

*5135 Dixie Hwy location has relocated to
6801 Dixie Hwy Ste 134*

Dear Patient,

The offices of Tipton & Unroe would like to welcome you to our practice!
We are Louisville's premier provider for foot and ankle care, and have set the standard for clinical and surgical podiatric medicine in this community for over 30 years. It is our pleasure to provide you with excellent care in a friendly and comfortable atmosphere.

Enclosed are a New Patient Information Sheet, a Medical History form and a Patient Payment Policy Form. In order to minimize your wait in our lobby, please fill these three sheets out in advance of your first appointment.

Below is a list of the items to bring with you to your appointment:

New Patient Information Sheet

Medical History Form

Insurance Cards

Picture ID Accessible

List of Any Current Medications

Referral from your Primary Care Physician (if required by insurance)

Your Co-Payment (all co-pays are required at the time services are rendered)

Please call your insurance company if you have questions concerning a referral or your co-payment amount.

We are very pleased that you have chosen us to help you with all of your foot and ankle needs. At Tipton & Unroe, our goal is to get you back on your feet enjoying life, not watching it pass you by. Please contact our office if you have any questions.

Sincerely,

Staff of Dr.'s Tipton & Unroe P.S.C.



**TIPTON
& UNROE**
FOOT AND
ANKLE CARE

Dr Paul Tipton
Dr Bradford Unroe
Dr Ryan Lemmenes
Dr Dawn Masternick

Dixie Highway Office
6801 Dixie Highway
Suite 134
Louisville, KY 40258
502.447.4500 tel

Factory Lane Office
12907 Factory Lane
Suite L
Louisville, KY 40245
502.243.3668 tel

Glenmary Ctr Office
8017 Bardstown Rd
Louisville, KY 40291
502.239.6600 tel

Bardstown, KY Office
118 Patriot Drive
Suite 106
Bardstown, KY 40004
502.349.5995 tel

Tipton and Unroe Foot and Ankle Care, P.S.C

Paul E. Tipton, D.P.M. – Bradford J. Unroe, D.P.M.

6801 Dixie Hwy Ste 134

Louisville, Kentucky 40258

(502) 447-4500 – (502) 449-0108

PLEASE PRINT IN BLUE OR BLACK INK

Today's Date:		Doctor you are seeing (Circle One) Tipton Unroe Lemmenes Masternick		
Patient's Last Name:		First Name:	Middle Initial:	
Street Address:				
Pt. City, State, Zip				
Email Address:		Work Phone:	Cell #:	
Home Phone:		Date of Birth:		Sex: M or F
Age:	Marital Status (Circle One): M S D W			New Patient: Y or N
SS#:				
Employer's Name:				
Employers Address:				
Employers City, State, Zip		Supervisor:		Phone:
Occupation:				

Responsible Party:		Relationship to Patient:		
RP Address:				
RP City, State, Zip		RP Work Phone:		RP Ext:
RP Home Phone:		RP Age:	RP Sex : M or F	
RP Date of Birth:		RP Martial Status (Circle One): M S D W		
RP SS#:				
RP Employer's Name:				
RP Employers Address:				
RP Employers City, State, Zip		RP Supervisor:		Phone:
RP Occupation:				

Name of Emergency Contact: (outside of the home):		Relationship:		
Phone # of Emergency Contact: (# outside of the home):		Sex: M or F		
Can we speak with this person regarding any medical or billing information: o Yes o No				

Please attach your insurance card to this form for the clerk to copy

How did you hear about us? <input type="checkbox"/> Referral (Who) <input type="checkbox"/> Radio <input type="checkbox"/> Television <input type="checkbox"/> Direct Mail <input type="checkbox"/> Other(Specify How)
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I hereby authorize the release of any medical information necessary to process my insurance. I authorize payment directly to the provider of services. I understand that I am financially responsible for any remaining or unpaid balances. I understand that there will be a \$40.00 fee applied to all returned checks.

