Premier Foot And Ankle Specialists

PATIENT REGISTRATION

PATIENT INFORMATION

Patient's Last Name | First | Middle | Mr. Mrs. Dr. Miss Ms. | Marital Status (Circle One) Single / Mar / Div / Sep / Wid

Nickname (Name I preferred to be called) | Birth Date (mm/dd/yyyy) | Sex M F | Spouse's Name

FL Street Address | Social Security # | Home Phone # ( )

City | State | Zip Code | E-Mail | Mobile Phone # ( )

NORTHERN Address | City | State | Zip Code

Pharmacy Name & Phone # | Primary Care Physician (PCP) | Date PCP Last Seen

PERSON RESPONSIBLE FOR BILL (IF DIFFERENT THAN ABOVE)

Name of Person Responsible for Bill | Birth Date (mm/dd/yyyy) | Sex M F | Relationship to Patient Self Spouse Child Other

Street Address | Social Security # | Home Phone # ( )

City | State | Zip Code | E-Mail | Mobile Phone # ( )

Employer | Employer Address | Employer/Work Phone # ( )

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD AND PHOTO ID TO RECEPTIONIST)

Primary Insurance | Subscriber Name | Birth Date (mm/dd/yyyy) | Social Security #

Insurance ID # | Group # | Policy # | Effective Date | Expiration Date | Co-Payment $

Secondary Insurance | Subscriber Name | Birth Date (mm/dd/yyyy) | Social Security #

Insurance ID # | Group # | Policy # | Effective Date | Expiration Date | Co-Payment $

IN CASE OF EMERGENCY

Name of Nearest Friend or Relative | Relationship to Patient | Home Phone # ( ) | Work or Mobile Phone # ( )

REFERRAL

How did you learn about us? (Please check all that apply) Dr. _____ Hospital/ER Lecture Insurance Plan

Phonebook Internet Website Friend/Family: _____ Other: _____

The above information is true to the best of my knowledge. I certify that I have insurance with the insurance company(ies) disclosed and assign directly to 1Foot 2Foot Centre for Foot and Ankle Care, PC all insurance benefits, if any, otherwise payable to me for service(s) rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature below on all insurance submissions. 1Foot 2Foot may use my health care information and may disclose such information to the disclosed insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

X _____

PATIENT/GUARDIAN SIGNATURE DATE

Premier Foot And Ankle Specialists

COMPREHENSIVE HEALTH REVIEW

Patient Name: _____ Date of Birth: _____ Today's Date: _____

HISTORY OF PRESENT ILLNESS / WHAT BRINGS YOU IN?

What is your specific foot/ankle problem? _____

_____

_____

When did the problem begin? _____

Which foot/ankle is involved? ☐ Right ☐ Left ☐ Both

First visit to a doctor for this problem? ☐ Yes ☐ No

Have you had a similar problem in the past? ☐ Yes ☐ No

How was the problem onset? ☐ Sudden ☐ Gradual

The problem is: ☐ Improving ☐ Worsening ☐ Unchanged

The problem is worst: ☐ AM ☐ PM ☐ At Rest ☐ With Activity

What aggravates the problem? _____

What improves the problem? _____

Is the problem painful? ☐ Yes ☐ No If so, rate your current pain: (none) 0 1 2 3 4 5 6 7 8 9 10 (worst)

Describe the pain: ☐ Sharp ☐ Dull ☐ Aching ☐ Throbbing ☐ Cramping ☐ Itching ☐ Popping

