

CAROLINA FOOT & ANKLE ASSOCIATES, PLLC

WELCOME TO OUR OFFICE

Please take a few moments to answer all of the following questions so that we may get to know you better.

Patient's Last Name: _____ First: _____ Middle Int: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Age: _____ Sex: _____ Marital Status: S ___ M ___ W ___ D ___ Social Security: _____

Date of Birth: _____ Home Phone: _____ Work Phone: _____

Cell Phone: _____ Employer: _____ Primary Care Doctor: _____

Primary Insurance: _____ Secondary Insurance: _____

Who carries the insurance? The patient Other: _____ DOB: _____

Preferred Pharmacy: _____ Location: _____ Phone: _____

Is the patient in a facility (ex: nursing home)? Name: _____ Phone: _____

If someone (other than the patient) is responsible for the patient's bill, please complete the following:
Responsible Party's Name: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____

In case of emergency, whom do we contact?: _____

Home: _____ Cell: _____ Work: _____

How did you learn about our office? _____

I authorize the release of any medical information necessary to process my insurance claim and request payment of benefits to the doctor. I hereby give permission to the doctor to administer treatment and to perform any minor procedures as may be needed in the diagnosis and/or treatment of my foot and ankle condition. I understand that services rendered should be paid for at the time of service unless other arrangements have been made.

I authorize payment of Medigap insurance benefits to the doctor. This authorization applies to all dates of service until revoked.

Signature: _____ Date: _____

CAROLINA FOOT & ANKLE ASSOCIATES, PLLC

AUTHORIZATION TO RELEASE INFORMATION TO FAMILY/FRIENDS

Name: _____

Date of Birth: _____

Carolina Foot and Ankle is authorized to release protected health information about the above named patient to the entities named below:

Entity to Receive Information – Initial each that is subject to this authorization:

____ Leave information on the voice mail

____ Give information to spouse

____ Give information to the following persons: _____

____ Email me at the following address: _____

Description of information to be received:

____ Financial Information ____ Results from tests or x-rays ____

____ Medical information as follows: _____ Other information: _____

Rights of the Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Carolina Foot and Ankle. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by a federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization. This authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

Signature of patient or Personal Representative

Date

Description of Personal Representative's Authority (attach necessary documents)

Notice of Privacy Practices

Our notice of privacy practices provides information about how we may use and disclose protected health information about you. It also provides information about your rights as a patient of our practice and whom you may contact at our office to ask questions about our privacy practices. By signing below, you are agreeing that you have had the opportunity to read our notice of privacy practices.

Signature of patient or Personal Representative

Date



Financial Policy

YOUR INSURANCE

Our relationship is with you, not your insurance company. If we are a participating provider with your insurance, we will file your claim for you. We do not, however, file third party payer claims or those for motor vehicle, worker's compensation or other accidents. If you do not have your insurance card at the time of service, it may be necessary for you to pay for your visit in full.

According to requirements of our insurance contracts, we are obligated to collect the patient's responsibility at the time we render our services. Therefore, any applicable co-pays and/or co-insurance must be paid at each visit. Patients with a history of not paying these fees may be discharged from our practice and their insurance carrier will be notified. Payment must be paid in full for any services considered by your insurance as "non-covered" or "not reasonable or necessary".

Some insurance companies may require a pre-certification or pre-authorization for certain services. While we will gladly assist you with this process, the final responsibility to insure that any such requirements are completed prior to treatment is yours. Denied charges due to lack of proper pre-certification/pre-authorization will be billed to you.

IF YOU DO NOT HAVE INSURANCE

A minimum deposit of \$150 is due at the time of check in for all self-pay patients. Charges for follow up visits will be due at the time of service.

NO SHOWS

Please try to give our office 24 hours advance notice of cancellation so we may offer the appointment to another patient. Repeatedly missing appointments without adequate notice may lead to dismissal from the practice.

RETURNED CHECKS

There is a \$25 service fee for all checks returned for non-sufficient funds. A third party service will attempt to have the check clear your account twice before returning it to us as uncollectable. Patients who have written returned checks will be required to pay for subsequent visits using cash or a credit card.

COLLECTIONS

If you are unable to pay your account in full as billed, please contact our office to make other financial arrangements. Patients wishing to make additional appointments will need to bring their account current prior to receiving any future services in our clinics. Overdue accounts with inactivity after 90 days may be assigned to a collection agency for follow up. Please note that patients referred to collections will regrettably be dismissed from our practice.

PATIENT REFUNDS

At the end of each month, we will issue patient refund checks for amounts over \$10 after all outstanding insurance balances have been settled. Due to administrative costs, credit balances under \$10 will be held on account for a return appointment.

MEDICAL RECORDS

In order that we may keep your information up to date, please inform us of any changes to your account, including insurance, address or phone number.

We are happy to complete disability, FMLA etc. forms for our patients. Before leaving the form with us, please make sure you have filled in the patient portion. There will be a \$15 fee for your first form and a \$5 fee for any related follow up form. Please allow five business days for processing. Due to HIPAA regulations, we are not able to fax forms to your employer.

