MAPLE SPRINGS AMBULATORY SURGICAL CENTER
MAPLE SPRINGS FOOT CENTER
PODIATRISTS- FOOT SPECIALISTS
10810 DARNESTOWN RD, SUITE 101
GAITHERSBURG, MD 20878
(301)- 762 FEET (3338)
(301)- 762- 1585 (FAX)
www.drstuartsnyder.com

NEW PATIENT PAPERWORK- Your insurance company requires that we obtain this information. Please fill it out **completely!**

LAST NAME: _____ **MIDLE INITIAL:** _____ **FIRST NAME:** _____

PREFERRED NAME (IF OTHER THAN LEGAL) _____ **DATE OF BIRTH:** _____

STREET ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

E-MAIL ADDRESS: _____

HOME # _____ **WORK #** _____ **Cell #** _____

BEST WAY TO CONTACT YOU: _____ **SOCIAL SECURITY NUMBER:** _____

LEGAL GUARDIAN OR POA NAME (If under 18 or incapable): _____

HEIGHT: _____ **WEIGHT:** _____ **SHOE SIZE:** _____ **GENDER:** _____

PRIMARY LANG: _____ **RACE:** _____ **ETHNICITY: Hispanic / Non-Hispanic**

PRIMARY CARE PHYSICIAN _____ **PHONE NUMBER** _____

MEDICAL HISTORY: Please circle if you have, or have had, any of the following:

Acid Reflux	Diabetes Type I	Hepatitis	Neurological Disorders	Rheumatoid Arthritis
Alcoholism	Diabetes Type II	High Blood Pressure	Osteoarthritis	Seizures
Cancer	Heart Attack	High Cholesterol	Osteoporosis	Stroke
Depression	Heart Disease	HIV/AIDS	PVD	TIA (mini stroke

LIST OTHER HEALTH HISTORY HERE: _____

SURGICAL PROCEDURES: Have you ever had any surgery? __Yes __No if yes, please circle:

Appendectomy	Foot/ Ankle	Heart Surgery	Hysterectomy	Knee Replacement
Cancer Related Surgery	Gallbladder Removed	Hip Replacement	Ingrown Toenail	Pacemaker

LIST OTHER SURGICAL HISTORY HERE: _____

FAMILY HISTORY: Please circle if your MOTHER and/or FATHER have, or have had any of the following

Cancer **Mom/Dad**	Eczema **Mom/Dad**	High Blood Pressure **Mom/Dad**	PVD **Mom/Dad**
Diabetes **Mom/Dad**	Heart Disease/Failure **Mom/Dad**	High Cholesterol **Mom/Dad**	Stroke **Mom/Dad**

LIST OTHER FAMILY HISTORY HERE: _____

MEDICATIONS (prescribed or OTC): Please list here or provide us with a medication list:

_____

_____

_____

_____

DRUG ALLERGIES: Please list here:_____

PHARMACY INFO: Name_____ Address_____
(RX are sent to your pharmacy electronically unless otherwise specified.)

SOCIAL HISTORY:
Marital Status: Single / Married / Widowed / Divorced / Separated
Who do you live with? _____
Are you currently pregnant? YES NO _____ **Are you nursing? YES NO** _____
How many children do you have?_____
Employment: Employed / Unemployed / Disabled/ Retired **Occupation:**_____
Tobacco Use: Smoker / Former Smoker / Never Smoked **Amount per day:**_____
Caffeine Use: None /Coffee / Tea / Soda **Amount per day:**_____
Exercise: Inactive / Light / Moderate / Vigorous

WHAT IS YOUR CURRENT FOOT/ANKLE DIFFICULTY?_____
WHEN DID THIS PROBLEM BEGIN?_____
HOW DID YOU HEAR ABOUT OUR PRACTICE?_____

Primary Insurance:	**Secondary Insurance:**
ID #:	**ID #:**
Group #:	**Group #:**
Policy Holder:	**Policy Holder:**
Policy Holder DOB:	**Policy Holder DOB:**

*I hereby give my permission to allow the doctor(s) to examine me and I understand treatments will be explained to me before they are started. I understand I am financially responsible for all charges for the services given to me, including the balance remaining after the payment of possible insurance benefits. Accounts that are over 90 days are subject to late, collection and rebilling fees. Should my account be turned over to an attorney, I agree to pay 100% collection fee of the balance owed and all court costs.

*Appointment Reminders are sent via e-mail and text message, if you do not wish to receive these reminders, please notify our staff.

Signature:_____ **Date:**_____
(Patient or Legal Representative)

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PATIENT HIPAA CONSENT FORM

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used to disclose to carry out treatment, payment and health operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name;_____

Signature:_____

Relationship to Patient (other than self):_____

Date:_____

Please select one:

_____ It is okay to leave detailed medical information regarding my treatment on voicemail.

_____ It is NOT okay to leave detailed medical information regarding my treatment on voicemail.

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Patient Financial Policy

- Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions in regards to finances, please discuss them with our front office staff or supervisor. Dr. Snyder does not answer questions about finances- he is the doctor not the administrator. 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 healthcare insurance carrier, payment for office services are due at the time of service. We accept VISA, MasterCard, Discover, American Express, Care Credit, cash or check.
- 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 doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period of time, we will look to you for payment.
- We have made prior arrangements with certain insurance companies and other health plans to accept an assignment of benefits. We will bill these plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment direct to you. Therefore, all charges for your care and treatment are due at the time of service.
- 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 some specialized 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.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those.
- Past due amounts are subject to collection proceedings. All costs incurred, but not limited to, collection fees and court costs shall be your responsibility in addition to the balance due to this office.
- There is a service fee of $35.00 for all returned checks. Your insurance company does not cover this fee.

Signature of Patient/Responsible Party:_____ Date:_____

Witness Signature:_____ Date:_____

_____ Patient initials to indicate copy received