Scott J. Hoffman, D.P.M.
1205 Ryan's Road
Worthington, MN 56187-0848
Phone: (507) 372-2986
Toll Free: (877) 560-3668

Thank you for choosing Dr. Hoffman & Associates, P.A.

You can help make our registration process faster and more efficient by completing the enclosed forms and returning them with you at the time of your appointment.

Please carefully fill out the insurance portion on the attached form.

- **Please be sure to sign where indicated on all forms.**
- **We do file insurance automatically as a courtesy to you.**
- **We request that you bring your insurance card(s) with you so that we can make a copy of them for our records.**
- **If you need a referral for insurance, please arrange that referral prior to your first visit.**
- **Motor vehicle accident and/or public liability:**
  - **It is ***your*** responsibility to have the billing and/or insurance information completed on the form and should accompany you to your first appointment.**

X-rays, MRI's, CT scans, Bone scans, etc:

- **Please remember to bring all films and/or reports with you to your appointment.**

Medical Records:

- **Please either hand carry or forward to our office any outside medical records pertaining to the podiatric problem(s) you are going to be seen for.**

Medications:

- **Please remember to bring a list of all medications with you to your appointment.**

PLEASE PROVIDE 24 HOUR NOTICE OF CANCELLATION IF YOU ARE UNABLE TO KEEP APPOINTMENT.

PLEASE ARRIVE 15 MINUTES PRIOR TO APPOINTMENT TIME TO COMPLETE REGISTRATION. FORMS MUST BE COMPLETED PRIOR TO CHECK-IN OR APPOINTMENT WILL BE RESCHEDULED.

A $50 NO SHOW FEE WILL BE CHARGED.

APPOINTMENT DATE:_____ **TIME:**_____

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Patient Financial Policy

Dr. Hoffman and staff value the trust that you place in us to provide your care. Your clear understanding of our financial policy is an important part of our professional relationship. Please make sure to ask if you have any questions about our fees, our policies or your responsibilities.

Prior to your appointment you will be required to complete our Patient Information Forms. This needs to be completed before you see the physician.

INSURANCE

Please present with a photo ID and your insurance card at each visit.
It is the ***patient's responsibility*** to ***provide current insurance information*** to the billing office.
It is ***your responsibility*** to call your insurance company to make sure we are in your network.
Referrals, if required, from your medical doctor need to be provided before you see your physician.

Your insurance policy is a contract between you and your insurance carrier. We file insurance as a courtesy to you and will help you in any way but we will not be involved in disputes between you and your insurance carrier. This includes but is not limited to: deductibles, co-pays, non-covered charges and "usual and customary" charges. You are ultimately responsible for the timely payment of your account.

Copayments are due at check in.

Payment Arrangements: Full balance is due at the time of service, however if you are unable to pay the full balance, payment arrangements can be made prior to your visit. We accept cash, checks, and all major credit cards.

Unpaid balances are subject to finance charges after 90 days and outstanding balances will be collected at check-in time.

Self Pay: We require that you pay one-half of estimated charges before you see the physician and one-half of estimated surgery charges before any surgical procedure is scheduled.

Additional Information and/or Fees:

- **$45 charge for insufficient funds check**
- **$25 for completing disability forms, per request.**
- **$25 for medical records that are not sent to referring or consulting physicians.**
- **$3.00 per disk for copies of x-rays.**
- **Parents or guardians of minors are responsible for full payment and will receive billing statements for the minors. It is preferred that minors be accompanied by a parent or guardian but in the event that is not possible, unaccompanied minors will not be treated without a signed release from a parent or guardian.**

I have read and agree to the financial policy of Dr. Hoffman & Associates, P.A.

_____

Patient Name (please print)

_____ _____

Patient/Responsible Party Signature **Date**

PLEASE COMPLETE AND RETURN

New Patient Info

Scott J. Hoffman, D.P.M.
1205 Ryan's Road
Worthington, MN 56187-0848

Appointment Date _____ Time _____

Chart _____

Account _____

Patient Name (please print) _____
Maiden

_____
First Middle In. Last

Address _____

City _____ St _____ Zip _____

Social Sec. # _____

Cell Phone _____

Home Phone _____

Date of Birth _____ Gender _____ Age _____

E-mail _____

Employer _____

Address _____

City _____ St _____ Zip _____

Work Phone _____

Parent or Guardian Name if Under 18 years of age:

_____ Work/Cell _____

Why are you seeing the doctor today? _____

_____

Current problem is the result of a:

❑ Motor Vehicle Accident ❑ Work Related Injury
❑ Liability ❑ Other

Date of Injury _____

State in which injury occurred _____

Guardian/Legal Representative

If you are not financially responsible for payment for your services, please write the information for the responsible party below.

