JEREMY BIER, D.P.M., FACFAS
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Board Certified, American Board of Foot and Ankle Surgery
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Patient Information

Date: _____

First Name: _____ Middle Initial: _____ Last Name: _____

DOB: _____ Gender: _____

Address: _____ Apt#:_____

City: _____State:_____ Zip Code: _____

Home Phone: _____ Mobile Phone: _____

Email Address: _____

Employers Name: _____ Work Phone: _____

Spouses Name: _____Spouses Work Phone:_____

If Patient is a minor, who is responsible for the patient? _____

How did you hear about us?_____

Primary care physician's name and address:_____

Preferred Pharmacy Name and Address: _____

Emergency Contact (Name & Phone #) :_____

Medical History:

Reason for today's visit: _____

_____

Do you have any medical problems or conditions? _____

_____

Medication History :

Medication Name	Dose (If unknown, write N/A)

Surgical or Hospitalization History :

Surgery or Hospitalization	Date	Reason	Complications

Allergies

Do you have any allergies to medications or other substances (pets, plants, food, etc.)? **YES**_____ **NO**_____

If yes, please list allergies and reactions (including rash, hives, throat swelling, and anaphylaxis):

Allergy	Reaction

Height: _____**Weight:** _____**Shoe Size**: _____

Have you EVER had any of the following? Please check Yes or No

	Yes	No		Yes	No
Anemia/Bleeding tendency			Ear/Nose/Throat problems		
Asthma/Breathing problems			Eczema/Skin disorder		
Behavioral problems			Eye disorder		
Blood transfusion			Growth disorder		
Bowel/Stomach problems			Heart disorder/defect		
Cancer/Leukemia			Kidney/Bladder problem		
Shingles			Liver disease		
Diabetes			Seizure or Epilepsy		
COVID-19			Thyroid disorder		

Please list any other medical illnesses or problems and provide details for any of the above conditions:

_____

_____

_____

Patient Family History:

Please indicate any major conditions/illnesses that the patient's immediate family members have had:

Relative	Condition	Living?	If deceased, at what age?
Parent: Mother			
Parent: Father			
Sibling:			
Other:			

Patient Social History:

Do you smoke? YES_____ NO_____ NEVER_____ If yes, packs/day_____

If no, previously? YES_____ NO_____ Years smoked_____ Packs/day_____

Do you use other tobacco products (i.e. Cigars / Chewing Tobacco / Vapes) ? YES_____ NO_____

Consume alcohol? YES_____NO_____

- If yes, Beer_____ Wine_____ Liquor_____ Approximate # of Drinks per Week _____

Review of Systems

Please indicate ALL that the patient has experienced within the past 6-12 months. Check Yes or No

Constitutional

	Yes	No		Yes	No		Yes	No
Fever			Fatigue			Weight. Gain (_____Lbs.)		
Chills			Feeling Poorly			Weight Loss (_____Lbs.)		
Sweats			Sleep Disturbances			Other_____ _____		

Cardiovascular

	Yes	No		Yes	No		Yes	No
Chest Pain			Cold Extremities			Irregular Heart Rhythm		
Palpitations			Cold Hands or Feet			Other		
Leg Swelling			Leg Pain with Walking					

Respiratory

	Yes	No		Yes	No		Yes	No
Shortness of Breath			Wheezing			Coughing up Blood		
Cough			Chest Congestion			Other:		
Rapid Breathing			Coughing up Sputum					

Gastrointestinal

	Yes	No		Yes	No		Yes	No
Abdominal Pain			Diarrhea			Change in Bowels		
Blood in Stool			Black/Tarry Stools			Vomiting Blood		
Vomiting			Decreased Appetite			Bowel Incontinence		
Nausea			Yellow Skin			Heartburn		
Constipation			Trouble Swallowing			Other:		

Review of Systems Continued

Neurological

	Yes	No		Yes	No		Yes	No		Yes	No
Headache			Poor Coordination			Numbness			Tremor		
Dizziness			Disorientation			Tingling			Memory Lapses/Loss		
Unsteady			Decreased Strength			Seizures			Other:		
Confusion			Burning Sensation			Fainting (Syncope)					

Musculoskeletal

	Yes	No		Yes	No		Yes	No
Joint Pain			Limb Pain			Muscle Pain		
Neck Pain			Joint Swelling			Muscle Weakness		
Back Pain			Muscle Cramps			Leg Swelling		

Integumentary

	Yes	No		Yes	No		Yes	No		Yes	No
Rash			Skin Wound			Unusual Growth			Skin Cancer		
Dry Skin			Change in a Mole			Itching			Other:		

Psychiatric

	Yes	No		Yes	No	
Depression			Anxiety			Other:

Hematologic/Lymphatic

	Yes	No		Yes	No		Yes	No	
Easy Bruising			Easy Bleeding			Swollen Lymph Nodes			Other:

Endocrine

	Yes	No		Yes	No		Yes	No
Excessive Thirst			Heat Intolerance			Skin Changes		
Cold Intolerance			Hair Changes			Other:		

Physician's Signature: _____Date: _____

Office Policy and Financial Agreement:

Dr. Bier and his office staff are committed to providing you with exceptional care. Your clear understanding of our office policy is important to our professional relationship. Please ask us if you have questions about our fees, financial policy or your financial responsibility.

