**WELCOME TO THE PODIATRY OFFICE OF DR. PAUL MEISSNER JR.**
MEDICAL AND SURGICAL FOOT SPECIALIST
PATIENT INFORMATION SHEET

NAME:_____
(Last) (First)

HOME ADDRESS: _____
(Street) (City) (State) (Zip)

HOME PHONE #:_____ CELL PHONE #: _____ WORK PHONE# _____

BIRTHDATE: ___/___/___ Age: _____ Last 4 SSN # _____

MARITAL STATUS: S M D W

Occupation: _____

Employer_____

E-Mail Address: _____

ETHNICITY: Are you Hispanic or Latino? Y N

PRIMARY LANGUAGE _____ RACE_____

WHO SHOULD WE CONTACT IN CASE OF EMERGENCY: _____ PHONE # _____

==========

**HAVE YOU SEEN ANOTHER PHYSICIAN FOR THIS PROBLEM?** YES_____ NO_____

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**WHO IS RESPONSIBLE FOR THE BILL (IF OTHER THAN PATIENT)? ____ SELF**

NAME: _____

HOME ADDRESS: _____

HOME PHONE #: _____

INSURED/CARD HOLDERS EMPLOYER:_____

WORK ADDRESS:_____ PHONE #:_____

==========

**PRIMARY INSURANCE:**

INSURANCE COMPANY NAME:_____

NAME OF CARD HOLDER:_____

ID NUMBER: _____ GROUP NUMBER _____

INSURED BIRTHDATE (IF DIFFERENT FROM PATIENT):_____

INSURED SOCIAL SECURITY # (IF DIFFERENT FROM PATIENT): _____

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**SECONDARY INSURANCE:**

INSURANCE COMPANY NAME:_____

NAME OF CARD HOLDER (SELF, SPOUSE, PARENT):_____

ID NUMBER: _____ GROUP NUMBER _____

INSURED BIRTHDATE (IF DIFFERENT FROM PATIENT):_____

INSURED SOCIAL SECURITY # (IF DIFFERENT FROM PATIENT): _____

# Paul J. Meissner Jr. DPM

## Podiatric Medicine and Surgery

1818 Pot Spring Road Lutherville MD 21093 Suite 110

Phone: 410-666-3338

Fax: 410-252-2519


PATIENT NAME: _____ DATE OF BIRTH _____

| | | | |
|---|---|---|---|
| **ENDOCRINE/GU/GI** | | | |
| BPH (PROSTATE) | YES | NO | |
| DIABETES | YES | NO | |
| HEPATITIS | YES | NO | |
| PREGNANT | YES | NO | NOT SURE |
| RENAL/KIDNEY STONES | YES | NO | |
| THYROID DISEASE | YES | NO | |
| ULCER (GI) | YES | NO | |
| **HEAD/HEART/LUNGS/NECK/EYE/EAR/THROAT** | | | |
| ACID REFLUX | YES | NO | |
| ASTHMA | YES | NO | |
| CATARACTS | YES | NO | |
| COPD | YES | NO | |
| EMPHYSEMA | YES | NO | |
| GLAUCOMA | YES | NO | |
| HEADACHES | YES | NO | |
| HEART ATTACK | YES | NO | |
| MIGRAINE | YES | NO | |
| PNEUMONIA | YES | NO | |
| SMOKE | YES | NO | FORMER |
| **HEMATOLOGIC IMMUNOLOGICAL SYSTEM INFECTION DISEASE** | | | |
| ANEMIA | YES | NO | |
| HIV | YES | NO | |
| IMMUNE PROBLEM | YES | NO | |
| LYME DISEASE | YES | NO | |
| TICK BITE | YES | NO | |
| TB | YES | NO | |
| MRSA | YES | NO | |
| **MUSCULOSKELETAL SYSTEM** | | | |
| ARTHRITIS | YES | NO | |
| BACK PROBLEM | YES | NO | |
| GOUT | YES | NO | |
| IMPLANT | YES | NO | |
| JOINT REPLACEMENT | YES | NO | SPECIFY: _____ |
| JOINT STIFFNESS | YES | NO | |
| PLATES/SCREWS | YES | NO | SPECIFY: _____ |
| SURGERY (OTHER) | YES | NO | SPECIFY: _____ |
| **NEUROLOGICAL SYSTEM** | | | |
| EPILEPSY | YES | NO | |
| MS | YES | NO | |
| NEUROPATHY | YES | NO | |
| PARKINSON'S DISEASE | YES | NO | |