Name _____

Address _____
(write "same" if you live with the guardian/legal representative)

City _____

State _____ Zip _____

Email: _____

Primary Phone: (_____) _____

Are you a student?
❑ No ❑ Full-time Student ❑ Part-time Student

Emergency Contacts

Name of Person (& relationship to patient) to contact in case of emergency:

_____

Work Phone _____

Hm/Cell Phone _____/_____

Address _____

City _____ St _____ Zip _____

Complete if Married (*patient*)

Name of Spouse _____ DOB _____

Work/Cell Phone _____/_____

Employer _____

Address _____

City _____ St _____ Zip _____

Family Doctor _____

Referring Physician _____

How did you hear about us? _____

_____

Insurance Assignment & Release

I certify that I am covered by the above listed medical insurance and I agree to assign all benefits, if any, otherwise payable to me directly to the provider of care for services rendered to me. 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.

The doctor may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining verification of insurance eligibility, determining insurance benefits payable for services and for obtaining payment for services provided to me.

I understand that my insurance may only pay a portion of the fee for the services provided. I understand that there may be a co-payment required at the time of my visit and there may be a balance remaining (or co-insurance) for which I am personally responsible for paying. I understand that co-payments are due and must be paid at the time of my visit.

_____
Signature of person assigned with financial responsibility for patient.

_____
Print the name of the person assigned with financial responsibility for patient.

_____ _____
Date Relationship to Patient

❑ **MEDICARE #**_____	❑ **MEDICAID #**_____ ***State***____
❑ **PRIMARY INSURANCE:** Name of Insurance Company: _____ Address of Insurance Company: _____ City _____State____ Zip_____ **POLICYHOLDER DOB:** _____ Name of Policyholder:_____ Policyholder Social Sec. # _____ /_____ /_____ Patient Relationship to Policyholder: ❑ Self ❑ Spouse ❑ Child ❑ Other - Please Define _____ Policy Number of INSURED: _____ Group NAME: _____ Group NUMBER: _____ Does your Insurance Company Require Pre-authorization? ❑ YES ❑ NO	❑ **SECONDARY INSURANCE:** Name of Insurance Company: _____ Address of Insurance Company: _____ City _____State____ Zip_____ **POLICYHOLDER DOB:** _____ Name of Policyholder:_____ Policyholder Social Sec. # _____ /_____ /_____ Patient Relationship to Policyholder: ❑ Self ❑ Spouse ❑ Child ❑ Other - Please Define _____ Policy Number of INSURED: _____ Group NAME: _____ Group NUMBER: _____ Does your Insurance Company Require Pre-authorization? ❑ YES ❑ NO

FINANCIAL AGREEMENT:

I understand that I am financially responsible for all charges not covered by insurance. In the event that there is a balance unpaid by insurance. I guarantee the balance be paid:

❑ Cash ❑ Check ❑ CC/Debit Card #_____ _____ _____ _____ exp:___ ___

I understand any balance is considered delinquent after 90 days:

X _____

PRE-AUTHORIZATION

Our office will pre-authorize surgeries; however, pre-authorization does not guarantee payment. Questions regarding payment or benefits should be directed to your insurance carrier.

If your insurance company requires that you go to a specific hospital or facility in order to receive benefits for surgery, tests, or therapy, it is your responsibility to let us know.

Guidelines when calling your insurance company:

Is pre-authorization required?

Is a second opinion required?

Are you in a waiting period for pre-existing conditions?

X_____ Date _____

PLEASE COMPLETE AND RETURN

Medical History

Dr. Hoffman & Associates, P.A. Foot & Ankle Specialists

Name:_____ Date: _____

Medication	Dosage
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	

Medication	Dosage
14.	
15.	
16.	
17.	
18.	
19	
20.	
21.	
22.	
23.	
24.	
25.	
26.	

Pharmacy Name: _____

Review of Systems

Check all symptoms/conditions you currently have or have had in the past and explain:

❑ Thyroid Disease _____
❑ Diabetes _____
❑ Heart Disease _____
❑ Heart Murmur _____
❑ Valve Problems _____
❑ High Blood Pressure _____
❑ Chest Pain _____
❑ Dizziness _____
❑ Fracture/Broken Bone
Body Part _____
❑ Joint Pain
Body Part _____
❑ Joint Swelling
Body Part _____
❑ Back Pain/Injury _____
❑ High Cholesterol _____
❑ Osteoporosis _____
❑ Carpal Tunnel _____
❑ Rheumatoid Arthritis _____
❑ Multiple Sclerosis _____

❑ Parkinsons _____
❑ Stroke _____
❑ Seizure _____
❑ Nervous Disorder _____
❑ Epilepsy _____
❑ Headaches _____
❑ Asthma or Emphysema _____
❑ Pneumonia _____
❑ Lung Disease _____
❑ Ulcers _____
❑ Rectal Bleeding _____
❑ Change in Bowel Habits _____
❑ Hepatitis (Jaundice or Liver Disease)
❑ Gallbladder Disease _____
❑ Heartburn _____
❑ Double Vision _____
❑ Nosebleeds _____
❑ Difficulty Swallowing _____
❑ Hoarseness _____
❑ Ringing in Ears _____

