



*Advancing Foot and Ankle Care for the Carolinas*

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To Whom It May Concern:

In an effort to comply with Medicare requirements and guidelines, Carolina Foot & Ankle Associates created a policy for all new nursing home patients to facilitate the appointment process. Unfortunately, we continue to have problems with patients arriving without authorization to be treated, without adequate medical histories or without a clear reason for the referral.

**Because of this concern, we are now requiring a family member or power of attorney to be with the patient at each visit.**

Effective immediately, all patients from your facility require the following:

1. For new patients, paperwork must be completed in full and returned to CFA for our staff to review **prior to scheduling**. We are happy to send and receive the paperwork via fax for your convenience. If the patient is not responsible for his or her bills, the power of attorney must sign on the patient's behalf. Please provide the following information:
  - a. Complete list of current medications & allergies
  - b. Complete medical problem list (if the patient does have severe PVD, returning a copy of the attached PVD form will ensure coverage for palliative services)
  - c. Copy of all insurance cards
  - d. A written order stating the reason for the patient's appointment
2. Any established patients receiving routine foot care must pay the \$42 visit fee at the time of service. If the patient is not responsible for their bills and there is no power of attorney, please note that **we will hold the facility responsible** for any unpaid routine care charges.
3. Medicare patients who do not have secondary coverage must pay their coinsurance at the time of service.

If you have any questions regarding the above policy, please feel free to contact me directly. Thank you in advance for your cooperation.

Sincerely,

Julia Gold  
Practice Administrator

**Carolina Foot & Ankle Associates, PLLC**

1501 Tate Blvd SE Suite 203

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828-304-0400

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Dear Colleague:

I have advised a mutual patient of ours ( \_\_\_\_\_ DOB: \_\_\_\_\_ )  
that due to his/her medical condition, listed below, the performance of palliative foot care  
may pose a health hazard when performed by a non-professional.

**SEVERE PERIPHERAL VASCULAR DISEASE**

IF... You agree that this patient has a systemic condition that has resulted in severe  
circulatory embarrassment,

AND... You are providing care to this patient for this condition at least every 6 months

THEN... Please sign below and have the patient bring this form to our office on the next  
visit. This will ensure coverage for palliative services.

Thank you for your cooperation.

Sincerely,

The Physicians of Carolina Foot & Ankle Associates

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Physician Name (please print): \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**NOTE: MEDICARE REQUIRES THAT THIS FORM BE SIGNED BY A MEDICAL  
DOCTOR, NOT A PHYSICIAN ASSISTANT OR A NURSE**

**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: \_\_\_\_\_