☐ Burning ☐ Tingling ☐ Clicking ☐ Shooting ☐ Stabbing ☐ Other: _____

Describe previous treatments: _____

Is this from an injury? ☐ Yes ☐ No If so, is it work-related? ☐ Yes ☐ No _____

PAST MEDICAL HISTORY

☐ Diabetes Type 1 2 Duration ____ years Last Blood Sugar ____ HbA1c ____

☐ Acid Reflux
☐ Anemia
☐ Anesthesia Complications
☐ Arthritis (☐ Osteo / ☐ Rheum)
☐ Asthma
☐ Back Problems/Sciatica
☐ Blood Clot/DVT
☐ Cancer: _____
☐ Cellulitis/Skin Infection (☐ MRSA?)
☐ Circulation Problem
☐ Dementia/Alzheimer's
☐ Excessive/Easy Bleeding
☐ Fibromyalgia
☐ Foot/Leg Ulcer
☐ Gout
☐ Healing Problems/Keloids
☐ Heart Disease/Heart Attack
☐ High Blood Pressure (☐ Low BP?)
☐ High Cholesterol
☐ Hormone Therapy
☐ Immune Disorder/HIV
☐ Kidney Disease (☐ Dialysis)
☐ Liver Disease (☐ Hepatitis)
☐ Leg Cramps/Leg Pain at Rest
☐ Lung Condition: _____
☐ Mitral Valve Prolapse/Murmur
☐ Multiple Sclerosis
☐ Nervous Disorder/Depression
☐ Neuropathy
☐ Osteomyelitis/Bone Infection
☐ Parkinson's Disease
☐ Previous Addiction to: _____
☐ Pulmonary Embolism
☐ Rashes/Skin Condition
☐ Raynauds Disease/Phenomena
☐ Seizure Disorder/Epilepsy
☐ Sickle Cell Disease/Trait
☐ Sleep Apnea
☐ Stomach Ulcers
☐ Stroke ☐ Rt ☐ Lt (year _____)
☐ Thyroid Condition (☐ Hi ☐ Lo)
☐ Varicose Veins
☐ Women – Are You Pregnant or Breast Feeding?

☐ Other problems not listed: _____

PAST SURGERIES

☐ Foot/Ankle Surgery: _____

☐ Joint Replacement: _____

☐ Open Heart/Bypass Surgery

☐ Hysterectomy ☐ Tubal ligation ☐ C-Section

☐ Stent Placement: Heart Leg

☐ Cosmetic Surgery: _____

☐ Appendix ☐ Gallbladder ☐ Tonsils/Add

☐ Leg Bypass ☐ Open Fracture Repair

☐ Carotid Surgery ☐ Vein Surgery

☐ Hernia repair ☐ Thyroid ☐ Back surgery

☐ Other: _____

_____

	Mother	Father	Sister	Brother	GrandParent
☐ Cancer	M	F	S	B	GP
☐ Diabetes	M	F	S	B	GP
☐ Gout	M	F	S	B	GP
☐ Heart Disease	M	F	S	B	GP
☐ High Blood Pressure	M	F	S	B	GP
☐ Severe Arthritis	M	F	S	B	GP
☐ Anesthesia Complications	M	F	S	B	GP
☐ Foot Problems	M	F	S	B	GP
☐ Other: _____	M	F	S	B	GP

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COMPREHENSIVE HEALTH REVIEW

Patient Name: _____

MEDICATIONS (include RX meds, OTC meds, and vitamins)

Medication	*Dosage*	*Medication*	*Dosage*

ALLERGIES

- ☐ **None**
- ☐ Adhesives/Tape
- ☐ Aspirin
- ☐ Codeine
- ☐ Cortisone
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetics
- ☐ Penicillin
- ☐ Seafood/Shellfish
- ☐ Sulfa Drugs
- ☐ _____

SOCIAL HISTORY

Occupation: _____

☐ I Drink Alcoholic Beverages How much/often? _____

☐ I Use or Have Used Tobacco Products Type: _____

Packs/Day _____ Years _____ When Stopped? _____

☐ I Use or Have Used Drugs that are Illegal _____

I Live With: ☐ No One ☐ Spouse ☐ Children ☐ Parents ☐ Other

I Stand _____ % of My Day

I Exercise Each Week: ☐ 0 days ☐ 1-2 days ☐ 3+ days

List Sports/Activities: _____

☐ My foot/ankle problem limits my activities

I am: ☐ Single ☐ Mar ☐ Div ☐ Sep ☐ Widowed

REVIEW OF SYSTEMS

CONSTITUTIONAL
- Recent Weight Changes
- Fever/Chills
- Nausea or Vomiting
- Fatigue

EYES
- Eye Disease/Injury
- Wear Glasses/Contacts
- Blurred or Double vision
- Glaucoma

EARS/NOSE/MOUTH/THROAT
- Hearing Loss
- Nose Bleeds
- Sore Throat/Voice Change
- Sinus Problems
- Difficulty Swallowing

CARDIOVASCULAR
- Chest Pain
- Palpitations
- Arrhythmia/Irregular Heart Beat
- Leg Pain when Walking
- Swelling of Hands/Feet

MUSCULOSKELETAL
- Muscle Pain or Cramps
- Joint Pain
- Stiffness/Swelling Joints
- Low Back Pain
- Trouble Walking

