SIMMONS' PODIATRY, P.A. 1861 Admiralty Blvd., Rockledge, Florida 32955
Orlando (407)647-2914 Kissimmee/ST Cloud (407)414-8590 Brevard (321)728-1996
NEW FAX (321)305-6005
PERSONAL AND CONFIDENTIAL INFORMATION

I am Dr. Richard Alan Simmons, a podiatrist who has been licensed in Florida since 1982. I began my practice in Winter Park, Florida and maintained an office-based practice until 1994. I transitioned the practice providing basic podiatric care to the homebound elderly in the greater Central Florida area. You will interact with my employees: Cara (office manager) and Chris (office assistant.)

Insurance filing and billing are performed by SAMMY EHR.

The practice is limited to those patients who are homebound by Medicare criteria. If you are unsure if you meet Medicare's criteria, please contact your primary care physician's office. Second, there needs to be a medical necessity for the services rendered. Typically, that "medical necessity" is pain. Frail, bed-bound, diabetic or persons with poor circulation meet a unique medical necessity for foot care. The lighting in your home should be bright for the doctor to see your feet. The doctor does not climb stairs.

The following pages need to be filled out as completely as possible, mailed to or faxed back to my office, before we can schedule your visit. The "Notice of Privacy Practices" is available from our website at http://www.MobilFootDoc.com or you can request a copy from me directly. If you are under the care of a home health care agency (e.g., Wuesthoff, Florida Hospital Home Care, VNA-ORHS, Parrish, Omni, Kindred, etc.) you may ask the agency to fax to my office their plan of care, also known as HCFA/CMS-485. Appointments are scheduled according to your location and one of 4 time blocks: 8-9:30, A.M. (9-12), 10-2, or P.M. (12-5). We regret we cannot schedule exact appointment times. **ALL NAIL POLISH MUST BE REMOVED PRIOR TO VISIT PLEASE!**

I look forward to seeing you soon.

HOSPICE PATIENTS PLEASE NOTE

If you are under the care of a hospice agency please let us know. As you are aware, Hospice is not a replacement for supplemental insurance to Medicare Part B. All physicians (including podiatrists) must bill Medicare part B for services rendered. Medicare pays 80% of the allowable and the remaining 20% is the responsibility of the patient or is paid by the supplemental insurance. Hospice does not pay the annual deductible ($233 for 2022) or the 20% co-pay: these are the responsibility of the patient.

What to expect: on the day of your visit you (the patient) should be seated comfortably in a reclining chair or in bed. The doctor will bring a stool on which he sits at the foot of a reclining chair; if in bed, please provide a chair or have the bed raised to standing height. **Please have available a towel or chucks (that is at least 30 inches by 18 inches) or other absorbent material (not a paper towel) that will go under the patient's feet to catch clippings.** For the comfort of the patient, the feet and nails may be soaked with plain warm-water for approximately fifteen minutes (bed-bound, a warm-moist towel can be placed on the toes). When he arrives, the doctor will be in live communication with Cara (cell phone). This allows the doctor to spend more time listening and no time writing. Occasionally the doctor will talk directly with Cara. To help with this process, please have the television and radio turned off during the visit. Any prescription will be faxed or submitted electronically to your pharmacy by the end of the day. Any thick, fungal and/or infected nails will be collected and sent to Bako Pathology Services.

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Patient Name: **Patient ID:** **Referred By:**

Please Print All Information in BLACK ink. You may mail or fax.

For the service to be paid by Medicare, the 1995 correct coding initiative requires completion of this form. Please sign and date in the appropriate box at the middle of the office policy page.
(Name information should be EXACTLY as it appears on the Medicare Card.)

PATIENT NAME: _____ **PHONE**: _____

ADDRESS: _____

(IF ALF, please indicate):_____

EMAIL: _____@_____ **PLEASE NOTE ANY GATE CODES or special directions.**

D.O.B: _____ Weight: _____ Height: _____ Sex: _____

Race: African American / Asian/ White/ Native Hawaiian / Am.Indian **Ethnicity**: Hispanic/Non-Hispanic/Not Specified

Preferred Language: _____

PRIMARY CARE PHYSICIAN: (Please put first and last name)

Name: _____ Phone: _____ Last Visit: _____

PHARMACY: _____ (nearest intersection) _____ **PHONE: _____**

Do you have: **Medicaid?** ☐ Yes ☐ No Or a **Medicaid replacement such as CarePlus/Staywell/etc?** ☐ Yes ☐ No

Are you under the care of a Hospice Agency?: ☐ Yes ☐ No Which agency & doctor? _____

EMERGENCY CONTACT PERSON: (If patient resides in an ALF, must have this information!)

