Dear Patient,

Welcome to Complete Feet.

We are pleased to provide high-quality custom foot orthotics and a carefully selected range of supportive, comfortable footwear designed to help you move and feel your best.

Enclosed in this packet, you will find the following forms:

- **Patient Intake Information (Demographics)**
- **Medical History Form**
- **HIPAA Release Form**
- **Patient Agreement**

Please complete all forms prior to your appointment and bring them with you to ensure a smooth and efficient visit.

Driving directions to our Hoover office can be found on our website. For your convenience, a QR code linking directly to our website and driving directions is included.

If you have any questions before your appointment, please feel free to contact our office at: **205-822-1606**.

Thank you for choosing Complete Feet. We appreciate the opportunity to care for you and look forward to seeing you.

Sincerely,
Michael Duvdevani, C.Ped
Owner
Complete Feet

Complete Feet®

Patient Intake Information

Name _____ Date of Birth_____

Preferred Name _____Social Security Number _____-_____-_____

Home Address _____City _____ St _____ Zip _____

Cell Phone _____ Other Phone _____ ( )Home ( )Work

I consent to receive appointment reminders and updates via SMS from Complete Feet. Message/data rates may apply. Reply STOP to opt-out.

**** If the patient is a minor --- Name of Parent / Guardian (circle one)* _____

Emergency Contact Name _____Relationship_____ Number_____

How did you hear about us? _____

Date of **last** orthotics_____ How many pair_____

Medical Information

Referring Physician _____ Number _____

Insurance Information

Primary Insurance _____ Name of Policy Holder _____ Relationship _____

Policy # _____ Group # _____ Policy Holder Date of Birth _____

Secondary _____ Name of Policy Holder _____ Relationship _____

Policy # _____ Group # _____ Policy Holder Date of Birth _____

Assignment of Benefits/ Authority for Release of Information/HIPAA Acknowledgement

I request that payment of authorized Medicare, Medicaid, or private insurance benefits be made to Complete Feet, for any covered services furnished to me by this facility. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents, Champus and its agents, or to a private insurance company and/or any information needed to determine these benefits payable for related services. If this is an insurance claim, I further agree to be responsible for the full amount of the charges from the date of service if my private insurance company does not pay for the charges in a timely manner, or if my physician, or I fail to provide the necessary paperwork to submit the claim for payment. I also hereby acknowledge that I have received a copy of The Notice of Privacy Practices and hereby consent to the use and disclosure of my personal health information for the purposes of treatments, payment, and health care operations. I also agree to pay ALL fees of attorneys and/or collection agencies needed to affect collection of any delinquent charges on my account. I also authorize my billing records to be released for this purpose.

X_____**Date**_____

Signature of Patient/Parent/Guardian

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MEDICAL HISTORY FORM

Name _____**Birthdate** _____ **Age:** _____ **Today's Date**_____

What brings you to see us today? _____

How long has this been going on? _____

Do you exercise regularly? _____ **if YES, what do you do?** _____ **How much (or how long)?** _____

Are you allergic to latex or any other kind of rubber material? _____ **If Yes, what kind?** _____

What do you do for a living? _____ **Does this require standing? If YES, how long?** _____

Primary Care Physician: Name: _____

Address and City: _____

Phone: _____

Have you had any of the following illnesses: (Please Circle)

Neuropathy	**Active Ulcer**	**Poor Balance**	**Ingrown Nails**
Knee Problems	**Neuroma**	**Hip Problems**	**Hepatitis**
Heel Spurs	**Allergies**	**Arch Problems**	**Diabetic Type: 1 2**
Overlapping Toes	**Bunions**	**Plantar Fasciitis**	

Leg Length Discrepancy? YES / NO If YES, which leg? _____ **How much of LLD?** _____

Physician that diagnosed the LLD? _____

Amputation(s)? YES / NO If marked YES, what was the date of amputation(s)? _____

Other: _____

_____ _____

Patient Signature **Date**

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Disclosure of Medical Information:

I,_____, hereby authorize Complete Feet and any of its agents and staff to give information concerning my health, well-being, treatment plan and appointment times to any of the following people:

_____ Spouse Name: _____

_____ Other Person Name: _____

Relationship: _____

_____ Other Person Name: _____

Relationship: _____

Other Forms of Communication:

For Complete Feet to be able to send you any requested forms and information via email, you must include the email information below. Failure to do so will result in us only being able to mail you the information via the post office.

Email Address (type clearly)**:** _____

Fax Number: _____

I authorize Complete Feet, or any of its staff, to leave a voice mail regarding my appointment times on any of the telephone numbers I have provided on my intake forms.

I authorize Complete Feet and its affiliates to communicate with me via the email addresses I have provided to Pedorthic Care.

I authorize Complete Feet to share information regarding my case with my physicians, and my insurance company.

I understand that I may revoke this consent at any time by giving Complete Feet written notice, and I also understand that I shall receive a written notice from Complete Feet confirming the revocation before it takes effect.

X_____ **Date:** _____

Signature of Patient/Parent/Guardian

X_____ **Date:** _____

Signature of Pedorthic Care Staff or Agent

Complete Feet®

Patient Disclosure and Understanding

Patient Name: _____ Date of Birth: _____

Initial_____ I understand that Complete Feet LLC will bill my insurance on my behalf. I further understand that I am responsible for any, and all charges not covered by my health insurance plan. I understand that the prices of my products are based on a fee schedule determined by my health insurance company. If I do not have insurance, Complete Feet will charge me for my visit and my products based on the Complete Feet usual and customary fee structure.

Initial_____ I understand that Complete Feet LLC and/or my insurance company may change their fee schedules from time to time. I agree to pay any, and all fees in full based on the current price on the date of my service.

Initial_____ I understand that Complete Feet LLC will construct my products based upon instructions given by my physicians.

Initial_____ I grant Complete Feet LLC authorization to communicate with my medical team (including my physicians, nurses, and other medical staff) when necessary.

Initial_____ I understand that Complete Feet LLC will construct a custom product for me, and that this product will not fit anyone other than myself. I also understand that if for any reason I want to cancel my order, I can only do so within 24 hours following my appointment and I will be charged $100 for the office visit and the materials used during my appointment.

Initial_____ I understand that Complete Feet LLC will offer a 90 day warranty period from the day I pick up my custom products. Complete Feet LLC will adjust my products at no additional cost during the warranty period. I also understand that Complete Feet LLC will assess and charge me additional fees after the warranty period has ended.

Initial_____ I understand that Complete Feet LLC will charge a $50 office visit fee for any appointments scheduled after my warranty period in addition to the charges for any materials, products, and services performed at the time of my appointment. I understand that the office visit charge (if no products are rendered) is not covered by my insurance company.

Initial_____ I understand that this agreement is valid as long as I am a patient at Complete Feet, LLC and holds no time limit.

Initial_____ I understand that the DMEPOS standards are displayed in this office, these standards were disclosed to me, and I know that I have the option of receiving a copy of them for my records if I ask for them.

X_____**Date**_____

Signature of Patient/Parent/Guardian