WELCOME TO SAJI ENTERPRISES, PC
New Patient Paperwork
Podiatry Services - Dr. Saji J Simon
Foot and Ankle Services - Dr. Regina Snow
Phone 215-990-9015 Fax 215-979-6720

Print Patient Name________________________________ Date of Birth______________ Sex ____M____F

Employed____Y____N Occupation:____________________ Email________________________________

Home Address____

Home#__________________________ Work#___________________ Cell #________________________

(Please circle one) Married Single Divorced Widowed

**** Please <u>circle</u> which number above to use for reminder calls.**

Race (check one) ☐ Ethnicity – Hispanic ☐ Non-Hispanic

☐ American Indian or Alaska Native

☐ Asian

☐ Black or African American

☐ Native Hawaiian or other Pacific Islander

☐ White__________________

☐ Other____

Preferred Language______________________________________

Emergency Contact _______________________________________Phone #_________________________

Date of last your podiatry visit:____

Reason for your visit: ____Pain Level: _______________

Are you receiving skilled nursing care/therapy in the home? Agency__________________________________

Are you receiving hospice care? Agency____

Primary Physician's Name____

Physician Contact Number__________________________________Date Last Seen____________________

How did you hear about us? (**Please circle**)

Physician Internet Insurance Friend Family Other____________________________________

House Calls: Are you homebound, or is it a challenge to get out of the house for services? _____Yes ____No

<u>Insurance Information</u>

Primary Insurance Name and Policy #____

Secondary Insurance Name and Policy #____

Medicare ID (if not listed above as primary) ____

Policy Holders Name________________________________Social Security # ________________________

Policy Holders Date of Birth ______________________ Patient's Relationship to Policy Holder___________

Patient's Name_____________________________________Shoe Size: _________________________________

Smoker______ pack(s)/day _____ years Previous smoker - YES NO How much/long: ________________

Caffeine Intake__________________________ Alcohol Intake____

Height ____________ Weight ______________

Immunizations

Have you had a Flu shot this season? YES NO Date_____________________

Have you had the pneumonia vaccine? YES NO Date____________________

Other____

Falls Assessment

Number of falls in the last 3 months_______________ Dates____

Were you treated?____

Medications

Please list (or attach) all current medications taken (including supplements) include name of drug, dose, how often taken and how it is taken (i.e. Tylenol 325mg tablet twice a day by mouth).

1.______________________________________ 8.____________________________________
2.______________________________________ 9.____________________________________
3.______________________________________10.____________________________________
4.______________________________________11.____________________________________
5.______________________________________12.____________________________________
6.______________________________________13.____________________________________
7.______________________________________14.____________________________________
Other:____

Allergies Yes No If yes, please list:

____
____
____

Surgeries - List all surgeries you have had. Begin with the most recent. Please give the year.

____
____

EXPLANATION OF PAYMENT POLICY & CONSENT TO TREAT

I hereby authorize Dr. Saji Simon and/or Dr. Regina Snow to release medical information pertinent to the filing of insurance claims for me. I authorize my insurance carrier to pay benefits directly to Dr. Saji Simon and/or Dr. Regina Snow on any unpaid services filed on my behalf. I understand that I AM RESPONSIBLE for payment to Dr. Saji Simon and/or Dr. Regina Snow for charges for the above patient regardless of my insurance coverage. I also understand that Dr. Saji Simon and/or Dr. Regina Snow are not ultimately responsible for collecting my insurance or negotiating settlements of claims. I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have had the opportunity to read and understand the Notice. I also hereby give Dr. Saji Simon and/or Dr. Regina Snow permission to diagnose and administer treatment for my foot and/or ankle condition and authorize any release of information obtained in the course of my treatment. I allow Dr. Saji Simon and/or Dr. Regina Snow to receive and release my personal and medical information that may be pertaining to my treatment, medical history, and diagnosis.

