Kevin J. O'Brien, DPM, BS, BA

2017 N Stockton Hill RD
Kingman, AZ 86401

500 N Lake Havasu Ave #D104
Lake Havasu City, AZ 86403

928.854-4307 (P) / 928.854.4339 (F) / drobriendpminc@gmail.com / havasupodiatrist.com

MEDICAL HISTORY

Patient Name _____ Date of Birth _____ Phone _____
Height: _____ Weight: _____ Shoe size: _____ Width: _____
Present foot/ankle complaint _____ PLEASE CIRCLE: **RIGHT** or **LEFT**
Is your problem due to an accident? **YES** or **NO** Date of injury? _____ Location of injury? _____
SELECT ONE: ___ Industrial ___ Personal injury ___ Auto injury ___ other: _____
How long has this condition been bothering you? _____
Have you treated this condition? **YES** or **NO** Type of Treatment: _____
Have you had previous care by a foot specialist? **YES** or **NO** Doctor's Name: _____

Do you *currently* suffer from or have you ever been treated medically or surgically for any of the following? (Check all that apply)

___ Heart Disease
___ Diabetes___ I___ II
___ High Blood Pressure
___ Low Blood Pressure
___ Respiratory Disease
___ Thyroid (High or Low)
___ Circulation Disease
___ Varicose Veins
___ Stomach Ulcers
___ High Cholesterol

___ Drug Abuse
___ Alcohol Abuse
___ Keloid Scars
___ Arthritis ___RA
___ Hepatitis
___ Gout
___ Asthma
___ Kidney Disease
___ Liver Disease
___ Leg Cramps

___ Immune System Disorders
___ Cancer
___ Alzheimer's
___ Bleeding Disorder
___ Epilepsy
___ Neuropathy
___ Restless Leg Syndrome
___ Fibromyalgia
___ Osteoporosis/Osteopenia
___ Anxiety

___Parkinson's
___ M.S.

Please list any other medical problems Dr. O'Brien should be aware of: _____
_____

Primary Care Physician: _____ Last Visit: _____ Phone: _____

- Are you currently on Home Health or Hospice: **YES** or **NO**

Smoking Status (Please select one):

___ Current Every Day Smoker ___ Current some day smoker ___ Former smoker
___ Never smoker ___ Quit within past year ___ Smokeless tobacco

- Alcohol Use (Please circle one): None Rarely Weekly 1 – 2 times per week 3 times or more per week Daily
- Are you pregnant? **YES** *or* **NO** Delivery Date? _____
- Past Surgical History:_____
- Pharmacy: _____ Medication allergies & reactions: _____
- What medicines are you currently taking? (INCLUDING ASPIRIN AND VITAMINS)

I hereby give permission to Dr. O'Brien to examine and treat my podiatric problems. I have answered all of the above to the best of my knowledge. I understand and agree that I am financially responsible for all services rendered to me.

Patient Signature_____ Date _____

Parent/Guardian signature_____ Date_____

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PATIENT INFORMATION

PATIENT INFORMATION:

Last Name: _____ First name: _____
Date of Birth: _____ Age: _____ Sex: MALE or FEMALE
Social Security Number: _____ Phone: _____ Email:_____

Marital Status: Single / Married / Divorced / Widowed / Living Together
Employment: Unemployed / Full Time / Part Time / Student / Retired

Race: ___ African American ___ European ___ Hispanic ___ Asian ___ Hawaiian
___ Latin American ___ American Indian ___ Pacific Islander ___ White
Ethnic Group: ___ African American ___ Asian ___ Hispanic ___ Hispanic/Latino
___ Latin American ___ Latino ___ Non-Hispanic/Latino ___ Unknown

Mailing/Permanent Address: _____City: _____ State: ___ Zip: _____

RESPONSIBLE PARTY: Self / Mother / Father / Spouse / Guardian / Other: _____

RESONSIBLE PARTY INFORMATION (if other than patient):

Last Name: _____ First name: _____
Date of Birth: _____ Relation to Patient: _____
Mailing/Permanent Address: _____
City: _____ State: _____ Zip Code: _____ Phone: _____

IN CASE OF EMERGENCY CONTACT:

Last Name: _____ First Name: _____ Relation: _____
Primary Phone: _____ Secondary Phone:_____

If you would like us to bill your insurance, please make sure you have provided your insurance cards and completely answer all of the following. If the required information is not available at the time of service, you will be responsible for all fees associated with your visit at the time of service. You may email information to office email at drobriendpminc@gmail.com .