Name: _____ Relationship to patient: _____

Address:_____

City:_____ State: _____ Zip:_____ Phone:_____

Power of Attorney:_____ (name)

Does this person also have Durable Medical Power of Attorney? _____

Last Time You Were Hospitalized: When: _____ Why:_____

Where: _____ How Long: _____

Any Surgeries: _____

Please Explain Why You Need Foot Care: _____

How Long Have You Had This Problem?: _____

Medicare considers homebound to mean that the patient has a medical condition that **only** allows him/her to leave the home with the use of assistive devices (cane, walker, wheelchair, ambulance, etc.) or another person OR your doctor believes that your health or illness could get worse if you leave your home, AND it is difficult for you to leave and you typically cannot. Bedbound persons are homebound. Patients with severe dementia and/or Alzheimer's are also considered homebound.
By this definition, I believe the patient ☐ IS ☐ IS NOT Homebound.

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Patient Name: **Patient ID:** **Referred By:**

(the term "patient" throughout this office policy refers to the patient whose signature or signature of his/her guardian is below)

PATIENT'S ADDRESS: _____

DOB:_____ **Medicare #:** _____ **SS #:** _____

SECONDARY Insurance (If none write "none"): _____ Policy #: _____

Address:_____

City:_____State:_____Zip:_____**PHONE:**_____

POA/RESPONSIBLE PARTY: NAME_____ **RELATIONSHIP:**_____

Mail any bills to: _____

Phone: _____ COMMENTS: _____

➔X DATE: ←

SIGNATURE of the Patient or Guardian for the Patient

OFFICE POLICY 2022

Payment or authorization to file an insurance claim form is required at the time of service. Dr. Richard A. Simmons is an authorized Medicare provider. This means that this office will not collect more than the MEDICARE APPROVED AMOUNT on Medicare APPROVED PROCEDURES (Medicare Part B allows coverage for services and items which are medically reasonable and necessary for the treatment/diagnosis of the patient). For 2022, the annual deductible for Medicare Part B will be TWO HUNDRED THIRTY-THREE dollars ($233.00) which is the responsibility of the patient. Medicare Part B will pay EIGHTY PERCENT (80%) of the approved amount for services rendered. The remaining TWENTY- PERCENT (20%) is the responsibility of the patient. Simmons' Podiatry, P.A. does not bill the Medicare approved amount. It is understood that there are some services (such as the debridement of painful ulcerated skin lesions, corns, calluses and/or mycotic [thick, discolored with fungus] toenails) and/or the excision of a portion or margin of toenail without the injection of an anesthetic agent, though medically necessary, may be determined that they are NOT covered by Medicare and that payment for these services will be the responsibility of the Patient or guardian. Other services include but are not limited to the following: telephone calls requiring a medical decision, telephone consultation by the ATTENDING PHYSICIAN with nurses or other health care providers in the coordination of medical care, written orders and laboratory tests which may be requested by voice, telephone, fax etc., and others. The use of any audio, photography and/or video recording as is necessary is authorized. It is understood that that the patient or guardian will inform Simmons' Podiatry, P. A. in the event of any change in Health Care Coverage. An additional $80.00 out of pocket may be required for services rendered after January 01, 2022. Basic podiatry services are provided. **Simmons' Podiatry P.A. IS NOT A PROVIDER FOR ANY HMO OR PPO**

