## Elizabeth E. Auger, DPM PC

1575 W 7000 S, West Jordan UT 84084
9355 S 1300 E, Sandy UT 84094
4460 S Highland Dr., Ste. 400, Holladay UT 84124

Phone: (801) 619-2170
Fax: (801) 553-9562

## PATIENT INFORMATION

Patient Name: ______________________ Date of Birth: ______________

Address: ______________________ City: ____________ State: _______ Zip:___________

Home phone: ( ______ ) _________ - __________ Work: ( ______ ) _________ - __________ Cell: ( _______ ) _________ - __________

E-mail: ______________________ Social Security Number: __________ - ______ - ___________

Spouse's Name (if applicable): ______________ Marital Status (circle): S M D W Other______________

Patient Relationship to Responsible Party (circle): Self Spouse Child Other ______________

Nearest relative (not living with you) ______________ Phone: ( ______ ) ________ - ________________

**Primary Care Physician:** ______________ City: ____________ **How did you hear about us?**______________

**Preferred Pharmacy:** ______________ City: ____________ Preferred Language: ______________

Ethnicity (circle): Hispanic or Latino Not Hispanic or Latino Race: ______________

Patient's Employer Name: ______________ Phone: ( _______ ) __________ - _______________

Address: ______________ City: ______________ State: ______ Zip: ______________

Accident Information (if applicable): Date: _____ /_____ /__________ Work Related? ________ Auto? _________ Other? ________________

## RESPONSIBLE PARTY INFORMATION

❑ **SELF / SAME AS ABOVE**

Name of Responsible Party: ______________________________________
Last First Middle

Address: ______________________ City: ______________________

State: ________ Zip Code: _______________ Date of Birth: ______ / _____ / ___________ Sex (circle): Female Male

Home Phone: ( ______ ) ________ - ________________ Work: ( ______ ) ________ - ______________ SSN: _________ - ______ - ____________

Resp. Party's Employer: ______________________ Phone: ( _______ ) _______ - _____________________

Address: ______________________ City: ______________________ State: _______ Zip: _____________

## INSURANCE INFORMATION

**PRIMARY** Insurance Company: ______________________ Phone: ( ______ ) ________ - _________________

Address: ______________________ City: ______________________ State: _______ Zip: ____________

Contract (ID) Number:______________________ Subscriber's Name: ______________________

Patient Relationship to Subscriber (circle): Self Spouse Child Other Insured's Date of Birth: ______ /______ /_________

Group Name: ______________________ Group #: ______________________ Co-pay amount: $ _______________

**SECONDARY** Insurance Company: ______________________ Phone: (_______) ________ - __________________

Address: ______________________ City: ______________________ State: _______ Zip: ___________

Contract (ID) Number: ______________________ Subscriber's Name:______________________

Patient Relationship to Subscriber (circle): Self Spouse Child Other Insured's Date of Birth: ______ / _____ /_________

Group Name: ______________________ Group #: ______________________ Co-pay amount: $ _______________

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## CONSENT AND CONDITIONS OF SERVICE

As either the Patient or the legally authorized representative of the Patient, the following consents, understandings, and agreements are made on my own behalf, or on behalf of the Patient in partial consideration of the health care services to be provided to the Patient by ***Elizabeth E. Auger, DPM*****;** to provide health care services to Patient and to administer physician orders for the benefit of the Patient for this visit and any subsequent visits. It is understood that this consent may be revoked in writing at any time. It is understood that there is risk of substantial and serious harm involved in such health care services, and such risk is accepted in the hope of obtaining beneficial results from such services. No promises of any particular outcome or successful result have been made, it being understood and accepted that there is some uncertainty involved in the outcome of health care services for which this consent is given. It is understood that physicians are separately responsible to explain what they do.