❑ Infections after Surgery _____
❑ Venereal Disease _____
❑ Hepatitis _____
❑ (HIV) AIDS _____
❑ Osteomyelitis _____
❑ Kidney Stones _____
❑ Blood in Urine _____
❑ Painful Urination _____
❑ Frequent Rashes _____
❑ Skin Irritation _____
❑ Swelling of the Feet _____
❑ Paralysis _____
❑ Numbness _____
❑ Depression _____
❑ Anxiety _____
❑ Schizophrenia _____
❑ Bipolar Disorder _____
❑ Drug or Alcohol Abuse _____
❑ Other Please Explain _____
_____

Reviewed by Provider: _____ Date: _____

PLEASE COMPLETE AND RETURN

Medical History

Dr. Hoffman & Associates, P.A. Foot & Ankle Specialists

Name:_____ Date: _____

Surgeries/Hospitalizations/Illness	Year
1.	
2.	
3.	
4.	
5.	

Surgeries/Hospitalizations/Illness	Year
6.	
7.	
8.	
9.	
10.	

Have you ever had general anesthesia? ❑ No ❑ Yes

Have any problems with anesthesia? ❑ No ❑ Yes

Describe: _____

Have you ever had a blood transfusion? ❑ No ❑ Yes

Date of last tetanus booster: _____

Are you pregnant? ❑ No ❑ Yes

Family History *(please circle sister or brother)*

Member	Age	Living/ Deceased	Health Status or Cause of Death
Father		❑ L ❑ D	❑ Heart Disease ❑ Diabetes ❑ Cancer (location _____) ❑ Stroke ❑ High Blood Pressure ❑ Thyroid Disease Other _____
Mother		❑ L ❑ D	❑ Heart Disease ❑ Diabetes ❑ Cancer (location _____) ❑ Stroke ❑ High Blood Pressure ❑ Thyroid Disease Other _____
Sister or Brother		❑ L ❑ D	❑ Heart Disease ❑ Diabetes ❑ Cancer (location _____) ❑ Stroke ❑ High Blood Pressure ❑ Thyroid Disease Other _____
Sister or Brother		❑ L ❑ D	❑ Heart Disease ❑ Diabetes ❑ Cancer (location _____) ❑ Stroke ❑ High Blood Pressure ❑ Thyroid Disease Other _____
Sister or Brother		❑ L ❑ D	❑ Heart Disease ❑ Diabetes ❑ Cancer (location _____) ❑ Stroke ❑ High Blood Pressure ❑ Thyroid Disease Other _____

Social History

Occupation _____ Employer _____ Length of Employment _____

Marital status _____

Exercise (type/frequency) _____ Special Diet (describe) _____

History of illegal drug abuse? ❑ No ❑ Yes Describe: _____

Do you smoke? ❑ No ❑ Yes _____packs per day for_____years Year you quit smoking _____

Alcohol use ❑ No ❑ Yes ❑ 1-2 drinks per week ❑ 3-5 drinks per week

❑ 1-3 drinks per month Other _____

Reviewed by Provider: _____ Date: _____

PLEASE COMPLETE AND RETURN

Medical History

Dr. Hoffman & Associates, P.A. Foot & Ankle Specialists

Name:_____ Date: _____

Allergies

Please tell us of any allergies you have and potential reactions (i.e. nausea, hives) when encountered:

- ❑ Aspirin: _____
- ❑ Codeine: _____
- ❑ Demerol: _____
- ❑ Iodine: _____
- ❑ Novocain: _____
- ❑ Penicillin: _____
- ❑ Sulfa: _____
- ❑ Other: _____

Are you now or have you been under another doctor's care for any reason in the last two years?

❑ Yes ❑ No

If yes, for what reason?_____

What is your shoe size? _____

What is your last known weight?_____

What is your last known blood pressure? _____

Please indicate which foot/ankle problems you now have or have had in the past:

❑ Ankle Pain	❑ Heel Pain
❑ Athlete's Foot	❑ Ingrown Nails
❑ Bunions	❑ Numbness in Feet, Legs, Toes
❑ Corns & Calluses	❑ Plantar Warts
❑ Cramps in Feet/Legs	❑ Swelling in Feet, Legs, Toes
❑ Flat Feet	❑ Tired Feet

Have you been diagnosed with any of the following? (you must indicate Yes or No)

	Yes	No
Diabetes	❑	❑
Hypertension	❑	❑
Peripheral Vascular Disease	❑	❑
Onychomycosis	❑	❑
Plantar Fasciitis	❑	❑

Treatment Consent

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

_____

Signature of patient, guarantor or responsible party

_____

Print name of person whose signature appears

_____ _____

Date Relationship to patient

❑ ❑ ❑ ❑

I certify the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions I may have made in the completion of this form.

Patient Signatures:_____ Date: _____

Reviewed by Provider: _____ Date: _____