Email address:

_____

PATIENT INFORMATION (INFORMACIÓN PARA EL PACIENTE)

Name (Nombre)_____ Date of Birth: _____/_____/_____
First (Primero) Middle (Cenrtro) Last (Apellido) (Fecha de Cumpleaños)

Social Security # (Número de Seguro Social): _____ Sex (Género): □ M □ F

□ Single (Solo) □ Married (Casado) □ Divorced (Divoricado) □ Widowed (Viudo)

Address (Dirección):_____
Street (Calle) City (Ciudad) State (Estado) Zip (Codigó Postal)

Home phone (Teléfono de casa): ( ) _____ Work phone (Teléfono Trabajo): ( ) _____

Cell phone (Teléfono cellular) ( ) _____ Spouse phone (Teléfono de su Esposa): ( ) _____

PATIENT EMPLOYER INFORMATION (INFORMACION DEL EMPLEADOR DEL PACIENTE)

Patient's Employer (Empleador del Paciente):_____

Address (Dirección):_____
Street (Calle) City (Ciudad) State (Estado) Zip (Codigó Postal)

Patient's Occupation (Ocupación del Paciente): _____ Work Contact (Trabajo Contacto)_____

Contact ph # (Contacto ph #): ( )_____ Contact Fax # (Contacto Fax #) ( )_____

work related injury (Trabajo lesion relacionado)? □ Yes (Sí) □ No

Have you notified your personnel department (Ha notificado el department de persona)l? □ Yes (Sí) □ No

Describe your injury (Describir su lesion): _____

POLICY HOLDER (GUARANTOR) EMPLOYER INFORMATION (ASEGURADO ((GARANTE)) INFORMACION DEL EMPLEADOR)

Policy holder name (Nombre del Asegurado): _____

Address (Dirección): _____
Street (Calle) City (Ciudad) State (Estado) Zip (Codigó Postal)

Policy holder date of birth (Fecha de Cumpleaños de Asegurado) : _____/_____/_____ Social Security # (# de Seguro Social): _____

Sex (Género) □ M □ F

Policy holder employer name (Empleador del Asegurado): _____

Address (Dirección): _____
Street (Calle) City (Ciudad) State (Estado) Zip (Codigó Postal)

EMERGENCY CONTACT INFORMATION (INFORMACIÓN DE CONTACTO DE EMERGENCIA)

Name (Nombre): _____ Address (Dirección): _____

Home phone (Teléfono de casa): ( ) _____ Cell phone (Teléfono cellular): ( )_____

Work Phone (Teléfono Trabajo): ( ) _____

CONSENT FOR RELEASE OF YOUR MEDICAL INFORMATION (CONSENTIMIENTO PARA LA DIVULGACIÓN DE SU INFORMACIÓN MÉDICA)

I hereby give my permission for Southern Star Foot and Ankle to release my medical information to:
(Yo doy mi permiso para que Southern Star Foot and Ankle para liberar mi información médica para:)

_____

My medical information may be released (Mi información médica puede ser divulgada): □ verbally (verbalmente) □ written (escrito)

EXPLANATION OF PAYMENT POLICY AND INSURANCE FILING PROCEDURES

(EXPLICACIÓN DE LA POLÍTICA DE PAGO Y PROCEDIMIENTOS DE PRESENTACIÓN DE SEGUROS)

I hereby authorize Southern Star Foot and Ankle to release medical information and necessary data pertinent to the filing of insurance papers in the interest of the patient named above and the facility. I understand that I am responsible for payment to Southern Star Foot and Ankle for charges for the above patient, regardless of my insurance coverage. I also understand that Southern Star Foot and Ankle is not ultimately responsible for collecting my insurance or negotiating settlements of claims.

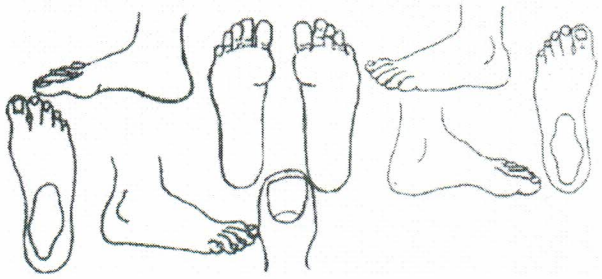
(Por la presente autorizo a Southern Star Foot and Ankle para liberar información médica y los datos necesarios pertinentes para la presentación de los papeles del seguro en el interés del paciente arriba mencionado y las instalaciones. Yo entiendo que soy responsable por el pago de Southern Star Foot and Ankle de los cargos para el paciente antes, a pesar de mi cobertura de seguro. También entiendo que Southern Star Foot and Ankle no es en última instancia responsable de recoger mi seguro o negociar la liquidación de reclamaciones.)

Patient/Guarantor's signature (Paciente / Garante firma):_____ **Date (Fecha):**_____

PATIENT HISTORY FORM (FORMA DE LA HISTORIA DEL PACIENTE)

Please fill out the following confidential form for our records. Please indicate where you feel pain on the foot and ankle diagram below.
(Por favor rellene el siguiente formulario confidencial para nuestros registros. Indique donde sente el dolor en el pie y tobillo en la diagrama a continuación.)

