Thank you for choosing ***Family Foot and Ankle Solutions, P.A***. for your foot and ankle needs! We will strive to provide you with the best possible foot and ankle care. To help us meet all of your needs, please fill out these forms *COMPLETELY*. If you have any questions or need assistance, please ask us. We will be happy to help. *PLEASE PRINT CLEARLY*

Last Name:_____ **First:**_____ **Middle:**_____
DOB:_____ **SS #:**_____ **GENDER:** *Circle One* **M/F**
Address: _____ **City/State/Zip**_____
Home Phone # _____ **Cell Phone #** _____ **Other:**_____
Marital Status: *Circle One* **Married/Single/Divorced/Widow**
Race: *Circle One* **African American/Native American/Caucasian/Asian/Hispanic/Other /Decline**
Ethnicity: *Circle One* **Hispanic or Latino/Non Hispanic or Latino/Other/Decline**
Preferred Language: *Circle One* **English/Spanish/Other/Decline**
Employer: _____ **Occupation:** _____ **Phone:** _____
Primary Care Physician: _____ **Phone #:** _____
Address:_____ **Date Last Seen:** _____
May we send a letter to your PCP concerning your evaluation and treatment today? YES / NO
Preferred Pharmacy: _____ **Phone:** _____
Address: _____

Emergency Contact: _____ **Phone #:** _____
Relationship to you: _____
May we leave a message on an answering machine/voice mail at provided phone number(s)? Yes/No
Who can we leave messages with? *Please Provide Name* _____ *Circle One* **Spouse/Child/Other**
We provide your Personal Health Record (PHR) within 4 days of your visit. The PHR *requires* an email address.
Please provide your email address: _____

Primary Insurance: _____
Policy #: _____ **Group #:** _____
Address: _____
Subscribers Name: _____
DOB: _____
Relationship to patient: *Circle* **Spouse/Parent/Self/Other**
Address:_____
Home Phone #: _____ **Cell #:**_____

Secondary Insurance: _____
Policy #: _____ **Group #:** _____
Address: _____
Subscribers Name: _____
DOB: _____
Relationship to patient: *Circle* **Spouse/Parent/Self/Other**
Address:_____
Home Phone #: _____ **Cell #:**_____

If someone (*other than the patient)* is responsible for payment (co-pays, deductibles, etc) please complete the following:
Responsible Party's Last Name:_____ **First:**_____ **Middle:**____
DOB:_____ **SS #:**_____ **GENDER:** *Circle One* **M/F**
Address: _____ **City/State/Zip**_____
Home Phone # _____ **Cell Phone #** _____

The undersigned guarantees payment to Family Foot and Ankle Solutions, P.A. of all charges and services provided to the patient. I understand that I am personally responsible for all charges not covered by my insurance and that it is my responsibility to understand the individual health insurance coverage. I authorize the release of medical information necessary to process any claim. I authorize payment of benefits to Family Foot and Ankle Solutions, P.A., as agreed upon at the time of treatment. I certify that all information provided by me is correct.

PATIENT SIGNATURE: _____ **DATE:** _____

Signature of Authorized Representative: _____**Relationship:** _____

Last Name:_____ First:_____

What is the reason for your visit today? _____
The pain quality is: *Circle any that apply* Aching/Burning/Constant/Dull/Sharp/Shooting/Throbbing/Tingling
How long has this bothered you? _____ days/weeks/months/years *(Circle One).*
Are you having any: *Circle any that apply* Fever/chills/nausea/vomiting?
Is condition due to an accident/injury? Yes/No Date of accident/injury_____
Please list any over-the-counter or prescription products or any previous treatment you have tried: _____
_____

Please list all Medical problems you are currently being treated for: _____
_____

Please list all medications you are currently taking:_____
_____
Are you allergic to any of the following: *Circle any that apply* LATEX/LOCAL ANESTHETICS/ SULFA DRUGS/GENERAL ANESTHESIA/PENICILLIN/ANTIBIOTICS/ ADHESIVE TAPE/SEDATIVES/CODEINE/IODINE/ASPIRIN
OTHER_____ No Known Allergies

Have you ever had any surgical procedures on your foot/ankle? Yes / No
If Yes list type of surgery:_____
_____
Please list all other surgeries:_____
_____