OTHER: _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY: _____

DATE: _____/_____/_____

# Paul J. Meissner Jr. DPM

## Podiatric Medicine and Surgery

1818 Pot Spring Road Lutherville MD 21093 Suite 110

Phone: 410-666-3338

Fax: 410-252-2519


PATIENT NAME: _____ DATE OF BIRTH _____

PLEASE COMPLETE THE FOLLOWING MEDICAL QUESTIONAIRE

### FOOT PROBLEMS:

| | | | |
|---|---|---|---|
| AMPUTATION(S) | YES | NO | SPECIFY: _____ |
| BROKEN FOOT | YES | NO | SPECIFY: _____ |
| BUNIONS | YES | NO | |
| COLD FEET | YES | NO | |
| CONTRACTED TOES | YES | NO | |
| CORNS/CALLOUSES | YES | NO | |
| FROSTBITE | YES | NO | |
| FUNGUS NAILS | YES | NO | |
| FUNGUS SKIN | YES | NO | |
| HEEL PAIN | YES | NO | |
| INFECTION(S) | YES | NO | |
| INGROWN NAILS | YES | NO | |
| NEUROPATHY | YES | NO | |
| NUMBNESS/TINGLING | YES | NO | |
| PLANTAR FASCITIS | YES | NO | |
| ARCH PAIN | YES | NO | |
| POOR CIRCULATION | YES | NO | |
| RAYNAUDS | YES | NO | |
| SORES | YES | NO | |
| SURGERY (FOOT/FEET) | YES | NO | SPECIFY: _____ |
| TIRED FEET | YES | NO | |
| ULCER (FEET/LEG) | YES | NO | |
| WALKING ISSUES | YES | NO | WHAT: _____ |

### CIRCULATORY SYSTEM

| | | |
|---|---|---|
| ARTERY DISEASE | YES | NO |
| BLOOD CLOTS | YES | NO |
| CHOLESTEROL HIGH | YES | NO |
| CRAMPS FEET/LEGS | YES | NO |
| HIGH BLOOD PRESSURE | YES | NO |
| STROKE | YES | NO |
| TAKING COUMADIN | YES | NO |

### CONSTITUTIONAL/PSYCHOLOGICAL SYSTEM

| | | | |
|---|---|---|---|
| ANXIETY | YES | NO | |
| CHILLS | YES | NO | |
| DEMENTIA | YES | NO | |
| DEPRESSION | YES | NO | |
| DIZZINESS | YES | NO | |
| FAINTING | YES | NO | |
| WEIGHT ISSUES | YES | NO | SPECIFY: _____ |

### DERMATOLOGICAL SYSTEM

| | | | |
|---|---|---|---|
| CANCER | YES | NO | WHAT KIND: _____ |
| DERMATITIS | YES | NO | |
| DRY SKIN | YES | NO | |
| PSORIASIS | YES | NO | |
| ECZEMA | YES | NO | |

## PATIENT HISTORY

Generally speaking, are you in good health now? Yes____ No____

Height_____ Weight_____ Blood Pressure_____

Do you have a **PERSONAL** history of **Diabetes**? Yes____ No____

Are you subject to prolonged bleeding? Yes____ No____
If yes, do you take a blood thinner?
(i.e. Coumadin or Aspirin, please circle)

Do you have **ALLERGIES** to drugs, medicines or other substances? Yes____ No____
If yes, please list:_____

List all current medications:

_____ _____ _____

_____ _____ _____

Have you had any serious **ILLNESSES** or **OPERATIONS**? Yes____ No____
If yes, what type and when? (Please list)

| **ILLNESS OR OPERATIONS** | **Date** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Do you have a PRIMARY CARE PHYSICIAN?** Yes____ No____
Name:_____
Address:_____
Phone #:_____
**Date last seen:**_____

