



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

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 Init. _____

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 Insurance Company: _____	Policy Holder _____
Relationship to Patient: _____	Date of Birth _____
Secondary Insurance Company: _____	Policy Holder _____
Relationship to Patient: _____	Date of Birth _____

If someone (other than patient) is responsible for the patient's bill, please complete the following:	
Responsible Party Name: _____	
Mailing Address _____	City _____ State _____ Zip _____
If the patient is in a facility, Name _____	Phone Number _____
Example: Nursing Home	

In case of emergency, whom do we contact? _____

Home # _____ Cell# _____ Work# _____

How did you learn of 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 or 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 occasions of service until it is revoked.

DATE _____ SIGNATURE _____

AUTHORIZATION FOR RELEASE OF INFORMATION TO FAMILY AND/OR FRIENDS

Name of Patient _____ 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: _____

Description of information to be received

_____ Financial information _____ Information results from tests or x-rays.

_____ Family Billing Information:

_____ Medical information as follows: _____

_____ Other information as described: _____

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.

_____ Date _____
Signature of Patient or Personal Representative

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



ACKNOWLEDGEMENT OF RECEIPT

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 THIS FORM, YOU AGREE THAT YOU HAVE HAD THE OPPORTUNITY TO READ OUR NOTICE OF PRIVACY PRACTICES.

I HAVE READ A COPY OF THE NOTICE OF PRIVACY PRACTICES FOR CAROLINA FOOT & ANKLE.

PATIENT NAME (PLEASE PRINT)

SOCIAL SECURITY NUMBER OF PATIENT

SIGNATURE OF PATIENT OR REPRESENTATIVE

DATE

Patient's Name _____ Date _____ Age _____

This information is important for our records and for your health.

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? (eg: back or leg pain) _____

7. List previous (and current) treatments for the condition. _____

8. Do you have any 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. (Give dates) _____

Do you have any artificial joints? ____ Yes ____ No

Do you have a heart valve implant? ____ Yes ____ No

Do you have 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 _____

Patient's Name _____ Date _____

GENERAL HEALTH INFORMATION

Who is your family doctor? _____ Date of last exam? _____

Do you currently have any problems in the following areas?

Yes	No		Yes	No	
___	___	Fever _____	___	___	Fibromyalgia _____
___	___	Recurrent infections _____	___	___	Diabetes _____
___	___	Hearing loss _____			# of Years _____
___	___	Chest pain _____			Check B.S. Daily? Y / N
___	___	Shortness of breath _____			Last HgA1c _____
___	___	Persistent cough _____	___	___	Emphysema _____
___	___	Abdominal pain _____	___	___	Tuberculosis _____
___	___	Black tarry stools _____	___	___	Angina _____
___	___	Pain with urination _____	___	___	Past heart attacks (when?) _____
___	___	Increased frequency of urination _____	___	___	Stomach ulcers _____
___	___	Painful joints (if yes, where?) _____	___	___	Hiatal hernia _____
___	___	Joint swelling _____	___	___	History of blood clots _____
___	___	Skin lesions _____	___	___	Hepatitis _____
___	___	Persistent rashes _____	___	___	Cirrhosis _____
___	___	Seizures _____	___	___	Kidney disease _____
___	___	Depression or mood swings _____	___	___	Gout _____
___	___	Increased thirst _____	___	___	Anemia _____
___	___	Bleeding disorders _____	___	___	Cancer _____
___	___	High blood pressure _____	___	___	HIV _____
___	___	Asthma _____	___	___	Other _____

List any diseases in family: _____

ALLERGIES Please "X" those that apply:

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

MEDICATIONS (List all medications you take regularly.)

Physician reviewed all information above

Carolina Foot & Ankle Associates, PLLC

1501 Tate Blvd SE Suite 203

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828-304-0400

828-304-0142 (fax)

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

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**