Circle (Circule) : RIGHT (DERECHO) LEFT (IZQUERDO)



Patient Name (Nombre del Paciente): _____

Age(Edad): _____ Race (Etnicidad): _____ Gender (Género): _____

Height (Altura): _____ Weight(Peso): _____ Shoe Size (Tamaño del zapato) : _____

Current Foot or Ankle Problem (Pie o Tobillo Problema): _____

Nature of Pain eg. Sharp, Dull, Achy,etc. (Naturaleza del Dolor eg. intenso, leve, dolorido, etc): _____

Location of Pain (Localización del Dolor): _____

Onset /What Happened? (El Inicio /¿Qué pasó?) : _____

Course of Illness eg. Constant,Worsening,etc. (Curse de la Enfermedad eg. Constante,empeoramiento,etc.): _____

Aggravating Factors /What makes pain Worse? (Factores agravantes /¿Qué empeora el dolor?) _____

Treatment /What makes pain better? (Tratamiento /Lo que hace mejor el dolor? _____

REVIEW OF SYSTEMS (REVISIÓN DE LOS SISTEMAS)

Do you wear Glasses or Contacts? (¿Usted usa lentes o pupilentes?) _____Yes(Sí) _____No

MEDICAL HISTORY (HISTORIA MÉDICAL)

- ☐ Acne
- ☐ Acid Reflux (GERD)
- ☐ Anemia / Sickle Cell
- ☐ Anxiety
- ☐ Arthritis
- ☐ Joint Replacement
- ☐ Asthma
- ☐ Basal Cell Cancer
- ☐ Bleeding Disorder
- ☐ Cancer
- ☐ Cataracts
- ☐ Charcot Foot
- ☐ Charcot Marie Tooth Disease
- ☐ Depression
- ☐ Diabetes
  - ○ Insulin
  - ○ Non Insulin
- ☐ Diverticulitis
- ☐ Fibromyalgia
- ☐ GI bleeding / Ulcers
- ☐ Gout
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Hepatitis A, B, C
- ☐ Hernia
- ☐ High Blood Pressure (Hypertention)
- ☐ High Cholesterol
- ☐ Immune Diseases (AIDS, HIV)
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Malignant Melanoma
- ☐ Mitral Valve Prolapse
- ☐ Muscular Disorders
- ☐ Pulmonary Fibrosis
- ☐ Peripheral Vascular Disease
- ☐ Raynaud's Disease
- ☐ RSD
- ☐ Rosacia
- ☐ Squamous Cell Cancer
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Wart

List any other medical problems you have not listed above (Enumere cualquier otro problema médico que no ha enumerados anteriormente):

_____

_____

Surgeries and Hospitalizations (Cirugías y Hospitalizaciones): _____

_____

_____

Allergies (Alergias): _____

_____

_____

Medications (Medicamentos): _____

_____

_____

_____

Pharmacy (Farmacia) _____

Social History (Historia Social):

Occupation (Ocupación): _____

Disabled (Discapacitado)? ___Yes (Sí) ___No Retired (Retirado)?___Yes(Sí) ___No

Sports & Exercise (Deportes y Ejercicio)? ___Yes (Sí) ___No Type of Activities (Tipo de Actividad): _____

Tobacco (Tabaco): ___Yes (Sí) ___No How much per day & what kind? (¿Cuánto por día y qué tipo?) _____

Alcohol: ___ Yes (Sí) ___No How much per day & what kind? (¿Cuánto por día y qué tipo ?) _____

Caffeine (Cafeína): ___ Yes (Sí) ___No How much per day & what kind? (¿Cuánto por día y qué tipo?) _____

Family History (Historia Familiar): List medical problems your parents have/had:

Mother (Madre) _____Alive (Vivo) _____Deceased (Fallecido): _____

Father (Padre) _____Alive (Vivo) _____Deceased (Fallecido): _____

Your Family Physician (Su médico de familia): _____

Date last seen (Month/Year) (Fecha de última cita (mes / año)) _____

Your Family Physician Phone Number (El Número de teléfono de Médico de familia) (____) _____

Whom may we THANK for referring you to our office? (¿ A quién le damos las gracias por referirlo a nuestra oficina?) _____

I hereby give Southern Star Foot and Ankle permission to diagnose and administer treatment for my foot and/or ankle condition and I authorize any release of information obtained in the course of my treatment.

(Yo doy Southern Star Foot and Ankle permiso para diagnosticar y administrar el tratamiento para el pie y / o condición de tobillo y yo autorizo a cualquier divulgación de la información obtenida en el curso de mi tratamiento.)

Signature (Firma): _____ **Date (Fecha):** _____

Southern Star Foot and Ankle Privacy and Financial Policy

Thank you for choosing Southern Star Foot and Ankle as your healthcare provider. We are committed to your treatment being successful. Please read and sign our financial policy prior to treatment. Please take note of the following office policies:

- FULL PAYMENT is due at the time of service. If you are contracted with an HMO, PPO, POS or Third Party Insurance Company, then CO-PAYMENT/CO-INSURANCE does apply and will be collected at each visit.
- YOU are responsible for providing us with any UPDATED insurance information prior to treatment; otherwise, YOU will be responsible for the balance.
- Failure to cancel your appointment (failure to notify us you will not be coming) at least one (1) day before your appointment WILL result in a $50.00 non-cancellation fee as you are blocking out time slots other patients could use.