Do you Smoke? Never_____ Previously, but quit:_____ Current packs per day:_____
Do you drink Alcohol? ___Never ___Rarely ___Moderate ___Daily. How much do you weigh? _____
What is your height? _____ What is your shoe size? _____ Women – Are you pregnant? YES/NO

CHECK ANY OF THE FOLLOWING CONDITIONS THAT MEMBERS OF YOUR IMMEDIATE FAMILY HAVE/HAD:
__Bleeding Disorder __Cancer __Diabetes __Heart Disease __Problem with General Anesthesia__High Blood Pressure
Other:_____

CHECK ANY OF THE FOLLOWING CONDITIONS THAT YOU HAVE/HAD:
__Arthritis __Blood clots __Blood in the stool __Blurred vision __Bruising __Carpal tunnel __Chest pain __Fainting Spells __Heat or cold intolerance __Hearing loss __Headaches __Heartburn __Hepatitis __Jaundice __Kidney Problems __Palpitations __Psoriasis __Ringing in the ears __Sciatica __Seizures __Shingles __Shortness of breath
Other:_____

Who can we thank for referring you? _____

I certify that all information on my intake form(s) is correct to the best of my knowledge. I understand that it is my responsibility to notify the physician and/or staff of any and all updates to my information. I understand that providing incorrect information can be dangerous to my health. I hereby authorize Family Foot and Ankle Solutions to retrieve my medical and/or medication history and perform the necessary services I may need.

SIGNATURE: _____ DATE: _____

Last Name:_____ **First:**_____

Family Foot and Ankle Solutions, P.A. appreciates the confidence you have shown in choosing us to provide your foot care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. This financial policy contains important details about billing and payments for our professional services. It outlines your responsibility concerning billing and payment for our services.

Insurance: Family Foot and Ankle Solutions, P.A. participates in most insurance plans, including Medicare. If we participate with your plan we will bill the insurance carrier directly and you will be responsible for co-payments, deductibles, non-covered services, etc. Please remember that your insurance coverage is a contract between you and your insurance company. Insurance policies often do not provide full payment of medical costs, and you are responsible for any services which your insurance plan does not cover. Contact your insurer directly for any questions regarding your coverage. Medicare patients are responsible for their 20% co-insurance and yearly deductible. Having secondary insurance DOES NOT mean that your services are covered 100%. Secondary insurers will pay based on your primary carrier. We will bill your secondary carrier as a courtesy. You are responsible for any remaining balance.

Referrals: Insurance companies sometimes require their members to obtain a referral from their primary care doctor before seeing a specialist such as a podiatrist. It is your responsibility to obtain a referral if needed**.** In the absence of the required authorization or referral, the patient's visit may be rescheduled or the patient may be personally responsible for payment for the services rendered. We are unable, through contractual obligations with insurance carriers, to back-date referrals. Be aware that most referral authorizations are good for a certain number of visits and have an expiration date. If you have any questions about obtaining a referral we will be happy to assist you. Written or verbal authorizations from insurance plans are not a guarantee of payment.

Co-Payments: Co-payments, coinsurance, deductible and any service not covered by patient's insurance plan are the patient's responsibility. All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company.

Non-Payment: If your account becomes more than 90 days past due, you will be required to pay your account in full within 10 days. Payment arrangements can be made with our billing office if you are unable to pay in full. If your account is sent to an outside collection agency we will add a $35 processing fee to your balance. We encourage you to call our billing staff if you need assistance.

Missed Appointments: If you must cancel an appointment, please give our office as much notice as possible so that we may allow other patients to utilize your appointment time.

Returned Checks: You will be charged a $40 returned check fee if a personal check is returned for non-payment/insufficient funds.

Accepted forms of payment are CASH, CHECK, VISA, MASTERCARD, and AMERICAN EXPRESS.

I have read and understand the payment policy and agree to abide by its guidelines.

SIGNATURE:_____ **DATE:**_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the notice.

_____ _____

Patient Name (please print) Date

_____

Signature

_____

Parent or Authorized Representative (if applicable)

ALL PATIENTS MUST COMPLETE OUR INFORMATION, INSURANCE FORMS AND SIGN THE FINANCIAL AGREEMENT BEFORE SEEING THE DOCTOR.