

First Coast Foot & Ankle Clinic

Patient Information

Full Name _____ Social Security Number _____

Birthdate _____ Age _____ Sex _____ Race _____ Marital Status (circle one) M S W D

Address _____ City,St,Zip _____

Home Phone _____ Cell Phone _____ WorkPhone _____

Email Address: _____

Pharmacy Name: _____ Phone # _____

Address _____

Emergency Contact

Name _____ Relationship _____ Phone # _____

Primary Care Physician _____ Phone # _____

Insurance Information

Primary Insurance Name _____ Phone # _____

Insured's Name _____ Relationship _____ DOB: _____

Policy Number _____ Group Number _____

Do you have a secondary insurance? (Circle one) YES NO

Secondary Insurance Name _____ Phone # _____

Insured's Name _____ Relationship _____ DOB: _____

Policy Number _____ Group Number _____

Referrals

Please check all that apply

____ Physician _____ Phone # _____

____ Google, Website or other search engine

____ Family/Friend _____

____ Insurance Company

____ Other: _____

Medical History

Medication Allergies: _____

Medications (Please list current prescription and over the counter medications) INCLUDE DOSAGE

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Social History

Have you ever used tobacco products? (circle one) YES NO if yes, continue below:
of years used _____ Amount each day _____ Do you currently use tobacco? _____

Do you currently consume alcohol/beer/wine regularly? (circle one) YES NO Amount per week _____

Past Medical History

Indicate which of the following you have had in the past and/or currently have (circle all that apply)

- | | |
|--|--|
| Diabetes (Type 1/Type 2) | Kidney Problems |
| Arthritis | Neurological Disorder |
| Asthma | High Cholesterol |
| Fibromyalgia | Psychological Care |
| Heart Condition | High Blood Pressure |
| Gout | Diabetic Ulcers |
| Hepatitis A, Hepatitis B, or Hepatitis C | Numbness/tingling in feet, legs, hands |
| HIV Positive | Stomach Problems |
| Other: _____ | |

Past Surgical History (please list all including foot/ankle surgeries)

Height _____ Weight _____ Shoe Size _____

First Coast Foot & Ankle Clinic

What specific problem with your foot/feet brings you to our office today? _____

If the problem is related to an injury or accident, please describe what happened: _____

How would you describe the pain/discomfort you are experiencing? Please circle any of the following

Aching Blistering Discolored Draining Enlarged Infected Inflamed Ingrown Painful Reddened Swollen
Tender Throbbing Other: _____

How would you rate your pain/discomfort on a scale of 1-10 (10 being the worst)? _____

Where on your foot/feet is the pain located: _____

When did this problem first start? _____ Was it gradual or sudden? _____

Has the problem stayed the same, improved, or worsened since it started? _____

What are some things that make the problem worse? Please circle any of the following

Walking Climbing Cold Weather Dancing Driving Exercise Jogging/Running Standing Stretching Sports
Barefoot Working Walking Upstairs Other: _____

What are some of the things that you have done to make the problem feel better? Please circle any of the following

Aspirin Compression Elevation Decreased Activity Ice Massage New Shoes NSAIDS Physical therapy
Rest Soaking Surgery Other: _____

Is the problem worse in the morning or at the end of the day? _____

Does rest help relieve the pain/discomfort? YES NO

Have you seen a physician for this problem? YES NO

If yes what were the treatments prescribed _____

Have you taken any over the counter medications or prescribed ones? _____

Has the problem affected your ability to work, enjoy sports/hobbies, or carry on your usual daily routine? _____

Are there any other issues with your feet and/or ankles which you would like to be addressed? _____

I certify that the above information is accurate and true to the best of my knowledge

Patient/Guardian Signature: _____ Date: _____

First Coast Foot & Ankle Clinic

Financial Policy

Thank you for choosing First Coast Foot & Ankle Clinic as your foot care provider. We are committed to providing you with quality and affordable health care. Please read the following office financial policy carefully and feel free to ask us any questions that you may have.

We participate in most insurance plans and will help you receive your maximum allowable benefits. We will accept and file your primary insurance as well as many secondary insurance plans. **It is your responsibility to make sure your insurance is in network and that we do participate with your insurance plan.** If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have verified coverage, payment in full for each visit is required until we can verify your coverage.

If you are self-pay, please be prepared to pay in full at the time of service either by credit card or cash. We have a list of self-pay prices that are discounted according to the diagnosis/problems that you are experiencing.

All co-payments and deductibles must be paid in full at the time of service; unless prior arrangements have been made with our billing department. This arrangement is part of your contract with your insurance company.

Please be aware that some, of perhaps all, of the services you may receive may be non-covered or not considered reasonable or necessary by Medicare and other insurers. You must pay for these services in full at time of service.

If you have a referral based HMO/PPO insurance, it is your responsibility to make sure you have a valid referral upon each visit.

We accept cash, checks and credit cards. Any returned checks are subject to a \$25.00 returned check fee. The amount of the check as well as the \$25.00 fee will be assessed immediately and will be required to be paid in full by either cash or credit card.

Invoices are sent out every 30 days. Your prompt payment will assist us in keeping the cost of healthcare down. If your account is older than 90 days you are subject to collection procedures. Should your account be referred to a collection agency or attorney for collections, you will be held responsible for all cost of collection as applies.

Partial payments will not be accepted unless otherwise approved by our billing department. We understand that temporary financial problems arise that can affect timely payment of your balance, but you must contact the office to make payment arrangements.

There is a charge of \$20.00 for completion of all forms including disability, FMLA, etc. The practice requires 7-10 business days from the date payment is made for completion. X-rays CDs are available upon request and are subject to a \$10.00 fee.