With regards to medical care and services provided, or to be provided, it is agreed that the **ATTENDING PHYSICIAN** (Dr. Richard A. Simmons, or his assignee) will provide medical care and services to the patient to the best of his skill and knowledge, which medical care in the light of circumstances is possible and practical. Not all foot care conditions can be addressed in a home setting. The patient will cooperate fully with the **ATTENDING PHYSICIAN** by obtaining such medications as are prescribed, by following the instructions of the **ATTENDING PHYSICIAN**, by adhering to such treatment regimen or course of action as may be set forth and, by paying all fees and charges in full as billed or as provided by prior special arrangements. In the event of disputed collections for which **SIMMONS' PODIATRY, P.A.** is found to be correct, the patient or **GUARDIAN** agrees to pay the amount of disputed collections, plus collections fees (if any), plus 1% (12% APR) per month of the remaining balance. For this and future claims, your signature below authorizes Dr. Richard A. Simmons, **SIMMONS' PODIATRY P.A.** and any other requested outside laboratory (Including Bako Pathology Services) to furnish information to insurance carriers concerning your illness and treatment and authorizes assignment of insurance payment (if any or applicable) for medical surgical services rendered. It is understood that the patient is responsible for any amount not covered by insurance (except appropriate government programs). I, the patient or guardian whose signature is below, have read the above information and a copy of this has been provided to me at my request. The use of any audio recording, video recording, and/or photography as is necessary is authorized by the signature below. **Treatment of the patient, release of the patient's Medical Information including HCFA/485 to SIMMONS' PODIATRY, P.A., the release of information to the patient's insurance companies and to any outside laboratory (including Bako Pathology Services) not associated with SIMMONS' Podiatry, P.A., and request of the release of medical information from other health care practitioners and providers involved in the care or treatment of the patient, is also authorized by this signature.** I acknowledge that the patient was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so desired) and understood the Notice. The demographics and medication information (3 pages) and the "Review of Systems" (2 pages) were completed by me or my responsible party and are correct to the best of my knowledge.

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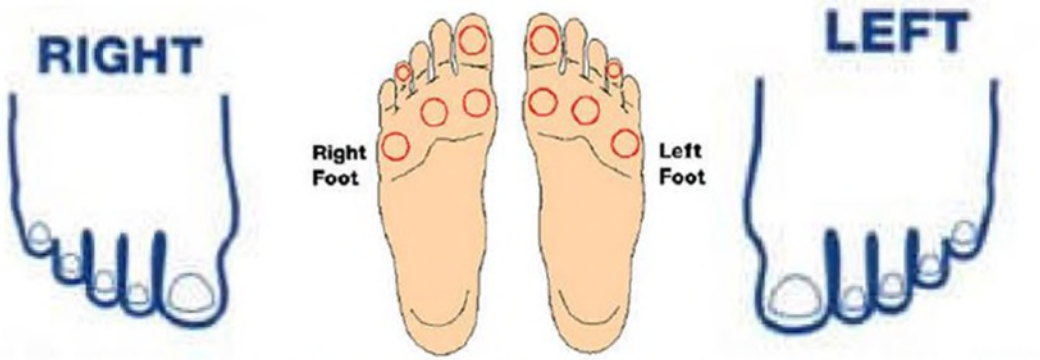
Patient Name: **Patient ID:** **Referred By:**

Include any over-the-counter medications.
ALLERGIES and REACTIONS: _____
_____

MEDICATIONS:	DOSE:	HOW OFTEN:



PAIN INDICATOR: Please put a " + " on any areas of the feet where you may be experiencing pain.
If you do not experience any pain, no marks need to be made. Center Picture is bottom of the feet.

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Patient Name: **Patient ID:** **Referred By:**

REVIEW OF SYSTEMS – PAGE 1

Please put a vertical slash in-between dashes to create a "+" sign for symptoms that pertain to the patient. **If the "--" is not changed the patient DOES NOT have these symptoms.**

Ears, Nose, Mouth, Throat:
(--) difficulty with hearing,
(--) difficulty with swallowing,
(--) sinus problems
(--) teeth or gum problems,

Genitourinary:
(--) current need for kidney dialysis,
(--) post menopausal,
(--) urinary difficulty,

Endocrine:
(--) cold intolerance**,**
(--) dry skin,
(--) hair loss, (--) height loss,
(--) hyperglycemia: Diabetes (high blood sugar),
(--) diet controlled
(--) treated with insulin
(--) treated without insulin
(--) erythematous rash (redness of the skin caused by capillary congestion),
(--) thyroid problem,

Hematologic / Lymphatic:
(--) blood clotting problem,
(--) bruise easily,
(--) calf pain,
(--) leg swelling,
(--) pale pallor (skin pale or gray),

Musculoskeletal:
(--) arthralgia, (neuralgic pain in a joint or joints),
(--) arch pain,
(--) arthritis,
(--) broke foot bones,
(--) difficulty getting out of a chair,
(--) difficulty/limited exercise,
(--) flat feet,
(--) gout,
(--) hammertoes,
(--) heel pain,
(--) hip pain,
(--) muscle tenderness,
(--) podalgia (pain in the foot, due to gout, rheumatism, etc.),
(--) Joint Implants: (Where?)_____