GASTROINTESTINAL
- Indigestion/Heartburn
- Diarrhea
- Blood in Stools
- Stomach Pains

RESPIRATORY
- Shortness of Breath
- Chronic/Frequent Cough
- Wheezing

GENITOURINARY
- Frequent Urination
- Painful Urination
- Kidney Stones
- Blood in Urine

INTEGUMENTARY
- Rash or Itching
- Dry Skin
- Change in Hair/Nails

HEMATOLOGICAL
- Bruise Easily
- Slow to Heal

ENDOCRINE
- Hormonal Problem
- Excessive Thirst
- Excessive Urination
- Too Hot/Too Cold

NEUROLOGICAL
- Migraines
- Frequent Headaches
- Numbness/Tingling
- Dizzy Spells
- Paralysis/Tremors

PSYCHIATRIC
- Anxiety
- Depression
- Nervousness
- Insomnia
- Confusion/Memory Loss

STATS

Age _____ Height _____ Weight _____ Shoe Size _____

For Office Staff

BP _____ P _____ O2 Sat BMI Temp

I understand that completing this paperwork is a chore. The information I have provided is true to the best of my knowledge. I recognize that the information I have provided will help me receive better care. I thank you for taking such an interest in my health.

X _____ _____

PATIENT/GUARDIAN SIGNATURE DATE

FINANCIAL POLICY

1. **All co-payments are due at the time of visit.** This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered a violation of the contract you have with your insurance company. Our office accepts cash, checks (post-dated checks are not accepted), credit and debit cards.
2. Co-insurance and unmet deductibles are due prior to scheduled surgeries and procedures. Once benefits are verified and your financial responsibility calculated, you will be notified of the payment amount and due date.
3. You are ultimately responsible for payment of charges for services you receive from our office.
4. In accordance with your insurance member handbook, it is your responsibility to provide accurate insurance information and to present your insurance ID card at the time of your visit. If you do not have insurance or do not present a valid insurance card, you will be responsible for payment at the time of service. We will provide you with a copy of our billing form so that you can obtain reimbursement from your insurance company.
5. It is your responsibility to ensure that our physicians are in your insurance network.
6. If your plan requires a referral, it is your responsibility to obtain this prior to being seen by our provider.
7. Payment is due for rendered services 10 days from receipt of your billing statement. **Outstanding balances must be paid in full prior to any additional visit unless prior arrangements have been made with our billing department.**
8. There is a service fee of $35 for each time a check is returned. The bank may return your check up to three times before considering it nonnegotiable. Your insurance company does not cover this fee.
9. A scheduled appointment means that time has been reserved for you. Cancellations for appointments must be received at least 24 hours prior to the scheduled appointment. Cancellations for scheduled surgery must be received at least 5 days prior to the scheduled surgery date and time. If you are late for your appointment you may be asked to make a new appointment, however, we will do our best to work you into our schedule.
10. Patients who fail to keep or fail to cancel a scheduled appointment may be charged a $25.00 No Show Fee. There is a $100.00 cancellation fee for scheduled surgeries or in-office procedures that are cancelled less than 5 business days from the date and time of surgery unless cancellation is due to insurance denial or medical necessity.
11. Medical records requests must be received in writing at least 72 hours prior to the date needed. Fees for medical records are set in accordance with allowable amounts as defined by the Commonwealth of Florida. Fees must be received prior to record delivery. No more than 5 pages may be faxed.
12. Administrative Services: There is a $25.00 charge for each required Administrative Service, payable prior to service completion. This Administrative Service Fee covers specific administrative services such as forms completion for family medical leave and disability, letters for insurance authorizations for brand or non-formulary drugs, letters for employers, school, health clubs, and any other administrative items not covered by insurance.
13. In the event your insurance company should happen to send payment to you (the patient), you agree to forward said payment to our office to be applied to your account.
14. SELF-PAY: Payment in full is due at the time of service if you do not have health insurance coverage.