PRIMARY INSURANCE:

Insurance Company Name: _____ Member ID#:_____
Primary Insured: Self / Mother / Father / Spouse / Other: _____

PRIMARY INSURED'S INFORMATION (if other than patient):

Last Name: _____First name: _____Date of Birth: _____

SECONDARY INSURANCE:

Insurance Company Name: _____ Member ID#:_____
Primary Insured: Self / Mother / Father / Spouse / Other: _____
Member ID#:_____

PRIMARY INSURED'S INFORMATION (if other than patient):

Last Name: _____First name: _____Date of Birth: _____

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FINANCIAL AGREEMENT & INSURANCE AUTHORIZATION

Please initial and/or check next to each of the items below stating that you have read and understand:

1. ____ If your deductible has not been met, you understand that you will be responsible for all charges related to your visit. **MEDICARE** HAS A DEDUCTIBLE THAT SOME SECONDARY INSURANCE PLANS DO NOT COVER. Please check your coverage *prior* to your appointment.

2. ____ You are responsible for paying your co-payment **at the time of your visit**. Co-payments will not be billed to patients.

3. ____ If you do not have proper insurance documentation at the time of your visit, you will be required to pay in full for all services rendered.

4. ____ Our office DOES *NOT* guarantee that your insurance carrier will pay. If a claim is denied or not paid by your insurance carrier, you are responsible for the full amount of your bill.

5. ____ You understand that if your account goes unpaid after three statements have been sent OR within ninety (90) days following your visit (whichever comes first), your account may be turned over to collections. You understand that an additional 40% of the balance will be added to your bill to offset the fees associated with the collection agency. You agree to pay all collection/legal fees as well as late charges for all unpaid balances on your account.

6. ____ Our office handles all billing with an outside source. You understand that all billing inquiries should be directed to our biller at (928) 237.4433

7. ____ You authorize Dr. Kevin J. O'Brien, DPM to furnish any required documentation to your insurance company concerning your illness and/or treatment.

8. ____ You understand our office is *not* responsible for verifying patient's coverage, benefits, and/or deductible

9. ____ I understand that Dr. O'Brien DPM Inc does not verify if your insurance is in network, as that responsibility lies on the patient. As a result, I understand I may be responsible for additional fees.

10. ____ You understand that you may be charged a fee of up to $25.00 for each missed appointment or appointment cancelled without twenty-four (24) hour notice.

11. ____ You understand that if multiple appointments are missed, cancelled, or rescheduled, you may be discharged from this office and Dr. Kevin J. O'Brien, DPM may discontinue treatment.

12.____ You understand that any payments made with credit/debit will have a 3.5% processing fee.

Please Initial ONE:

_____ I DO want Dr. Kevin J. O'Brien, DPM to submit the claim for today's visit to my insurance company for payment. I authorize payment directly to Dr. Kevin J. O'Brien, DPM for all surgical and/or medical benefits otherwise payable to me for his services.

_____ I DO *NOT* want Dr. Kevin J. O'Brien, DPM to submit the claim for today's visit to my insurance company for payment. I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR PAYING IN FULL FOR ANY OFFICE VISITS AND/OR TREATMENTS AT THE TIME OF SERVICE.

_____ I DO NOT have insurance/medical coverage and understand that I am a SELF PAY patient. I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR PAYING IN FULL FOR ANY OFFICE VISITS AND/OR TREATMENTS AT THE TIME OF SERVICE.

_____ _____

Patient Signature Date

Parent/Guardian signature _____ Date _____

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NOTICE OF PRIVACY POLICIES & PATIENT CONSENT FORM

Our Notice of Privacy Policy provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent.

By signing this form you are agreeing to the privacy practices of Dr. Kevin J. O'Brien, DPM as disclosed in the Notice of Privacy Policy. You also consent to our use and disclosure of protected health information about you for treatment, payment, and health care options. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

You understand by signing this consent, it will be effective immediately with no expiration date.

