CONSENT *for* TEST RESULTS

PINNACLE
Foot and Ankle Clinic

I give **Pinnacle Foot and Ankle Clinic** permission to leave x-ray, lab results, prescriptions and other medical information or advice on: *(please check all that apply)*

☐ Voicemail at Home
Home Number:_____

☐ Voicemail at Work
Work Number:_____

☐ Voicemail on Mobile Device
Mobile Number:_____

☐ Family member / friend
Name / Phone Number:_____

Name / Phone Number:_____

Name / Phone Number:_____

Name / Phone Number:_____

☐ Other
_____

_____

_____

_____ _____
Name of Patient (Print or Type) Date of Birth

_____ _____
Signature of Patient Date

CONFIDENTIAL PATIENT HEALTH RECORD

PINNACLE
Foot and Ankle Clinic

Today's Date:_____

Patient Name:_____ Date of Birth:_____

Street Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone: _____

Work Phone:_____ Email Address: _____

Sex: ☐ Male ☐ Female Social Security No._____

Employer:_____ Occupation:_____

Marital Status (circle one): Single Married Divorced Separated Widowed

If applicable:

Name of Spouse: _____ Spouse's Employer:_____

Spouse's Work Phone:_____

Name and Phone Number of Emergency Contact: _____

HOW DID YOU HEAR ABOUT US?_____

RESPONSIBLE PARTY: (Primary Insurance Holder)

Relationship to Responsible Party: ☐ Self ☐ Spouse ☐ Son ☐ Daughter ☐ Other:_____

Name:_____ Date of Birth:_____

Street Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone: _____

Work Phone:_____ Email Address: _____

Sex: ☐ Male ☐ Female Social Security No._____

Employer:_____ Occupation:_____

CONSENT FOR MEDICAL TREATMENT I, the undersigned patient, having come to **Pinnacle** Foot and Ankle Clinic voluntarily to obtain medical advice and treatment, give my informed consent to be evaluated and treated by the medical doctors and staff of **Pinnacle** Foot and Ankle Clinic. This includes all verbal discussions, physical examinations, and medical procedures that may be deemed necessary by my care providers. I can, at any time, withdraw my consent for specific procedures after discussion with my care providers.

Patient Name:_____ Date:_____

Signature:_____ Relationship to patient: ☐ Self ☐ Parent ☐ Guardian

MEDICAL HISTORY

PINNACLE
Foot and Ankle Clinic

Patient Name:_____

Name of Primary Care Physician (PCP): _____ PCP Phone: _____

Height:_____ Weight:_____ ShoeSize:_____

Do you have or have you ever had...

(please check all that apply)

- ☐ AIDS/HIV
- ☐ Allergies
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Anxiety
- ☐ Alcohol Dependency
- ☐ Back Pain
- ☐ Bleeding Disorders
- ☐ Blood Clots
- ☐ Bronchitis
- ☐ Cancer
  Type:_____
- ☐ Chemical Dependency
- ☐ Chest Pain
- ☐ Chronic Diarrhea
- ☐ Circulatory Problems
- ☐ Cirrhosis
- ☐ COPD
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Depression
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Elevated Cholesterol
- ☐ Fainting
- ☐ Foot or Leg Cramps
- ☐ Foot Ulcer
- ☐ Gout
- ☐ Glaucoma
- ☐ Gallbladder Disease
- ☐ Headaches
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Hypothyroidism
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Hemophilia
- ☐ Hernia
- ☐ High Blood Pressure
- ☐ Kidney Failure
- ☐ Kidney Stones
- ☐ Jaundice
- ☐ Liver Disease
- ☐ Migraines
- ☐ Nervous Disorders
- ☐ Osteoporosis
- ☐ Pace Maker
- ☐ Phlebitis
- ☐ Pneumonia
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Shortness of Breath
- ☐ STD
- ☐ Stroke
- ☐ Stomach Ulcer
- ☐ Sinus Infection
- ☐ Swelling in Feet/Legs
- ☐ Urinary Tract Infection
- ☐ Tuberculosis
- ☐ Varicose Veins

Check any of the following you or your relatives have had:

	Arthritis	Osteoporosis	Cancer	Diabetes	Heart Trouble	Stroke	Anxiety	Bleeding Disorders
Father	☐	☐	☐	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐	☐	☐	☐
Sister	☐	☐	☐	☐	☐	☐	☐	☐
Spouse	☐	☐	☐	☐	☐	☐	☐	☐
Children	☐	☐	☐	☐	☐	☐	☐	☐
Grandparents	☐	☐	☐	☐	☐	☐	☐	☐

MEDICAL HISTORY (cont'd)

PINNACLE
Foot and Ankle Clinic

Patient Name:_____

Please list any prescription medications you are currently taking or have taken in the last year:

Medication Name	Diagnosis

Please list any over-the-counter medications you are currently taking, include vitamins, herbals, supplements:

Product	Symptom	Quantity and Frequency

Are you allergic to any of the following (please check all that apply):

☐ Adhesive tape ☐ Aspirin ☐ Codeine ☐ Iodine ☐ Local Anesthetics ☐ Penicillin ☐ Sulfa

Other Drug Allergies: _____

Food/Animals: _____

Please list all the surgical procedures you have had:

Procedure	Date of Procedure

MEDICAL HISTORY (cont'd)

PINNACLE Foot and Ankle Clinic

Patient Name:_____

Please describe any hospitalizations you have had in the past 20 years, include date and diagnosis:

_____

_____

_____

_____

_____

Date of last Tetanus Vaccination:_____

Tobacco Use: # of years smoked _____ Packs per Day _____Quit Date _____

Alcohol Use: # of glasses per week _____ Type Consumed_____

Substance use:
Name of Substance(s)_____ Last Date of Use _____

CURRENT HEALTH CONDITION

Overall Health (check one): ☐ Excellent ☐ Good ☐ Fair ☐ Poor

What is the reason you are here? _____

_____

_____

Have you seen other physicians for this condition? ☐ Yes ☐ No

Name of Physician _____ Type of Treatment _____

Results: _____

_____

When did this condition begin? _____

Has this condition occurred before? ☐ Yes ☐ No Do you wear orthotics? ☐ Yes ☐ No

OFFICE POLICY

PINNACLE
Foot and Ankle Clinic

To Our Patients

Each time you check in at the front desk, please notify us of any changes in your insurance coverage, home address, phone number, e-mail address, or Primary Care Physician. This allows the physician to always have the most current information to contact you regarding test results or updates on your medical status. This will also allow us to bill your insurance correctly.

Insurance Billing

There are over 1,000 insurance companies in the U.S. and different plans of coverage to choose from, therefore, it is impossible for our office to know the covered benefits of your insurance plan. Your insurance will be billed as a courtesy. It remains your responsibility to know what your insurance covers. You will need to know the following:

a) what information is required by your insurance
b) if referrals must be obtained
c) what co-payments are due
d) if your insurance covers as risk foot care (trimming nails & calluses).
e) if your insurance covers orthotics, diabetic shoes, or medical supplies.

Though we are happy to assist you, we must emphasize that as your podiatric medical provider, our relationship is with you, not your insurance company and knowing the above information will expedite the process of your treatment and avoid unexpected account balances.

Referrals

Required referrals must be obtained and presented at the time of your initial visit or prior to services rendered. If you do not have the required referral, we may ask you to reschedule your appointment.

Insurance Cards

You must present your insurance card at the time of your initial visit prior to services rendered. If you do not have your card, we may ask you to reschedule your appointment.

Orthotics

Orthotics are custom made inserts made especially for you. Orthotics are not always covered by insurance. The cost for a pair of custom orthotics is $395 for the first pair and $295 for each additional pair. A $100 deposit is required prior to the devices being sent for fabrication with the remaining balance due the day the devices are dispensed to you. Children's orthotics are $275 up to a children's size 10. We are happy to bill your insurance for the devices if they are deemed a covered benefit by your insurance provider. If your insurance denies payment, you must understand that you are financially responsible for the payment of these devices.

Financial Policy

Full payment of services received and any outstanding account balance is always expected at the time of service. We accept Visa, MasterCard, personal checks and cash. If your check is returned, your account will be charged the amount of the check plus a $50 processing fee. Should your account become delinquent and forwarded to collections, you shall be assessed maximum legal collection fees. All copays (agreement with your insurance company) are required before each visit. If you have a deductible that has not been met, 50% of service charges are to be paid at the time of your visit. Our office staff cannot predict the total cost of your visit and will not be held liable for accuracy of quotes given over the phone.

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Pinnacle Foot and Ankle Clinic, Inc all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

I have read and received a copy of these policies.

_____ _____ _____

Printed Name of Responsible Party Signature Date

Thank you for taking the time to read these policies. Should you have any questions, please do not hesitate to ask.

ACKNOWLEDGEMENT *of* RECEIVING NOTICE *of* PRIVACY PRACTICES

PINNACLE
Foot and Ankle Clinic

Pinnacle Foot & Ankle Clinic reserves the right to modify the privacy outlined in the notice.

I have received a copy of the Notice of Privacy Practices for Pinnacle Foot and Ankle Clinic.

_____
Name of Patient (Print or Type)

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient Representative (required of the patient is a minor or an adult who is unable to sign this form.) Relationship to Patient

FOR OFFICE USE ONLY

An attempt was made to obtain an acknowledgement or receipt of the Notice of Privacy Practices. The acknowledgement was not obtained because:

- ☐ Individual refused to sign
- ☐ Other: _____

_____