Patient and the undersigned, if other than the patient, each jointly and severally agree to pay for all health care services rendered to Patient from ***Elizabeth E. Auger, DPM*** including, but not limited to, any amounts not paid by any insurance company or other third party payor. Patient and the undersigned, if other than the Patient, remains responsible for all co-payments, deductibles, co-insurance, and/or non-covered services regardless of amount paid by insurance or third party payor. It is the policy of ***Elizabeth E. Auger, DPM*** to require payment of all office charges at the time they are given, unless prior arrangements have been specifically made. In the event that payment in full for charges incurred was not made, Patient and the undersigned, if other than the Patient, each jointly and severally agree to pay interest at the rate of 18% annually on all past due balances from the original due date, plus court cost and reasonable attorneys' fees, with or without suit, incurred in collecting any past due balance, and a collection fee if my account is assigned to a collection agency. Furthermore, the Patient or the undersigned, if other than the patient, each jointly and severally agree to pay a *$20.00 billing fee for any co-payments not paid for at the time of service* and to pay a service charge of $20.00 plus any bank charges in connection with any check or other instrument tendered by the Patient or the undersigned but returned unpaid to ***Elizabeth E. Auger, DPM***. In addition, it is the policy of ***Elizabeth E. Auger, DPM***, to assess a fee for missed appointments. The Patient and the undersigned, if other than the Patient agrees to pay *$25.00 for a missed (no-show) appointment* if the office of ***Elizabeth E. Auger, DPM*** is not notified within 24 hours of the appointment date.

**I have read the above and accept financial responsibility, in full, for this account.**

_______________________________________________ ____________________
**Signature of Patient or Legally Authorized Representative** **Date**

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## AUTHORIZATION FOR ASSIGNMENT - PAYMENT

I, the undersigned, authorize the release of any medical or other information necessary for my insurance to process payment of received services. I also request that payment of authorized Medicare, Medicaid, or health insurance benefits are to be made to ***Elizabeth E. Auger, DPM*** for services rendered to myself or to the Patient, if acting as the legally authorized representative of the Patient.

_______________________________________________ ____________________
**Signature of Patient or Legally Authorized Representative** **Date**

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## ACKNOWLEDGMENT OF REVIEW/RECEIPT OF PRIVACY PRACTICES

I, the undersigned, acknowledge that I have been given the opportunity to read the *Privacy Practices*. I understand that ***Elizabeth E. Auger, DPM*** takes every precaution to safeguard my *"Protected Health Information" (PHI)*. By signing this acknowledgment I am Consenting to ***Elizabeth E. Auger, DPM*** use and disclosure of my *PHI* to carry out treatments, payment, and health care operations. If I do not sign this consent, or later revoke it, ***Elizabeth E. Auger, DPM*** may decline to provide treatment to myself, or to the Patient, if acting as the legally authorized representative of the Patient.

_______________________________________________ ____________________
**Signature of Patient or Legally Authorized Representative** **Date**

**Patient name:** ________________________________ **Date of Birth:** ____________________

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# Payment Policy

**Patient name:** ____________________________________________________ **Date of Birth:** ________________________

Thank you for choosing us as your ***podiatry provider***. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

**1. Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't 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.

**2. Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

**3. Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

**4. Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

**5. Claims submission.** We will submit your 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; we are not party to that contract.

**6. Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

**7. Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

**8. Missed appointments.** Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

**I have read and understand the payment policy and agree to abide by its guidelines:**

______________________________________________________________ ____________________

**Signature of patient or Legally Authorized Representative** **Date**

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# Patient History

DATE: ____________________

PATIENT NAME: ____________________ DATE OF BIRTH: ____________________

## CURRENT ALLERGIES: *Check all that apply.*

❑ ADHESIVE TAPE ❑ MORPHINE ❑ SULFA DRUGS
❑ ASPIRIN ❑ PENICILLIN ❑ LATEX
❑ CHEMICALS ❑ FOODS ❑ CODEINE
❑ ANTIBIOTICS ____________________
OTHER: ____________________
REACTION: ____________________