Premier Foot And Ankle Specialists

CONSENT TO TREATMENT

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Premier Foot AND Ankle Specialists Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice. Patient Initials:

AUTHORIZATION REGARDING PRIVACY POLICY

Due to the recent implementation of the Patient Privacy Act (HIPPA), I hereby authorize Premier Foot AND Ankle Specialists to leave messages at my home with family members and/or answering machines regarding the following: (1) Confirm or Change Appointment, (2) Results of testing ordered by the physician, and/or (3) Any pertinent information that may be relative to my care. Patient Initials:

ACKNOWLEDGMENT OF RECEIPT OF FINANCIAL POLICY

I acknowledge that I was provided a copy of the Premier Foot AND Ankle Specialists Financial Policy and that I have read (or had the opportunity to read if I so chose), understand and will comply by the policies stated. Patient Initials:

CONSENT TO VIEW EXTERNAL PRESCRIPTION HISTORY

I authorize Premier Foot AND Ankle Specialists to view my external prescription history via electronic prescribing services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies and pharmacy benefit managers may be viewable by my provider and staff at Premier Foot AND Ankle Specialists and it may include prescriptions back in time for several years. Patient Initials:

PATIENT CONSENT

I hereby voluntarily consent to outpatient care by a Premier Foot AND Ankle Specialists Podiatrist, encompassing routine care, diagnostic procedures, examination and medical treatment including, but not limited to, minor surgical procedures, routine laboratory work, x-rays, ultrasound, photographs and administration of medications and injections prescribed by the Premier Foot AND Ankle Specialists Podiatrist. I agree to ask questions to clarify treatment should I not understand the treatment plan. Patient Initials:

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance with the insurance company(ies) disclosed and assign directly to Premier Foot AND Ankle Specialists and its Podiatrists, all insurance benefits, if any, otherwise payable to me for service(s) rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I agree that should my account become delinquent and is referred to an attorney or collection agency for collection, I will be charged an additional 33 1/3% of any unpaid balance at the time of referral for all costs of collection and attorney's fees. I authorize the use of my signature below on all insurance submissions. Patient Initials:

Premier Foot AND Ankle Specialists may use my health care information and may disclose such information to the disclosed insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. Patient Initials:

Patients who do not show up for their appointment without a call to cancel will be considered a NO SHOW. Patients who No-Show two (2) or more times in a six month period will only be able to make SAME DAY APPOINTMENTS and will no longer be able to schedule ahead of time. Patients with three (3) or more NO-Shows may be dismissed from the practice thus they will be denied any future appointments. Patient Initials:

I have read and fully understand this Consent to Treatment. This authorization is valid as of the date I have signed below and will remain in effect as long as I am a Premier Foot AND Ankle Specialists patient. I have read this complete page and agree to all of its contents.

Name of Individual/Legal Representative (Print) **Signature of Individual/Legal Representative** **Date**

Premier Foot And Ankle Specialists

HIPPA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFOMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT. Our office safeguard's your protected health information. We are committed to the privacy and confidentiality of your health information whether created by us or maintained on our premises. We are required by state and federal regulations to implement policies and procedures to safeguard the privacy of your health information. We are required by state and federal regulations to abide by the privacy practices described in this notice including any future revisions that we may make to the notice that becomes necessary or authorized by law. Individual identifiable information about your past, present, or future health provisions of health care to you, or payment for the health care treatment or services you receive is considered protected health information. We are required to provide you with this Privacy Notice that contains information regarding our privacy practices that explains how, when and why we may use or disclose your protected health information and your rights and our obligations regarding any such uses or disclosures. Except in specified circumstances, we must use or disclose only the minimum necessary protected health information to accomplish the intended purpose of the use or disclose of such information. We reserve the right to change this notice at any time and make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future about you. Should we revise/change the Privacy Notice, we will post a copy of the new/revised Privacy Notice in our office. You may also request and obtain a copy of any new/revised Privacy Notice from our Privacy Practice Manager. We use and disclose protected health information for a variety of reasons. We have a limited right to use and/or disclose your health information for purposes of providing your supplies, payment, or for the operations of our company. For other uses, you must give us your permission and written authorization. Should it become necessary to release your protected health information to an outside party, we will require the party to have a signed agreement with us that the party will extend the same degree of privacy protection to your information as we do. The privacy law permits us to make some uses or disclosures of your protected health information without your consent or authorization. If you would like the complete copy of the HIPPA Notice, please as at the front desk.

*Signature :*_____ *Date:*_____

I certify that the information given by me in the information given by me in the applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security administration or it's intermediates or carriers any information needed for this or a related Medicare Claim. I permit a copy of this authorization to be used in place of the original document. I request payment of the authorized benefits payable for physician or organization furnishing the services or authorize such physician or organization to submit to Medicare for payment to me. I hereby authorize the release of any medical information necessary for the processing insurance claims and payment of medical benefits to myself or the party who accepts assignment. (Lifetime signature)

*Signature :*_____ *Date:*_____