can best accommodate you.

Study Policy

We are pleased to participate in the advancement and improvement of the latest health care service and product renderings. Therefore, we often conjointly collaborate on various clinical trials. Patients participating in any H2T clinical trials will need an initial evaluation by H2T physician. Medical insurance will be billed for the initial evaluation including X-rays and other associated procedures necessary for proper treatment. Co-payments and all uncovered services will apply. We will advise you of any complimentary or discounted product or service offers in conjunction with a clinical trial.

Treatment Protocol

H2T foot care clinic has a philosophy to decrease pain and improve function for our patients. By seeking treatment at H2T, you agree that corticosteroid injections may be administered for therapeutic and diagnostic benefits if deemed appropriate by the physician. You have the option to decline any treatment options at the time of service.

H2T does **NOT** participate nor process ANY workers compensation cases or claims.

No Show/ Cancellation/ Medical Records Policy

ALL scheduled no show appointments will be charged a $50 - no show fee. Patient is responsible to CALL the office to reschedule or cancel any appointment at least 24 hours in advance. Patients who are running 20 minutes late for his/her scheduled appointment will be rescheduled to the next available appointment/ day.

There will be a $15 fee for any copy of medical records, $30 fee for any CD X-rays and $30 fee for any paperwork to be filled out for any organization not limited to FMLA or employment. These fees apply for EACH REQUEST.

H2T utilizes electronic communications either through email or text messaging. Patient has the option to opt-out of these communications at anytime by following the instructions on the electronic communications received.

I, _____, have read, understand and acknowledge the policies stated above.

Signature_____ Date: _____

Effective July 2019

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PODIATRIC MEDICAL HISTORY QUESTIONNAIRE

Name:_____ **Home Phone:**_____
Address:_____ **Work Phone:**_____
City:_____ **State:**_____ **Zip:**_____ **Cell Phone:**_____
Birth Date:____/____/____ **Social Security (opt):**_____ **e-mail:**_____
Age_____ **Sex** _____ **Ht** _____ **Wt**_____ **Shoe size** _____
Occupation:_____
Primary Care Physician:_____ **Last Medical Exam:**_____
Previous Foot Physician:_____ **Last Foot Exam:**_____
Who may we thank for referring you?_____

1) INSURANCE INFORMATION

Do you have Insurance? Yes☐ No☐ Primary Insurance Company _____
Insurance Policy Holder's Name_____ **Relationship to patient**_____ **DOB**_____
Insured SSN_____ **Insured's Employer**_____
Secondary Insurance Company _____

☐ **Was the HIPPA – Notice of Privacy Practices form made available to you?**_____**(Please initial)**

2) CHIEF FOOT COMPLAINT

What is your main Foot Problem today?_____

Do you have any other Foot problems that need attention?_____

3) HISTORY OF PRESENT ILLNESS

When did the problem begin?_____**Where is the area of the problem?**_____

Was it caused by an injury? ☐ No ☐ Yes_____

Any Previous treatment? ☐ No ☐ if Yes, what have you tried?_____

Rate the your pain from 1 to 10 (ten being excruciating pain) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

4) PAST MEDICAL HISTORY

Do you have any of the following medical conditions?

Anemia	**Yes☐**	**No☐**	**Heart Trouble**	**Yes☐**	**No☐**
Back / Spine pain	**Yes☐**	**No☐**	**High Blood Pressure**	**Yes☐**	**No☐**
Blood Disease	**Yes☐**	**No☐**	**High Cholesterol**	**Yes☐**	**No☐**
Cancer	**Yes☐**	**No☐**	**HIV / AIDS**	**Yes☐**	**No☐**
Circulation Problems	**Yes☐**	**No☐**	**Kidney Disease**	**Yes☐**	**No☐**
Depression	**Yes☐**	**No☐**	**Leg Cramps**	**Yes☐**	**No☐**
Diabetes	**Yes☐**	**No☐**	**Osteoporosis**	**Yes☐**	**No☐**
Epilepsy/Seizure	**Yes☐**	**No☐**	**Rheumatic Disease**	**Yes☐**	**No☐**
Eye Disease	**Yes☐**	**No☐**	**Swelling of limbs**	**Yes☐**	**No☐**
Gout	**Yes☐**	**No☐**	**Stomach Trouble**	**Yes☐**	**No☐**
Hepatitis	**Yes☐**	**No☐**	**Stroke**	**Yes☐**	**No☐**
Headaches	**Yes☐**	**No☐**	**Tuberculosis**	**Yes☐**	**No☐**

Other **Yes☐** **No☐** **(list)**_____

Which of the above illnesses are in your immediate family?_____

List ANY medications you take prescription or over the counter:_____
_____

Do you have any allergies to medication? (if so, list)_____

List ALL major injuries, surgeries and hospitalizations:_____
_____

Are you pregnant or nursing? (if applicable) **Yes☐ No☐**

5) SOCIAL HISTORY

Marital status / Living arrangement ☐ Single ☐ Married ☐ Other_____
Do you use tobacco products? Yes☐ No☐ If yes, what type/ amount/ how long?_____
Do you use illegal drugs Yes☐ No☐ If yes, what type/ amount/ how long?_____
Do you drink alcohol? Yes☐ No☐ If yes, what / how much / how often?_____
Have you ever been exposed to or infected with any sexual transmitted diseases/ HIV? Yes☐ No☐
Hobbies & Activities?_____

6) REVIEW OF SYSTEMS

Do you currently have or chronically suffer from any of the following conditions?