## CURRENT MEDICATIONS: / DOSE:

| CURRENT MEDICATIONS | DOSE |
|---|---|
| | |
| | |
| | |
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| | |
| | |

## FAMILY HISTORY:

***Has anyone in your family had any of the following? If so, whom? (mother, father, sibling, grandparent, aunt, uncle etc.)***

❑ ARTHRITIS ____________________
❑ BIRTH DEFECTS ____________________
❑ CANCER (what kind?) ____________________
❑ DIABETES ____________________
❑ HEART ATTACK ____________________
❑ HIGH BLOOD PRESSURE ____________________
❑ OSTEOPOROSIS ____________________
❑ STROKE ____________________

## SURGICAL HISTORY:

***(List all surgeries you have had with approximate date)***

____________________

## SOCIAL HISTORY:

DO YOU SMOKE? ❑ CURRENT EVERYDAY SMOKER ❑ NEVER SMOKER
❑ CURRENT SOME DAY SMOKER ❑ FORMER SMOKER
# OF PACKS PER DAY __________ # OF YEARS __________
DO YOU DRINK ALCOHOL? ❑ YES ❑ NO
DO YOU CHEW TOBACCO? ❑ YES ❑ NO
DO YOU USE RECREATIONAL DRUGS? ❑ YES ❑ NO
IF FEMALE, ARE YOU PREGNANT? ❑ YES ❑ NO
**DATE OF LAST EXAM WITH PRIMARY CARE PHYSICIAN:**
____________________

## PAST MEDICAL HISTORY:

***Check all that YOU have been treated for.***

**HEART:**
❑ RHEUMATIC FEVER
❑ MURMUR
❑ CHEST PAIN
❑ ANGINA
❑ HEART ATTACK
❑ HYPOTENSION
❑ HYPERTENSION
❑ HEART DISEASE
❑ CONGESTIVE HEART FAILURE

**SKIN:**
❑ LESIONS
❑ MOLES
❑ ECZEMA
❑ RASHES
❑ CANCER

**ENDOCRINE:**
❑ DIABETES
❑ HYPOGLYCEMIA
❑ THYROID DYSFUNCTIONS

**GASTROINTESTINAL:**
❑ ULCERS
❑ HIATAL HERNIA
❑ REFLUX
❑ DIVERTICULITIS
❑ DIARRHEA
❑ IBS

**BLOOD:**
❑ ANEMIA
❑ BLOOD CLOTS
❑ BLEEDING TENDENCIES

**LIVER:**
❑ LIVER DYSFUNCTION
❑ HEPATITIS

**MUSCULOSKELETAL:**
❑ SERIOUS INJURIES
❑ BACK PROBLEMS
❑ DEFORMITIES
❑ LOSS OF STRENGTH
❑ JOINT PAIN
❑ LUPUS
❑ CRAMPS
❑ OSTEOARTHRITIS
❑ RHEUMATOID ARTHRITIS

**NEUROLOGIC:**
❑ DEPRESSION
❑ WEAKNESS
❑ NUMBNESS
❑ STROKE
❑ SEIZURES
❑ MIGRAINES
❑ NERVOUS CONDITION

**LUNGS:**
❑ ASTHMA
❑ PNEUMONIA
❑ SHORTNESS OF BREATH
❑ EMPHYSEMA
❑ PULMONARY EMBOLISM

**KIDNEYS:**
❑ KIDNEY
❑ BLADDER
❑ PROSTRATE PROBLEMS

OTHER: ____________________

## REASON FOR VISIT:

WHAT IS YOUR **FOOT** PROBLEM? ____________________

WHEN DID IT START? ____________________ RATE YOUR PAIN (1 = Least painful, 10 = Most painful): __________
DESCRIBE ANY ACCIDENT OR EVENT INVOLVED WITH INJURY: ____________________

WHEN WAS YOUR FIRST VISIT TO A DOCTOR FOR THIS PROBLEM? ____________________

REVIEWED BY: ELIZABETH E AUGER, DPM ____________________ DATE: ____________________