We will need a copy of your insurance cards for our files. If you do not have it at the time of your visit you will be responsible for payment at the visit. This is due to the short time frame most insurance companies have for filing a claim.

Co-Payments: By insurance policy rules we **MUST** collect your co-payment at the time of the visit. **Should you not pay at the time of service, you will receive a statement from our biller, and an administrative fee of$10.00 will be charged to you.**

Office Policy and Financial Agreement Continued:

Referrals: The insurance companies which utilize referrals have become strict about their use. Referrals are being processed electronically and cannot be back dated. **This means that you must have the referral at the time of your visit, or your credit card will be charged for all cost associated with your care at the time of the visit.**

Please be aware that most insurance companies have a 90 day filing period for claims, if we are not notified of any changes at the time of service (new insurance company, subscriber ID numbers, group numbers etc.) and the time limit has passed for filing of your claim; you will be responsible for all balances not paid by your insurance company.

Self-Pay Patients: Payment is expected at the time of service unless other arrangements have been made prior to your visit. Should you not pay at the time of service, you will receive a statement from our biller and an administrative charge of $10.00 will be charged to you.

Medicare: We will submit claims to Medicare. Patients will be responsible for any deductible and co-insurance balances.

Return Checks: There is a $25.00 fee for all checks being returned to us.

There is a .75 cents per page charge for copies of medical records plus postage. There is a $10.00 charge for copies of x-rays place onto a disc.

Appointments: **24 hours' notice** would be appreciated for any cancellations.

You are responsible for the timely payment of balances. It is your responsibility to notify us as soon as possible of any insurance plan changes or home address information etc. Thank you for taking time to review our policies. Please feel free to ask any questions or share with us special concerns.

I understand that all applicable copayments and deductibles are due at the time of service. I agree to be financially responsible and make full payment for all charges not covered by my insurance company. I authorize my insurance benefits be paid directly to Preferred Footcare, LLC or its doctors for services rendered. I authorize representatives of Preferred Footcare, LLC to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

***Please refer to our website, STAMFORDFOOTCARE.COM, for a list of insurances accepted by your provider.**

Patient Portal Sign Up:

Access your personal records securely, 24/7, on a computer, smartphone, or tablet.

I read and agree to all the above (Portal Sign Up, Office Policies, and Financial Agreement) :

Patient or Legal Guardian Name (Print): _____

Patient or Legal Guardian Signature: _____Date: _____

CREDIT CARD ON FILE AUTHORIZATION:

Due to lncreasiog high deductible plans, we are requiring patlents to store a credit card on flle with us.

Patient visits shall be invoiced directly to their respective insurance provider. Following the processing or the claim and receipt of the Explanation of Benefits (E0B), any outstanding charges not covered by the insurance will be promptly billed to the patient. Notification of any remaining balance will be conveyed to the patient via phone and/or by mail. After 60 days, should the balance persist unpaid, and our attempts to contact the patient prove unsuccessful, your card will be charged.

****Charges will not be incurred on the credit card on file without prior notification to the patient.****

Name as it appears on the credit card: _____

Card Number: _____

Expiration Date: _____/_____ (MM/YYYY) Security Code: _____ (3- or 4-digit code)

Billing Zip Code: _____

**By signing below, I authorize Preferred Footcare, LLC/Dr. Jeremy Bier to charge any outstanding balances due on my account after my insurance pays. I understand this charge is my responsibility.

Signature: _____Date:_____

PATIENT PREFERRED METHOD OF COMMUNICATION

To All of Our Patients:

To communicate with our patients effectively, it is our policy to leave a message confirming appointments. It is our office policy NOT to leave any medical information or results in a telephone message without your permission. We do this in order to comply with medical confidentiality regulations.

Please indicate below whether we have your permission to speak with a family member or to leave a message on your answering machine/voicemail.

I hereby give permission for Dr. Jeremy Bier / Preferred Footcare staff to:

1. Speak with a family member or to leave a message on answering machine/voicemail
   Name of Family Member _____ Phone# _____
2. Leave test results, medication information or billing information on my answering machine or via voicemail: **Yes _____ No _____**

Patient or Legal Guardian Name (Print): _____

Patient or Legal Guardian Signature: _____ Date: _____

ACKNOWLEDGEMENT 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 or Legal Guardian Name (Print): _____

Patient or Legal Guardian Signature: _____Date: _____

I have the right to revoke this consent, in writing at any time, except to the extent that Jeremy A. Bier, D. P.M. has taken reliance on this consent.

****This section to be completed by Jeremy A. Bier, D.P.M. or office staff, if unable to obtain written acknowledgement from patient.**

I made a good faith effort to obtain a written of acknowledgement of receipt of the Notice of Privacy Practices from the above patient, but was unable to because:

Patient declined to sign this written acknowledgement.

Other (specify)

_____

_____

_____

Name and Title of Employee_____Date: _____