**PHARMACY NAME:** _____ **LOCATION:** _____ **PHONE:** _____

**I hereby give permission to Dr. Meissner to examine and/or perform diagnostic tests, and treat my condition medically, surgically or orthopedically. The undersigned consents to and authorizes the administration and performance of medical care that may be in the judgment of the physician considered advisable and necessary, why may include the performance of certain blood tests for communicable diseases such as Hepatitis and HIV. Dr. Meissner is authorized to furnish information, necessary to process claims, to an insurer, compensation carrier or welfare agency that may be providing financial acceptance for hospital care. I understand that although I have medical insurance, I am solely responsible for payment of medical bills. I agree to pay all fees billed to me immediately upon completion of all services unless other arrangements have been made in advance. I also understand that payment is not dependent upon my insurance.**

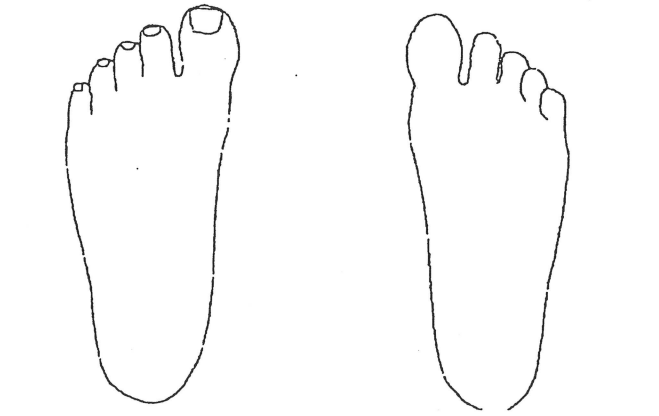
**SIGNATURE:** _____ **DATE:** _____
Signature of Patient or Legal Guardian

## Current Problem

What specific problem brings you to our office today? _____

Where is the pain/problem located? Please mark on the pictures below.

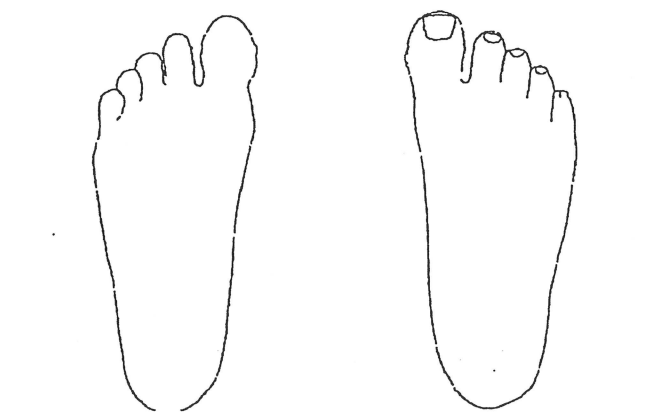
**Left Foot**



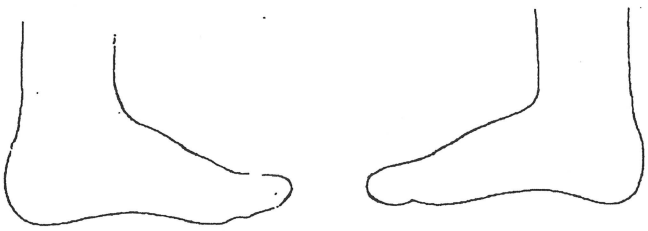
Top of Foot | Bottom of Foot

Inside of foot | Outside of Foot

**Right foot**



Bottom of Foot | Top of Foot



Outside of Foot | Inside of foot

How long ago did this problem first start? _____ Days / Weeks / Months / Years

Did your pain or problem: ☐ Begin all of a sudden ☐ Gradually develop over time

How would you describe your pain? ☐ No pain ☐ Sharp ☐ Dull ☐ Aching ☐ Burning
☐ Radiating ☐ Itching ☐ Stabbing ☐ Other _____

How would you rate your pain on a scale from 0 to 10? (please circle)
*(no pain)* 0 1 2 3 4 5 6 7 8 9 10 *(worst pain possible)*

Since the time your pain or problem began, has it: ☐ stayed the same ☐ become worse ☐ Improved

What makes your pain or problem feel worse? ☐ Walking ☐ Standing ☐ Daily activities
☐ Resting ☐ Dress shoes ☐ High heels ☐ Flat shoes ☐ Any closed toe shoe
☐ Running ☐ Other _____