You give your consent to disclose medical information to the following family members, friends, other physicians, companies, or entities:

Name	Contact Information	Relationship

You understand that if anyone not listed above requests information regarding appointments, payment, diagnosis, treatment, etc., we cannot disclose this information to them until a written authorization is received from you. This includes other physicians, spouses, parents, children, etc.

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Parent/Guardian signature _____ Date_____

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PRESCRIPTION

I understand that I am only to take prescription medication as prescribed. I will not take any sedatives, alcohol, or other medications in combination with any medications prescribed by Dr. Kevin O'Brien without prior approval.

I understand that certain medications require periodic follow up appointments. I understand that I will only be prescribed an amount of medication and a number of refills that Dr. Kevin O'Brien considers safe and is within the laws and regulations regarding that medication.

I understand that prescriptions will be provided only during regularly scheduled appointments. I am responsible for scheduling an appointment 3 days *prior* to needing a medication refilled. Refill requests must come by fax directly from the pharmacy and may take up to 72 hours (3 business days) for processing. Continuously calling the office will not get a prescription refilled any sooner.

REFILLS WILL NEVER BE PROVIDED BY TELEPHONE. I understand that Dr. Kevin O'Brien is under no obligation to provide these medications to me and that he reserves the right to discontinue any medications at any time.

☐ _____ ***PLEASE CHECK IF CURRENTLY BEING TREATED BY PAIN MANAGEMENT***

REGARDING PAIN MEDICATION:

I WILL NOTIFY DR. KEVIN O'BRIEN IF I HAVE A PAIN MANAGEMENT CONTRACT WITH ANY OTHER PHYSICIANS. If I fail to notify Dr. Kevin O'Brien of any pain management contracts I have and request or receive pain medication from him, I understand that the other physician/office will be notified that I am acting against my pain management contract. This may result in discontinuation of medications or discharge from one or both physicians.

If pain medication is prescribed by Dr. Kevin O'Brien, I will not seek or accept any pain medications to be prescribed by another physician. I understand that I cannot obtain pain medication from a different physician while receiving pain medication from Dr. Kevin O'Brien. I understand that lost or stolen medications will not be refilled under any circumstances. It is my responsibility to protect and secure my medications. This includes keeping the medication out of reach of children.

In addition, I accept the right of Dr. Kevin O'Brien's medical staff to terminate this agreement if I: *(1)* seek or obtain pain medication from a source other than Dr. Kevin O'Brien, *(2)* if I give, sell, or in any way distribute my prescribed medication to any other person(s), *(3)* if I in any way attempt to forge or alter a prescription, *(4)* my medical condition declines to the point at which in the judgment of Dr. Kevin O'Brien, continued therapy with this medication presents a danger to my wellbeing or safety, and/or *(5)* if there is evidence that I am no longer receiving therapeutic benefit from the medication or Dr. Kevin O'Brien determines that I am no longer a good candidate to continue the medication. By signing this agreement, I understand and will abide by the rules reviewed above. Failure to abide by this agreement may result in termination of medication prescriptions and/or possible termination of services from Dr. Kevin O'Brien and his practice.

I understand that Dr. Kevin O'Brien may require specialist evaluation of my treatment, and I agree to keep appointments when my physician refers me. I understand that if I regularly request pain medication over an extended period of time or I request large quantities of pain medication, Dr. Kevin O'Brien may refer me to pain management. I understand that if I refuse a referral to a pain management physician, Dr. Kevin O'Brien may discontinue further pain medication prescriptions.

Patient Name: _____ Signature: _____ Date: _____

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APPOINTMENT CONFIRMATION

Our office participates in text appointment confirmation and/or email appointment confirmation. Please list the cell phone number and/or email address below indicating which form of appointment notifications you prefer.

☐ Please text appointment confirmations to:

_____

☐ Please email appointment confirmations to:

_____

☐ Please check the box if you prefer to receive phone call confirmations

By signing this form, you are agreeing to receive text appointment confirmations and/or email appointment confirmations. Our office is not responsible for any fees that may be incurred by your phone company.

Patient Name: _____ Signature: _____ Date: _____