Patient's Signature ____ Date__________________________

Patient's Name_____________________________________ DOB________________________________

Past Medical History

If you now have or have ever had any of the following conditions, please circle and be more specific in the blank space below:

Thyroid Problems Hepatitis____________ Cancer________________________

Ear Disorders ______________ Multiple Sclerosis Hearing Loss Circulation Problems

Eye Disorders _____________ Heart Disease____________ ADD/ADHD Heartburn/Reflux

Lymphedema Anxiety Bipolar Disorder Back Problems Alcohol/Drug Dependency

Anemia ___________ Currently Pregnant Depression High Blood Pressure

Children/Pregnancies Asthma High Cholesterol Gout Rheumatoid Arthritis

Prostate Problems Breathing Problems Current Kidney Dialysis Fibromyalgia

Other Autoimmune Disease________________________ Lupus Osteoarthritis

Pre Diabetes Diabetes: Type I or Type II HIV/AIDS Osteoporosis/bone density

Kidney Problems__________ # of years _________ Neuropathy Parkinson's Alzheimer's/Dementia

Other____

If diabetic, who manages your diabetes?__________________________Phone #:______________________

Last A1C? ________________________________ Performed by/Date: _______________________________

Family History

Please circle any medical conditions that run in your family, and write which family member(s) are affected.

Diabetes _________ Gout __________ Heart Disease__________ Circulation Problems____________

High Blood Pressure__________ High Cholesterol___________

Other____

Pharmacy

Name______________________________________ Phone Number________________________________

Address____

Advance Directive

For those patients 65 years of age or older, do you have a living will or have someone to make decisions on your behalf? YES or NO

DNR or Full code (please circle one)

THIS ENTIRE PACKET MUST BE COMPLETED PRIOR TO YOUR VISIT. Please ask your doctor(s) to fax any missing clinical data to 215-979-6720. Return packet via email to gabrielle@drsimondpm.com, fax 215-979-6720, or mail to SAJI Enterprises, P.C., P.O. Box 60310, King of Prussia, PA 19406. Thank you.

Saji Enterprises, P.C.
Financial Policy-Fees

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our office staff or the doctor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We accept all forms of payment.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctors. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within 60 days, you will receive a bill.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all insurance changes and authorization/ referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- There are certain elective surgical procedures for which we require prepayment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery or at the time of your Pre-op appointment.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due to the office.
- Patients who are 90 days past due on their balance may be sent to collections, unless a payment plan has been put into place.
- Our preferred method of payment is cash or check. There is a service fee of $25.00 for all returned checks.
- In fairness to all of our patients, we understand that emergencies occur, but repeated no shows or cancellations with less than 24 hours' notice will result in a fee of $25.00. You might be asked to pay before you are seen by the doctor.
- Patients who come to the office fifteen minutes later than scheduled appointment might be asked to reschedule.
- **Attn: HOUSE CALL PATIENTS:** your travel fee is **$___**, and is **DUE** at time of service. **___ Please initial**. *Thank you.*
- Patient medical records are the property of Saji Enterprises, P.C. Any patient requesting a copy of their medical record may be charged a fee that follows guidelines set forth by the Pennsylvania Department of Health.

Signature of Patient/Financial Responsible Party_________________________________Date____________

Financial Responsible Party's Address (if not the patient)____

____

Printed Name of Patient/Financial Responsible Party____

Relationship to patient____

Saji Enterprises, P.C.
HIPAA Compliance Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we call, email, or text you to confirm appointments? YES NO (**circle options that are acceptable**)

(I **understand** that any information sent to me via email, and/or via text message from persons at Saji Enterprises, PC will **not be sent securely and will be unencrypted**. **I understand the risks** associated with that including, but not limited to, that my **Protected Health Information (PHI) may be read by an unintended third party**. I have been notified of the risks, I understand said risks, and **I still prefer to receive PHI via unsecure communications via email and text messages.** I understand that Saji Enterprises, PC and its staff are not responsible for any unauthorized access of my PHI communicated by way of unencrypted email and texts, and I bear the risk.)

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical information with family or a designated person? YES NO

If YES, please list name, phone number, and relationship to patient of those allowed:

____

____

This consent was signed by: ____

(PLEASE PRINT NAME)

Signature: ____ Date: ______________

Guardian/Witness: ____Date: ______________

P.O. Box 60310, King of Prussia, PA 19406
Patient Services 215-990-9015 Fax 215-979-6720

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ID #: ______________________________ **DATE:** ______________

Over the last *2 weeks*, how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	____	+ ____	+ ____
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).	TOTAL:			

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	
	Not difficult at all ________
	Somewhat difficult ________
	Very difficult ________
	Extremely difficult ________

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