Dear Patient:

It is with greatest pleasure that we welcome you to Hermes Healthcare PA serving greater Wichita and Central Kansas. The nursing team and I are very proud of the medical/nursing services we offer, including both specialized foot care and primary health care. We hope you will quickly feel at ease with our staff and confident of our care. For your convenience, we have included our new patient forms on our website. Please complete the consent to treat, patient information, medical history, and the financial responsibility forms, and mail to our Wichita office (if time allows) or bring them with you to your appointment. We also ask that you bring your insurance cards to your first appointment.

Billing Process: In most cases, your health insurance carrier will be billed within seven days after services have been provided. Medicare currently pays 80% of foot care procedures after the patient has met the deductible. Your insurance co-pay and deductible will be determined by your health insurance carrier based on the benefits, as stated in your policy. Federal and State insurance regulations prohibit the medical clinic from discounting or waiving your assigned co-pay or deductible. If you have questions regarding your co-pay and deductible, contact your health insurance carrier by calling the benefits telephone number on your insurance card. If you have any questions regarding the status of your account, or if you would like to pay your co-pay/deductible by telephone, please contact our office at 316.260.4110. Please be advised that the following will be reflected as surgical procedures on your bill: nail avulsion, callus removal, ingrown nail removal, and trimming of nails.

Important Note: Your first appointment will be billed as an initial visit (an increased charge), because a thorough assessment and review of your health history will be conducted to determine eligibility due to conditions including, but not limited to, diabetes, peripheral vascular disease, renal insufficiency, neuropathy, vitamin/protein deficiency.

Patient Portal: By providing Hermes Healthcare with your email address, you will be able to view your medical file through our website: hermeshealthcarepa.com.
If you have any questions, please do not hesitate to call us at 316.260.4110 or email us at info@hermeshealthcarepa.com. We look forward to meeting you and serving your medical needs.

Sincerely,

Jayne Hermes, Owner
APRN, NP-C, CFCN HH-PN02 (04/15)

HERMES HEALTHCARE PA

3343 West Central Avenue - Wichita, Kansas 67203

CONSENT TO TREAT

Name: ______________________ **DOB:** ______________ **Date:** ________________

How would you prefer to be contacted? *Please check all that apply*

Home Telephone:

☐ OK to leave message with detailed information.

☐ Leave a message with a callback number only.

Work Telephone:

☐ OK to leave message with detailed information.

☐ Leave a message with a callback number only.

Written Communications:

☐ OK to mail my home address.

☐ OK to mail my work/office address.

☐ OK to fax to provided fax number.

☐ OK to email to provided email address.

The Following Individuals May be Contacted: *for* **Protected Health Information** *and /or* **Insurance Information**

			for	Protected Health Information	and/or	Insurance Information
Name:	**Relationship:**	**Phone:**		☐		☐
Name:	**Relationship:**	**Phone:**		☐		☐
Name:	**Relationship:**	**Phone:**		☐		☐

CONSENT TO TREAT: I, as the patient or durable power of attorney for the patient, authorize Hermes Healthcare, Inc. to treat. I understand that Hermes Healthcare, Inc. will be asking for my medical history in order to plan the best course for my treatment. I also understand that certain services I may require are defined by Medicare as "surgery", (e.g. callus removal) and that surgical instruments are not used in this treatment and there is no intent by Hermes Healthcare, Inc. to break the skin in any way. I understand these procedures may also include and are not limited to, ingrown nail removals and foreign body removals. I authorize Hermes Healthcare, Inc. to access my medication history through a pharmacy network. I authorize Hermes Healthcare, Inc. to communicate with and send documentation to my treating healthcare provider.

ASSIGNMENT OF BENEFITS: I hereby authorize payment of my medical benefits, including, but not limited to Medigap benefits, private Insurance, Medicaid, Medicare and any and all other benefits payable by an insurer to Hermes Healthcare, Inc. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all records necessary to secure payment. If I am insured by Medicare, I request that payment of authorized Medicare benefits be made on my behalf to Hermes Healthcare, Inc. for any services provided to me. I authorize my holder of medical information about me to be released to CMS and its agents any information needed to determine these benefits or the benefits payable for related services. I agree to be personally responsible for payment of services which are not covered by insurance.

PHOTOGRAPHS: I hereby give permissions for Hermes Healthcare, Inc. to photograph my foot (feet). I understand the photographs will be used for medical documentation of my foot condition and teaching purposes only, and the photographs will become part of my permanent record.

ACKNOWLEDGEMENT: I acknowledge that I have received a copy of the Hermes Healthcare, Inc. notice regarding the use and disclosure of my health information.