Regular Insurance: We require all patients who are contracted with regular indemnity insurance to pay at the time of service unless other arrangements have been made with the office manager. We also require payment of any outstanding balance at time of office visit. We will provide you with the necessary documentation upon request.

Medicare Insurance: After your yearly deductible has been met, we will accept assignment of benefits as set forth in your Medicare Part B. Medicare sets the fees that we may charge and Medicare requires all patients to pay their 20% of the approved amount at the time of service. If you have supplemental coverage (MEDIGAP), we may be able to file this for you as well as if it is a plan that we participate in. Please provide us with your secondary insurance information so that we may appropriately inform you. Medicare does NOT cover ALL services. Our staff is aware of most of the non-covered services, and we will alert you prior to your treatment if possible.

HMO-PPO-POS-Third Party Insurance: All co-payments, co-insurance, and deductibles are due at the time of treatment. In the event your insurance coverage changes, please advise us immediately. If your plan requires a primary care physician referral, it is your responsibility to obtain the appropriate referral prior to the appointment. We will attempt to assist in reminding you when you need a referral. Please be advised that some, and perhaps all of the services provided may be NON-COVERED services under your plan and they may become YOUR responsibility regardless of what type of coverage you have.

Minor Patients: The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For the unaccompanied minor, treatment will be denied unless appropriate consent has been received and charges have been pre-authorized and payment has been made prior to treatment.

Delinquent Accounts: All accounts that are past due Ninety (90) days or more will be charged a cumulative interest rate of 12% or $50.00 collection fee, whichever is greater on all outstanding charges. Please keep your account current, and if this is not possible, please alert us immediately (to avoid the charges above). We are always able to find an amicable solution.

Returned Checks: All checks returned by the bank for "Insufficient Funds" will be charged with a $100.00 processing fee, and we do require the check be replaced by cash or money order within 7 days.

Refunds of Supplies: There will be NO refunds on any supplies dispensed. Unfortunately, every supply dispensed or prescribed may not work for all patients. However, we strive to ensure we make every effort to have a satisfactory outcome.

Additional Fees: Copies of digital x-rays will be provided upon request for a fee of $50.00 / disc. Disability forms that need to be completed by our office incur a charge of $50.00 / form. Copies of medical records will require 7 days written notice and incur a charge of $50.00.

Notice of Privacy Practices Acknowledgement: I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan, and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly. Obtain payment from third-party payers. Conduct normal healthcare operations such as quality assessments and physician certifications. I understand that Southern Star Foot and Ankle reserves the right to change these policies at any time and I may contact the office for an updated copy at any time. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

With the ever changing environment of healthcare, it is necessary we set guidelines for our patients to ensure no future misunderstandings. We all must work together to ensure your experience with our office is a good one.

I have read the above FINANCIAL POLICY. I understand and agree to comply with it.

Signature: _____ Date: _____

Authorization to Treat Minor Patient in Absence of Parent/Guardian

(Autorización para tratar la paciente menor en ausencia del padre / tutor)

Name of minor patient: _____ Date of Birth: _____
(Nombre del paciente menor de edad) (Fecha de nacimiento)

I certify that I am the parent and/or legal guardian of _____
(Yo certifico que soy el padre y / o tutor legal del) (*Name of child* / Nombre del Niño)

☐ I authorize (yo autorizo) _____
(*name of person bringing child to office*/ nombre de la persona que puede llevar al niño al consultorio)

to bring my child to office visits with Dr. _____
(para llevar a mi hijo a visitas de la oficina con el Dr.) (*name of physician* / nombre del médico)

☐ I authorize the minor child named above to come alone to office visits with Dr. _____
(Yo Autorizo que menor nombrado arriba puede vener solo a consultas con el Dr.) (name of physician / nombre del médico.)

and I consent to the examination and/or treatment of my child.
(y doy mi consentimiento para el examen y / o tratamiento de mi hijo.)

This authorization (Esta autorización):

☐ is effective on (Es efectivo en) _____

☐ is effective from (Es efectivo a partir de) _____ to (a) _____

☐ is effective until revoked by me in writing (es efectivo hasta que sea revocada por mí por escrito)

Parent/Legal Guardian Contact Information: (Padre / Tutor Legal Información de contacto:)

Home phone number _____
(número de teléfono de su casa)

Office phone number _____
(número de teléfono de la oficina)

Cell phone number _____
(Número de teléfono celular)

Other phone number _____
(Otro número de teléfono)

I reserve the right to revoke this authorization at any time by writing to the above-named physician.
(Me reservo el derecho de revocar esta autorización en cualquier momento mediante escrito dirigido al médico mencionado.)

Parent/Guardian Signature (Firma del Padre / Guardián): _____ Date (Fecha): _____

Witness Signature (Firma del testigo): _____ Date (Fecha): _____