What makes your pain or problem feel better? _____

What treatments have you had for this problem? _____

How has this problem affected your lifestyle or ability to work? _____

Was this problem caused by an injury? ☐ Yes (describe) _____ ☐ No

If yes, was it a work-related injury? ☐ Yes ☐ No

The federal government is requiring all physicians to start collecting the information below. This office must comply with this program or be penalized for non-participation. We appreciate your cooperation

## ADDITIONAL PATIENT HISTORY INFORMATION

**Name:** _____ **Date:** _____

**For all patients:**

**Smoking History: Check One**

Current Smoker ____ Former Smoker ____ Never Smoked____

**Alcohol History: Check One**

Has the patient received a current flu vaccination? Yes __ No__ If so, when? _____

**Recreational Drug History: Check One**

Never ____

Current ____ Type_____

Former ____ Type_____

**Please mark the box with "M" for your mother's side or "F" for your father's side.**

**FAMILY HISTORY**

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES ☐ CANCER ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE ☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE ☐ RHEUMATOID ARTHRITIS ☐ OTHER _____

**For those patients 65 years of age or older**

Has the patient received a current pneumonia vaccination? Yes __ No__ If so, when? _____

Do you have a living will or someone to make decisions on your behalf? Yes __ No__

**Fall History**

Any falls in the past year? Yes __ No__ If yes, how many?___ Injuries: Yes __ No__

MEDICARE AUTHORIZATION FOR TREATMENT, ASSIGNMENT, AND RELEASE

I hereby give Dr. Paul Meissner and his staff permission to treat my foot and/or ankle disorder. I, the undersigned, request that payment of authorized Medicare benefits be assigned directly to Dr. Paul Meissner for services furnished to me. I understand that by my signature, I request that payment be made and authorize the release of medical information necessary to pay the claim. If I have secondary insurance, my signature authorizes the release of all necessary information requested by the insurance company. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible for deductibles, coinsurance, and non-covered services. Coinsurance and deductibles are based upon the charge determination of the Medicare carrier. I authorize the use of this signature on all my insurance submissions.

_____

lient Signature/Guardian Date

# PATIENT HIPPPA ACKNOWLEDGMENT AND DESIGNATION DISCLOSURE FORM

## I. Acknowledgement of Practice's Notice of Privacy Practices

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP) and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms

_____ _____ _____ _____
Name of Patient Date of Birth Signature of Patient/Parent/Guardian Date

## II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal representative

I agree that the practice may disclose certain of my health information to a personal representative of my choosing, since such person is involved with my healthcare or payment relating to my healthcare. In that case the Physician Practice will disclose only information that is directly relevant for the person's involvement with my healthcare or payment relating to my healthcare

Print Name: _____ Last 4 digits of his/her SSN (required) _____
Print Name: _____ Last 4 digits of his/her SSN (required) _____
Print Name: _____ Last 4 digits of his/her SSN (required) _____

## III. Request to Receive Confidential Communications by Alternate Means

As provided by Privacy Rule Section 164.522(b), I hereby request that the practice make all communications to me by the alternative means that I have listed below.

**Home Telephone Number:** _____
__ OK to leave message with detailed information
__ Leave message with call back numbers only

**Written Communication Address:** _____
__ OK to main to address listed above
__ OK to email me at: _____

**Work Telephone Number:** _____
__ OK to leave message with detailed information
__ Leave message with call back numbers only

**Fax Communication:** _____
__ OK to fax to the number listed above

**Other:** _____

_____ _____ _____
Name of Patient (Print) Signature Date

Witness: _____ Date: _____

# FINANCIAL POLICY

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

**INSURANCE:** We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

**MEDICARE:** We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. However, that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any copayments, which are usually 20% for the allowed amount for an item or service

**SECONDARY INSURANCE:** Your medical claim will be forwarded to your secondary insurance (if any) after payment and /or explanation of benefits (EOB) is received from your primary insurance company.

**COPAYMENTS AND DEDUCTIBLES:** all copayments and deductibles must be paid at the time of services. This arrangement is part of your contract with your insurance company. Failure on our part to collect copayments or deductibles from patients can be considered fraud. Please help us in upholding the law by paying your copayment at each visit.

**SELF PAY:** Payment in full is due at the time of service if you do not have health insurance.

**NON-COVERED SERVICES:** Please be aware that some of the services that you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payment of these services.