I have read and understand the above financial policies of First Coast Foot & Ankle Clinic

Patient Name _____

Patient Signature _____ Date _____

Legal Representative Name (if applicable) _____

Signature _____ Relationship _____ Date _____

First Coast Foot & Ankle Clinic

Authorization to Release Information for Payment

I hereby authorize First Coast Foot & Ankle Clinic to release any medical or other information necessary to my insurance company to process claims for medical care, diagnostic testing and/or treatment provided to me by First Coast Foot & Ankle Clinic.

Name of responsible party if minor (please print): _____

Signature _____ Date _____

Authorization for Assignment of Benefits

I hereby authorize and assign First Coast Foot & Ankle Clinic to collect all patient payments and/or insurance benefits for services rendered. I agree to complete any additional forms which may be required by my insurance plan for assignment of benefits. I understand that I am financially responsible for all amounts not covered by my insurance plan.

Name of responsible party if minor (please print): _____

Signature _____ Date _____

Authorization for Assignment of Medicare Benefits

I hereby authorize and assign all payments of authorized Medicare benefits for services rendered to patient, directly to First Coast Foot & Ankle Clinic. I hereby authorize First Coast Foot & Ankle Clinic to release any medical information necessary to obtain payment. I understand that I am financially responsible for all amounts not covered by Medicare for which I have signed an advance beneficiary notice (ABN).

Name of responsible party if minor (please print): _____

Signature _____ Date _____

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I. Acknowledgement of Practice's Notice of Privacy Practices:

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

Name of Patient	Date of Birth	Signature of Patient/Parent/Guardian	Date
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II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain pieces of my health information to a Personal Representative of my choosing, since such person is involved with my healthcare or payment relating to my healthcare. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my health care.

Print Name: _____	Last four digits of SSN or other identifier: _____
Print Name: _____	Last four digits of SSN or other identifier: _____
Print Name: _____	Last four digits of SSN or other identifier: _____

III. Request to Receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

<p>Home Telephone Number:</p> <p>_____</p> <p><input type="checkbox"/> OK to leave message with detailed information</p> <p><input type="checkbox"/> Leave message with call back numbers only</p> <p>Work Telephone Number:</p> <p>_____</p> <p><input type="checkbox"/> OK to leave message with detailed information</p> <p><input type="checkbox"/> Leave message with call back numbers only</p> <p>Other: _____</p>	<p>Written Communication Address:</p> <p>_____</p> <p><input type="checkbox"/> OK to mail to address listed above</p> <p><input type="checkbox"/> E-mail me at: _____</p> <p>Fax Communication:</p> <p>_____</p> <p><input type="checkbox"/> OK to Fax at the number listed above</p> <p><input type="checkbox"/> E-mail me at: _____</p>
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IV. The following person(s) are not authorized to receive my Patient Health Information (PHI):

Print Name: _____	Print Name: _____
Print Name: _____	Print Name: _____

V. The HIPAA Privacy rule requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI. I understand that this accounting will not reflect disclosures that are made in the course of the Practice's ordinary health care activities related to providing patient treatment, obtaining payment for its services or its internal operations. Also, the Practice does not have to account for disclosures for which I have executed an Authorization permitting disclosures of my PHI.

Date of disclosure request	Disclosed to whom: address/fax	Description of disclosure	Purpose of disclosure	Dates of Service of disclosure	Person completing request	Date completed

1. The above authorizations are voluntary and I may refuse to agree to their terms without affecting any of my rights to receive healthcare at the Practice.
2. These Authorizations may be revoked at any time by notifying the Practice in writing at the Practices mailing address marked to the attention of "HIPAA Compliance Officer."
3. The revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.
4. I may see and copy the information described in this form, if I ask for it, and I will get a copy of this form after I sign it.
5. This form was completely filled in before I signed it and I acknowledge that all of my questions were answered to my satisfaction, that I fully understand this authorization form, and have received an executed copy.
6. This authorization is valid as of the date I have signed below and shall remain valid until changed or revoked.

Name of Patient (Printed)

Signature of Patient

Date

Do I Need a Test for PAD?

Peripheral Arterial Disease (PAD) is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain or kidneys, become narrowed or clogged. It affects over 8 million Americans, most over the age of 50. It may result in leg discomfort with walking, poor healing of leg sores/ulcers, difficult to control blood pressure, or symptoms of stroke. People with PAD are at significantly increased risk for stroke and heart attack. Answers to these questions will determine if you are at risk for PAD and if a vascular exam will help us better assess your vascular health status.

Name: _____

Date: _____

Circle "Yes" of "No":

		Test for PAD		
1.	Do you have a foot, calf buttock, hip or thigh discomfort (aching, fatigue, tingling, cramping or pain) when you walk which is relieved by rest?	Yes	No	<input type="checkbox"/>
2.	Do you experience any pain at rest in your lower leg(s) or feet?	Yes	No	<input type="checkbox"/>
3.	Do you experience foot or toe pain that often disturbs your sleep?	Yes	No	<input type="checkbox"/>
4.	Are your toes or feet pale, discolored or bluish?	Yes	No	<input type="checkbox"/>
5.	Do you have skin wounds or ulcers on your feet or toes that are slow to heal (8-12 weeks)?	Yes	No	<input type="checkbox"/>
6.	Has your doctor ever told you that you have diminished or absent pedal (foot) pulses?	Yes	No	<input type="checkbox"/>
7.	Have you suffered a severe injury to the leg(s) or feet?	Yes	No	<input type="checkbox"/>
8.	Do you have an infection of the leg(s) or feet that may be gangrenous (black skin tissue)?	Yes	No	<input type="checkbox"/>

Patient Signature: _____

Physician Signature: _____

Date: _____