INTEGUMENTARY (Skin)

☐ Deformed nails	☐ Itching	☐ Ulcerations
☐ Discolorations	☐ Skin Cancers	☐ Warts
☐ Eczema / Psoriasis	☐ Skin Rash	☐ Other_____

HEMATOLOGIC (blood)

☐ Bleeding disorder	☐ Take aspirin	☐ Take coumadin

NERVOUS

☐ Muscle jerking	☐ Paralysis	☐ Weakness
☐ Numbness / Burning	☐ Sciatica	☐ Other_____

MUSCULOSKELETAL

☐ Arthritis	☐ Sprains	☐ Tendonitis
☐ Fractures	☐ Stiffness	☐ Other_____

I hereby give Head to Toe Healthcare, PLC permission to treat me or my dependents as necessary. I understand my insurance company may assist me in paying all medical costs, but I am ultimately responsible for all medical services rendered and, if necessary, I agree to pay all reasonable and customary collection fees and/or attorney's fees that may be incurred due to any delinquent accounts I may have. I authorize the release of any medical information necessary to process my claim to my insurance company. I also authorize payment of medical benefits to my physician, directly, for services rendered. I understand that I am financially responsible for my bill.

****As a Courtesy, we will bill your insurance company for you****

Signature_____ **Date:**_____

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INSURANCE INFORMATION

Patient's Name: _____ **Date of Birth:** _____/_____/_____
Social Security Number: _____-_____-_____

VISION INSURANCE
Insurance Provider: _____
Member ID #: _____ **Group #:** _____
Insured Name: _____ **Insured Birth Date:** _____/_____/_____
Insured Employer: _____ **Relation to Insured:** ☐ **Self** ☐ **Spouse** ☐ **Child**

PRIMARY MEDICAL INSURANCE
Insurance Provider: _____
Member ID #: _____ **Group #:** _____
Insured Name: _____ **Insured Birth Date:** _____/_____/_____
Insured Employer: _____ **Relation to Insured:** ☐ **Self** ☐ **Spouse** ☐ **Child**

SECONDARY MEDICAL INSURANCE (IF APPLICABLE)
Insurance Provider: _____
Member ID #: _____ **Group #:** _____
Insured Name: _____ **Insured Birth Date:** _____/_____/_____
Insured Employer: _____ **Relation to Insured:** ☐ **Self** ☐ **Spouse** ☐ **Child**

☐ **Was the HIPPA – Notice of Privacy Practices form made available to you? _____(Please initial)**

(Eye patients)
Head to Toe Healthcare PLC – *Advanced Eye and Foot Care* provides comprehensive routine and medical eye exams. This includes not only vision correction but also screenings for other ocular conditions and systemic diseases. During your vision examination, should a medical condition arise, be advised that it is not covered under your routine eye benefits through your vision insurance plan. Medical exams are billed through your Major Medical Carrier and are subjected to their specific Co-pays, Deductibles, Co-insurance and will be due at the time of service. In the event that I do not wish the Doctor to proceed with a medical examination, I understand that it is my responsibility to immediately inform the doctor as she/ he can refer me to the appropriate specialty doctor.

(Eye and foot patients)
I hereby authorize any payment for my services today to Head to Toe Healthcare PLC – *Advanced Eye and Foot Care*. I understand that if my employer, insurance carrier or plan sponsor refuses payment to any portion of my claim, I am financially liable and responsible for the outstanding balance/ charges on my account. Any unpaid balance on my account or my family's account is subjected to 1.5% per month interest rate or 18% per year. Should there be any legal action filed, I am responsible for the collection fees, attorney fees, filling fees, and any cost the court determines. Obtained authorization does not guarantee payment and any denied services will be billed to the patient.

Patient/ Guardian 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 services or to allow insurance companies to process insurance claims for services rendered to you by us or other healthcare providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in 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 healthcare;
- 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.

Head to Toe Healthcare, PLC reserves the right to amend this Notice of Privacy Practices at any time in the future and to make the new Notice provisions effective for all health information.

If you have a question, concern, or complaint regarding our privacy practices, please contact our office directly for any further information.