Constitutional Symptoms:
(--) appetite good**,** (--) health status good
(--) appetite poor**,** (--) health status poor

Neurological:
(--) anesthesias**,**
(--) aphasia: loss of the ability to produce and/or comprehend language
(--) balance problems,
(--) confusion,
(--) difficulty speaking,
(--) difficulty walking,
(--) dysphasia: a language disorder in which there is an impairment of speech and of comprehension of speech,
(--) epilepsy,
(--) forgetfulness, dementia or Alzheimer's (circle what applies)
(--) hemiparesis (partial paralysis of one side of the body, usually from stroke or cerebral palsy)
(--) motor disturbances,
(--) numbness,
(--) paralysis,
(--) paresthesia (abnormal sensation of the skin, such as numbness, tingling, pricking, burning, or creeping on the skin that has no objective cause),
(--) Parkinson's
(--) tingling,

Durable Medical Equipment Use:
(--) Hospital Bed
(--) Power Lift Chair
(--) Hoyer Lift
(--) Walker
(--) Cane
(--) Diabetic Shoes with inserts
(--) P.E.G. or other feeding tube
(--) Kidney Dialysis port
(--) Urinary Catheter
(--) Wheelchair
(--) Power chair or scooter

Continued on next page

HISTORY OF FALLS:
Any falls within the last 12 months?_____; If Yes, When? _____ Was there any injury? _____
Hospitalized? _____ Physical Therapy ordered? _____

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REVIEW OF SYSTEMS – PAGE 2

Integumentary:
(--) skin-related symptoms,
(--) athletes foot,
(--) bunions,
(--) corn/calluses,
(--) dermatitis,
(--) discoloration,
(--) dry, scaly skin,
(--) eczema,
(--) erythematous rash (redness of the skin caused by capillary congestion),
(--) lower leg ulcers,
(--) non-healing wound,
(--) pruritus (an itch or sensation causing one to scratch),
(--) psoriatic flare-up (inflammatory arthritis),
(--) rash,
(--) skin sores,
(--) ulcerations,
(--) xerosis (dry skin),

Gastrointestinal:
(--) GI symptoms,
(--) constipation,
(--) diarrhea,
(--) heartburn,
(--) laxative use,
(--) stomach problems**,**

Eyes:
(--) eye or vision problem: _____
(--) Glasses (--) Macular degeneration

Cardiovascular:
(--) cardiovascular problems or chest symptoms,
(--) ankle/leg swelling,
(--) calf cramping
(--) change in color of extremity,
(--) change in temperature of extremity,
(--) claudication: leg pain when walking
(--) heart valve implant:_____
(--) cold feet,
(--) cold hands,
(--) blood thinning medication,
(--) elevated BP (blood pressure)
(--) feet swelling,
(--) heart attack,
(--) poor circulation,
Blood thinner medication? _____
such as Xarelto, Pradaxa, Coumadin, Eliquis
(--) stroke,
(--) syncope,
(--) varicosities,

Respiratory:
(--) breathing difficulties,
(--) respiratory symptoms,
(--) asthma,
(--) shortness of breath,
(--) supplemental oxygen,

Allergic / Immunologic:
(--) allergic symptoms
(--) medication reactions-cephalosporins,
(--) medication reactions-aspirin,
(--) medication reactions-penicillin.
(--) medication reactions-sulfa drugs.

Tobacco Use:
(--) Currently smoking cigarettes
#_____packs smoked per day
(--) Quit smoking all tobacco products: Estimate
Year began _____ - Year quit _____ (approx.)
(--) Never smoked cigarettes or tobacco products

(--) Alcohol use: drinks per day_____

LAST FLU VACCINATION: Month/Yr_____
LAST PNEUMONIA VACC: Month/Yr_____
(Write "None", or "UK", if unknown)

FAMILY HEALTH HISTORY:(A)Alive/(D)Deceased
Mother: (Name/Hx) _____ A/D
Father: (Name/Hx) _____ A/D
Siblings: (Name/Hx) _____ A/D
(Family Health History:Diabetes, Heart problems, cancer, etc.)

ADVANCED DIRECTIVES? ____NO ____YES
(If yes, mark the ones below that apply.)
(--) DNR: Do Not Resuscitate order
(--) Living Will Order
(--) Durable Power of Attorney order
(--) Surrogate decision maker
Name: _____
(--) Due to cultural/spiritual beliefs will not discuss