Upon your request, copies of x-rays and medical records may be made available for your pick up by giving us a 48 hour notice. As a courtesy, the first two x-ray films are free. Each film thereafter is \$10. There will be a minimum charge of \$10 for medical record copying; however, with your written authorization we are happy to fax your medical records directly to another physician at no charge.

By signing below I acknowledge that I have read the above financial information and agree to adhere to the policies outlined.

Signature of Patient or Responsible Party if a Minor

Date

CAROLINA FOOT & ANKLE ASSOCIATES, PLLC

GENERAL HEALTH INFORMATION

Patient Name: _____

Appointment Date: _____

1. Describe your foot problem (give specific location): _____

2. How long has it been bothering you (be specific): _____ Days _____ Weeks _____ Months _____ Years

3. Describe pain or discomfort (please circle):

Burning Throbbing Sharp Dull Aching Numbness Tingling Shooting

4. How intense is your pain? 0 = none, 10 = severe (circle one) 1 2 3 4 5 6 7 8 9 10

5. What causes the problem or makes it worse: _____

6. Are there any other problems associated with your foot complaint? (ex: back or leg pain) : _____

7. List previous and current treatments for the condition: _____

8. Do you have other foot problems that need attention? _____

9. Does anything else affect the problem? Yes ___ No ___ Explain if yes: _____

10. Is this a work injury? Yes ___ No ___ Auto Accident? Yes ___ No ___ Other? _____

11. **SURGICAL HISTORY**

Please list all past operations on any part of your body and the date: _____

Do you have (circle): Any artificial joints? Yes No A heart valve implant? Yes No Mitral Valve Prolapse? Yes No

12. **SOCIAL HISTORY**

Do you smoke? Yes No If yes, # packs per day: _____ How Many Years? _____

Do you drink alcoholic beverages? Yes No If yes, amount per week: _____

Do you use recreational drugs? Yes No If yes, which? _____

Are you or could you be pregnant? Yes No

Employment: Main activity includes (please circle): Sitting Standing Walking Lifting

The work place floor is (please circle): Concrete Carpet Rubbermat Other: _____

Physician reviewed all information above: _____

GENERAL HEALTH INFORMATION

Patient Name: _____

Appointment Date: _____

Who is your family doctor? _____

Date of last exam: _____

Do you currently have or have you had problems in the following areas?

	Yes	No		Yes	No	
_____	_____	_____	Skin Lesions _____	_____	_____	Abdominal Pain _____
_____	_____	_____	Skin Cancer _____	_____	_____	Stomach Ulcers _____
_____	_____	_____	Persistent Rashes _____	_____	_____	Hiatal Hernia _____
_____	_____	_____	Recurrent Infection _____	_____	_____	GERD _____
_____	_____	_____	Fever and/or Chills _____	_____	_____	Black Tarry Stools _____
_____	_____	_____	Vision Impairment _____	_____	_____	Hepatitis _____
_____	_____	_____	Hearing Loss _____	_____	_____	Cirrhosis _____
_____	_____	_____	Shortness of Breath _____	_____	_____	Kidney Disease _____
_____	_____	_____	Persistent Cough _____	_____	_____	Pain with Urination _____
_____	_____	_____	Asthma _____	_____	_____	Increased Frequency of Urination _____
_____	_____	_____	Emphysema _____	_____	_____	Increased Thirst _____
_____	_____	_____	Tuberculosis _____	_____	_____	Diabetes _____
_____	_____	_____	Chest Pain _____	_____	_____	# Years: _____
_____	_____	_____	Angina _____	_____	_____	Do you check BS Daily? Y N
_____	_____	_____	Past Heart Attack (when?) _____	_____	_____	Last HgA1C Date: _____ Value: _____
_____	_____	_____	Arrhythmia _____	_____	_____	Gout _____
_____	_____	_____	Stroke _____	_____	_____	Painful Joints (where?) _____
_____	_____	_____	History of Blood Clots _____	_____	_____	Joint Swelling _____
_____	_____	_____	Other Bleeding Disorders _____	_____	_____	Arthritis _____
_____	_____	_____	High Blood Pressure _____	_____	_____	Seizure Disorder _____
_____	_____	_____	Elevated Cholesterol _____	_____	_____	Cancer (where?) _____
_____	_____	_____	Anemia _____	_____	_____	HIV _____
_____	_____	_____	Depression or Mood Swings _____	_____	_____	Other: _____
_____	_____	_____	Fibromyalgia _____	_____	_____	_____
_____	_____	_____	Neuropathy or Nerve Damage _____	_____	_____	_____

List any diseases in the family: _____

ALLERGIES – Please X those that apply:

_____ No known allergies	_____ Aspirin	_____ Penicillin	_____ Sulfa Drugs
_____ Erythromycin	_____ Iodines/dyes	_____ Morphine	_____ Metals
_____ Codeine	_____ Foods	Other: _____	

MEDICATIONS – Please list all medications you take regularly: _____ I have provided a separate list of my medications

Physician reviewed all information above: _____