______________________________ ______________________

SIGNATURE DATE

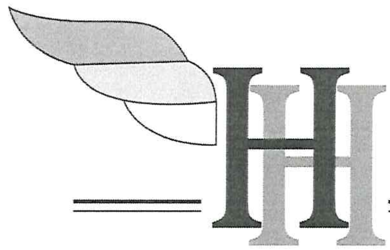
VERBAL CONSENT: When obtaining verbal consent to treat a patient is necessary to designate the reason for the verbal consent and have it witnessed, please do so in this area

Need for Consent: ______________________ Given By: ______________________

Taken By: ______________________ Witnessed By: ______________________

PATIENT INFORMATION FORM

Patient Information					
Name:	Enter Patient Name			**DOB:**	
Address:					
Phone:		**Fax:**			
SSN:		**Sex**		Marital Status:	
Email:					
Ethnicity:					
Contact Person(s):	Person 1	Person 2			
	Name:	Name:			
	Ph	Ph			
	Relationship:	Relationship:			
Responsible Party if not Self:	Name Relationship Address City, State, Zip Phone				
Responsible Party for Medical Decisions:	Name Relationship Address City, State, Zip Phone				



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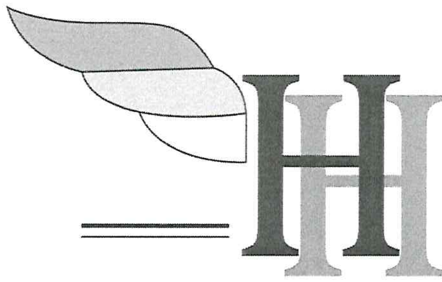
	Phone

Primary Care Physician Information	
Name:	Physician Name.
Address:	Address Line 1 Address Line 2 City, State, Zip
Phone:	Enter Phone Number.

Medicare Screening Information		
	Yes	**No**
Is the patient a veteran?	☐	☐
If yes, Did the VA refer the patient?	☐	☐
If yes, Does the patient have a Fee Basis ID Card?	☐	☐
Is the visit due to an accident?	☐	☐
Is the patient covered by an employer's work group health plan?	☐	☐

Mission to Disclose Protected Health Information:
In general the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.



HERMES HEALTHCARE PA
3343 West Central Avenue - Wichita, Kansas 67203

PATIENT MEDICAL HISTORY for FOOT CARE

Name: ______________________ **DOB:** ______________ **Date:** ______________

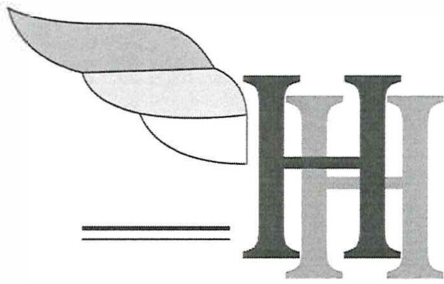
Name of Primary Care Provider: ______________________________

GENERAL

	Yes	No		Yes	No
Have you ever seen a podiatrist in the past?	☐	☐	**Have you been hospitalized for any reason in the last year?**	☐	☐
Are you a victim of violence or abuse?	☐	☐	*If yes:* Date: / Reason?		
Do you use alcohol?	☐	☐	**Recent travel outside the United States?**	☐	☐
If yes, how much per day?			*If yes:* Date: / Reason:		
Do you smoke cigarettes?	☐	☐	**History of or present cancer?**	☐	☐
If yes, Packs per day?	Years?		*If yes*, Radiation?	☐	☐
IV drug use?	☐	☐	*If yes*, Chemotherapy? *If yes,* What kind of Cancer?	☐	☐

PREVENTION HISTORY

Last Flu Shot	**Date:**	**Tetanus/Pertussis/Diphtheria**	**Date:**
Coronavirus Vaccine 1st Shot	**Date:**	**Last Dental Exam**	**Date:**
Coronavirus Vaccine 2nd Shot	**Date:**	**Mammogram/PSA**	**Date:**



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PATIENT MEDICAL HISTORY for FOOT CARE

Pneumonia Shot	Date:	Colonoscopy	Date:
Shingles Shot	Date:	Last Eye Exam	Date:

Signs and Symptoms

If your legs or feet hurt, describe where:

How would you describe the pain?
Check all that apply: ☐ Aching ☐ Burning ☐ Cramping ☐ Heaviness ☐Sharp ☐ Shooting ☐ Tingling ☐ Throbbing
☐ Other____

Is the pain ☐ constant or ☐ intermittent?	☐ Do you have leg pain when walking?	How far can you walk? ________________	☐ Does the pain go away when you rest?