**REFERRALS/AUTHORIZATIONS:** We are required to follow the guidelines of your managed care plan which mandates us that when you visit a specialist such as ours, you must have a referral from your primary care physician prior to seeking specialty care. Therefore, you are financially responsible for the services received, unless your referral is presented at the time of this visit. If you do not have a referral from your primary care physician at the time of a visit, you will be financially responsible for all services received due in full upon completion of the visit. Full credit will be given if a referral is presented to our office within 48 hours of this visit. You will also be given the option to reschedule your appointment

**CLAIM SUBMISSION:** We will submit you claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

**PATIENT BILLING:** You will be sent a statement for any outstanding balance owed after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. **If a second or third statement is required, a $10 rebilling fee will be added to your account for each subsequent statement. You will be sent up to three notices of your financial responsibility** (coinsurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. **If payment is not received after the third and last notice, you account will be forwarded to collections or small claims court, where additional fees will apply**. Please let the billing office know if you have any difficulties resolving your bill. Payment arrangements can be made on a case by case basis. We accept the following payment methods: Cash, Check or Visa/MasterCard/AMEX. An additional $50.00 will be added to your statement if the check is returned for insufficient funds. In the event that your insurance company should happen to send payment to you, the patient, we expect that you would forward it you our office to be applied to your balance.

**PRIVACY STATEMENT:** Any information disclosed in your records will remain confidential and will not be used for any other reason except in providing quality care and treatment as well as to submit your claim to your insurance company and contact you as needed.

**Assignment of Benefits**

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to **Dr. Paul J. Meissner Jr.** all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, copayments and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested by physicians to provide continuity of care. I authorize the use of this signature on all insurance submissions.

I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance and acknowledge I was provided with a copy of the Notice of Privacy Practices and understand and accept its terms. **I have read the above policy regarding my *financial responsibility* to for medical services provided. I agree to pay Dr. Paul Meissner Jr. any balance unpaid by my insurance carrier for myself or the below named person.**

PRINT Patient Name: _____ Signature: _____

**FINANCIALLY RESPONSIBLE PARTY**

PRINT Name: _____ Signature _____

Relationship to Patient: _____ Date: _____

# Medicare / Insurance Guidelines for Podiatry

Dear Patient,

We would like to take this time to explain that Medicare / Commercial Insurances have changed their rules for Podiatry coverage. What may have been covered in the past may not be covered now.

## Routine Foot Care General Information

Routine foot care is defined as:

*The cutting or removal of corns or calluses.

*The trimming, cutting, clipping or debriding of nails.

Routine foot care is not a covered Medicare benefit. Medicare assumes that the patient or caregiver will perform these services by themselves, and therefore, these services are excluded from coverage, with certain exceptions.

## Exceptions

Medicare allows exceptions to this exclusion when medical conditions exist that place the beneficiary at increased risk of infection and/or injury if a non-professional would provide these services. Medicare / Commercial insurances may cover routine foot care if the patient meets medical criteria.

The most common diagnoses that can represent the underlying conditions to justify coverage as exceptions to routine foot care exclusions are:

*Peripheral vascular conditions

*Diabetes mellitus with Neuropathy and or Peripheral Vascular Conditions*

*Peripheral neuropathies involving the feet*

When the patient's condition is one of those designated by an asterisk (*), routine procedures are covered only if the patient is under the active care of a doctor of medicine or osteopathy who documents the condition. It's always best to check with your insurance to find out if your foot care treatments will be covered by your insurance.

We are sorry that these changes may mean that you may have to pay for your foot care treatments out of pocket. These are insurance rules, not ours, and theses rules MUST be followed. All podiatrist MUST follow these rules. Please remember you put yourself at high risk if you do not have your feet treated professionally. This is for your safety and health. Please do not ask us to code this differently so it will can be paid, that would be considered fraud.

Thank you for the understanding and for your loyalty to our practice. We look forward to the continued treatment of your foot care needs.

Yours truly,

Dr. Paul J. Meissner, JR DPM PA

**Please sign this below acknowledging that you have read this document and you understand that your treatment may not be a covered benefit under your insurance guidelines. If you do not meet the medical criteria you will be held financially responsible. We will work with our patients at a discounted rate for these services.**

_____ _____

(Full Name) (Date)