Patient (or Responsible Party) Signature:

Date _____

Last name _____ First Name: _____ Middle Initial: _____

Age _____ Date of Birth: _____ Occupation: _____

Family Physician: _____ Height: _____ Weight: _____

Pharmacy Name: _____ **Pharmacy Phone #:** _____

What is the reason for your visit today? **(Be Specific)** _____

Please list **current prescription medications** that you are taking on a regular basis:

Please indicate whether **YOU** have a History of the following “**YES**” or “**NO**” next to each item:

Medical History:

YES	NO	Diabetes	YES	NO	Hernia	YES	NO	Sinus
YES	NO	High Blood Pressure	YES	NO	Gastritis/Colitis	YES	NO	Headaches/Migraines
YES	NO	Shortness of breath	YES	NO	Diverticulitis	YES	NO	Thyroid disease
YES	NO	Lung disease	YES	NO	Ulcers	YES	NO	Hepatitis
YES	NO	Asthma/Emphysema	YES	NO	Kidney diseases	YES	NO	HIV/AIDS
YES	NO	Poor circulation	OTHER: _____					

Allergies:

YES	NO	Penicillin	OTHER ALLERGIES: _____
YES	NO	Codeine	
YES	NO	Sulfa	
YES	NO	Aspirin	
YES	NO	Latex	

Surgical History:

YES	NO	Gall bladder	OTHER SURGERIES: _____
YES	NO	Hysterectomy	
YES	NO	Heart	
YES	NO	Lungs	
YES	NO	Vascular	

Social History:

Do you smoke?	YES	NO	Are you currently pregnant or trying to become pregnant?	YES	NO
Do you use alcohol?	YES	NO			

***I acknowledge that I (or responsible party) have received a summary of privacy policies for Tipton & Unroe Foot & Ankle Care. **INIT** _____

Summary Of Notice Of Privacy Practices

Uses and Disclosures of Health Information.

We will use and disclose your health information in order to treat you or assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization.

Except as stated in more detail in the Notice of Privacy Practices, we will not disclose your health information without your written authorization:

Uses and Disclosures Not Requiring Your Authorization.

- In the following circumstances, we may disclose your health information without your written authorization:
- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety
- To government agencies for purposes of their audits, investigations, and other oversight activities;
- To government authorities to prevent child abuse or domestic violence
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by law.

Patient rights. As our patient, you have the following rights.

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive a notice of our privacy practices.

***For further information on our Privacy Policies, please request a full copy at the time of your appointment.**

*** If you have a question, concern or complaint regarding our privacy practices, please contact our main office at 502-447-4500.**

TIPTON & UNROE PSC PAYMENT POLICY

Insurance: Tipton & Unroe participates in most insurance plans, including Medicare. If we participate with your plan we will bill the insurance carrier directly and you will be responsible for co-payments, deductibles, non-covered services, etc. Please remember that your insurance coverage is a contract between you and your insurance company. Insurance policies often do not provide full payment of medical costs, and you are responsible for any services which your insurance plan does not cover. Contact your insurer directly for any questions regarding your coverage.

Referrals: Insurance companies sometimes require their members to obtain a referral from their primary care doctor before seeing a specialist such as a podiatrist. It is your responsibility to obtain a referral if needed, and you must do so prior to your scheduled appointment or you will be forced to reschedule. If a referral is not received, you are financially responsible for any charges incurred for that date of service. We are unable, through contractual obligations with insurance carriers, to back-date referrals. Be aware that most referral authorizations are good for a certain number of visits and have an expiration date. If you have any questions about obtaining a referral we will be happy to assist you.

Co-Payments: All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. A \$20 processing fee will be charged for co-pays not collected at the time of service.

Non-Payment: If your account becomes more than 90 days past due, you will be required to pay your account in full within 10 days. Payment arrangements can be made with our billing office if you are unable to pay in full. If your account is sent to an outside collection agency we will add a \$35 processing fee to your balance and you will be discharged from the practice.

Missed Appointments/Missed Procedures: If you must cancel an appointment, please give our office as much notice as possible so that we may allow other patients to utilize your appointment time. If your appointment is canceled less than 24 hours before your visit you will be charged a \$25 missed appointment fee. If you cancel a scheduled procedure such as a nerve conduction study or nail removal with less than 24 hours notice you will be billed a \$50 procedure/missed appointment fee.

Returned Checks: You will be charged a \$40 returned check fee if a personal check is returned for non-payment.

I have read and understand the payment policy and agree to abide by its guidelines.

Signature of Patient or Responsible Party

Date