☐ Do you have foot pain/leg pain at night? ☐ if yes, is the pain relieved by hanging your foot down?	☐Have you ever had foot or leg wounds that were slow to heal? If yes: Location______________________________ Treatment______________________________

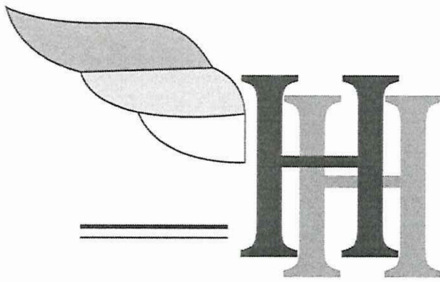
☐ Do you have changes in your hair and skin on your legs/feet?
☐ Decreased hair on your legs? ☐ Thick toenails ☐ Yellow or chalky toenails ☐ Funny looking toenails
☐ Thin skin ☐ Shiny skin ☐ Red or blue toe skin ☐ Red or brown discoloration of legs
☐ Cold feet ☐ Toe deformities (hammer/claw toes, etc.)
☐ Toe pain? Which toe____________________? ☐ Foot deformities: ☐ Bunion, ☐ high arch, ☐ flat foot
☐ Calluses ☐ History of ingrown toenails ☐ Swelling of your legs/feet

Medical History

☐ Heart disease ☐ Stroke or Transient Ischemic Attack ☐ Atrial Fibrillation or other arrythmia ☐ Aortic Aneurysm
☐ History of blood clot ☐ High Blood Pressure ☐ On mediation for blood pressure ☐ High cholesterol
☐ Atherosclerosis (plaque in arteries) ☐ Previous angioplasty, stents, or bypass surgery: __Heart or __legs
☐ Peripheral edema (swel ling) ☐ Peripheral vascular disease ☐ Raynaud's disease ☐ Varicose veins ☐ History of infections in legs/feet

Other systemic conditions:
☐ Diabetes Type 1 (insulin) ☐ Diabetes Type 2 ☐ Chronic Kidney disease ☐ Are you on Dialysis
☐ Neuropathy ☐ Liver disease

Nutritional conditions:
☐ Vitamin B12 Deficiency ☐ Vitamin D Deficiency ☐ Other Vitamin Deficiency ______________________



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PATIENT MEDICAL HISTORY for FOOT CARE

☐ Deficiency related to cancer treatment ☐ Deficiency related to alcoholism ☐ Deficiency related to Celiac disease
☐ Deficiency related to Chronic gastrointestinal conditions

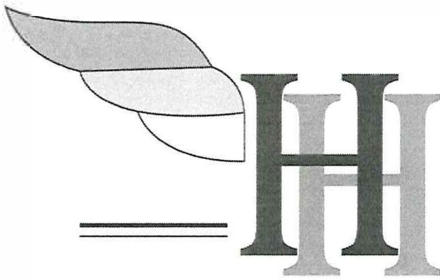
Functional conditions:
☐ Chronic back pain/issues ☐ Difficulty walking ☐ History of falls ☐ Memory impairment ☐ Restless Leg Syndrome
☐ Arm weakness: __ Right __ Left __ Both ☐ Leg weakness: __ Right __ Left __ Both
☐ Intellectual disability ☐ Obesity

SURGERIES

Date:	Procedure: Heart, Foot or Vascular

MEDICATION LIST Prescription and Over the Counter

Medication:	Dose:	Doses Per Day:



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PATIENT MEDICAL HISTORY for FOOT CARE

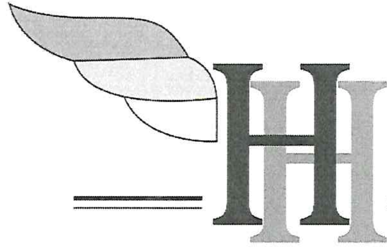
ALLERGIES
Medication/Anesthetic Allergies:

Significant Medical Family History: Relationship (Mother, Father, etc.)	**Heart, Kidney, Diabetes, Aneurysm**

Patient Signature: ______________________________ **Date:** ________________

Nurse Practitioner: ________________ **Signature**______________________________

Review Date: ________________ **Initials:** ______



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INSURANCE VERIFICATION

PATIENT NAME:

INSURANCE COMPANY NAME:

Insured's Name:	Relationship to Patient:
Policy I.D. Number	Group Number:
Insured's Date of Birth:	
Effective Date of Policy:	Is there a deductible: ☐ Y ☐ N
Co-Payment or Co-Ins. ☐ Y ☐ N	If yes, how much?
Is the practitioner in network? ☐ Y ☐ N	
Secondary Insurance:	
Insured's Name:	Relationship to the Patient:
Group Number:	Policy I.D. Number
Insured's Date of Birth:	Insurance Company Phone:

Our Financial Policy And How It Works For You

Whether you are paying cash or using insurance, you are always ultimately responsible for your bill. Co-pays are due at the time of service.

Your Responsibilities

- Please know and understand your insurance benefits.
- Please pay your co-pay at the time of your treatment.
- Please read and keep your Explanation of Benefits statements from your insurance.
- Please follow up promptly with claims not paid by your insurance company, or you will be billed directly for them.
- **Please make any cancellations with at least 12 hours' notice or you may be billed.**

Patient's signature:________________________________ Date: ____________________________________