COASTAL PODIATRY CENTER

Physicians & Surgeons of the Foot & Ankle

PATIENT'S NAME_____ SEX: M• F•
(Please Print) LAST FIRST MIDDLE

DATE OF BIRTH_____ SOCIAL SECURITY#_____-_____-_____ MARITAL STATUS: M• W• S• D•

RACE/ETHNICITY: ASIAN • BLACK/AFRICAN AMERICAN • MEXICAN AMERICAN INDIAN• WHITE/CAUCASIAN• OTHER•

HOME ADDRESS_____ APT #_____

CITY _____ STATE_____ ZIP_____

HOME PHONE (___)_____ CELL PHONE (____)_____

PLEASE PROVIDE **EMAIL** FOR BETTER SERVICE_____

PATIENT EMPLOYED BY _____ WORK PHONE (____)_____

RESPONSIBLE PARTY (INSURED)_____ RELATIONSHIP_____

SPOUSE/PARENT NAME _____ EMPLOYED BY _____ DATE OF BIRTH_____

PRIMARY INSURANCE _____ SUBSCRIBER'S NAME _____

ID# _____ GROUP#_____ _____

SECONDARY INSURANCE._____ ID# _____ GROUP# _____

PHARMACY NAME_____ PHARMACY NUMBER (____)_____

HOW DID YOU HEAR ABOUT US? _____

FAMILY PHYSICIAN _____ DR.'S PHONE (___)_____

DR.'S ADDRESS _____ CITY _____ LAST VISIT _____

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED? _____

PHONE (____)_____ RELATIONSHIP_____

PREVIOUS TREATMENT BY PODIATRIST YES ( ) NO ( ) IF SO, WHEN _____

DESCRIBE TREATMENTS BY YOU OR ANY OTHER HEALTH PROFESSIONAL_____

_____

CHIEF FOOT CONCERN(S) **(DATE OF TRAUMA)**_____

_____

FOOT_____ANKLE_____RIGHT_____LEFT_____BOTH_____ **DURATION**_____

DESCRIBE PAIN (SHARP, DULL, SHOOTING, STABBING, ETC)_____

SIGNATURE _____ DATE _____

Medical History

Have you ever been treated for (select all that applies):

- ☐ Corns/Calluses
- ☐ Warts
- ☐ Athlete's Foot
- ☐ Fungal Nails
- ☐ Ingrown Nails
- ☐ Neuroma
- ☐ Leg/Foot Ulcers
- ☐ Foot Numbness
- ☐ Bunions
- ☐ Broken Foot/Bone
- ☐ Broken Ankle
- ☐ Ankle Sprain
- ☐ Hammer/Mallet Toe
- ☐ Leg/Foot Cramp
- ☐ Flat Feet
- ☐ Arch pain
- ☐ High Arch Feet
- ☐ Knee Pain
- ☐ Lower Back Pain
- ☐ Heel Pain
- ☐ Rash
- ☐ In-Toeing
- ☐ Toe Walking
- ☐ Gait Problems
- ☐ Childhood Foot Problems

Do you get leg cramps after activity?

Does foot pain limit your desired activities?

Do you have any difficult walking?

Any pain in the calves or buttocks when walking?

Is the pain relieved by stopping & standing still?

List the sports and other actives in which you are involved:

_____

_____

_____

Patient Medical History: Have you ever been treated for:

- ☐ Stroke
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Phlebitis
- ☐ Vascular Disease
- ☐ Heart Condition
- ☐ Anemia
- ☐ Poor Circulation
- ☐ Eyes: Glaucoma
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Keloid/Thick Scar
- ☐ Gout
- ☐ Osteoporosis
- ☐ Alzheimer's
- ☐ Sciatica
- ☐ Lyme's Disease
- ☐ Rheumatic Fever
- ☐ Arthritis
- ☐ Headaches
- ☐ Hearing/Ear Disorder
- ☐ Epilepsy
- ☐ Nerve Disorder
- ☐ Psychiatric Disorder
- ☐ Asthma
- ☐ Lung Disease
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ Liver Disease
- ☐ Thyroid Problem
- ☐ Dark Urine
- ☐ Chronic Light Stool
- ☐ Weight Loss
- ☐ Cancer
- ☐ Stomach Ulcer
- ☐ None of the above

Other: _____

Surgical History: Surgical procedures and complications:

_____

_____

_____

Past Family & Social History

List immediate family members who have had:

Diabetes _____ Foot Problems _____

Arthritis _____ Heart Attack _____

Stroke _____ High Blood Pressure _____

Cancer _____ Birth Defects _____

# of Childbirths ____ Are you currently pregnant?

Are you slow to heal after cuts

Any abnormal bruising, bleeding or scarring?

Do you smoke now?

Did you ever smoke?

If you quit, what year did you do so? _____

Alcohol use? ☐ None ☐ Rarely ☐ Moderately ☐ Daily ☐ Quit

Recreational Drugs? Please Select

Are you currently taking any medications? Please Select

Are you taking Insulin? Please Select

List medications, dose & purpose below:

_____

_____

_____

_____

_____

_____

Are you taking your medications as prescribed? Please Select

Allergies: Is there a history of skin reaction or other outward reaction or sickness following an injection, oral or topical administration of:

Latex, Adhesive tape	☐	Penicillin	☐
Other antibiotics	☐	Empirin, Tylenol	☐
Aspirin, Advil, Aleve, Motrin	☐	Celebrex	☐
Other pain remedies	☐	Morphine	☐
Codeine	☐	Other narcotics	☐
Novocaine	☐	Other anesthetics	☐
Sulfa drugs	☐	Shrimp, Iodine or Merthiolate	☐

Clearly list additional medication, drugs, foods, etc.

_____

_____

_____

_____

Review of Systems: Are you currently experiencing any of the following:

General:	☐ Decreased Strength	☐ Weight change	☐ Decreased exercise tolerance	
Head:	☐ Headaches	☐ Vertigo	☐ Injury	
Eyes:	☐ Abnormal vision	☐ Double vision	☐ Diminished vision	☐ Increased drainage ☐ Pain
Ears:	☐ Change in hearing	☐ Tinnitus	☐ Bleeding	☐ Vertigo
Nose:	☐ Nose bleed	☐ Obstruction	☐ Discharge	☐ Inflammation of mucous membrane
Mouth:	☐ Dental difficulties	☐ Gum bleeding	☐ Use of dentures	
Neck:	☐ Stiffness	☐ Pain	☐ Tenderness	☐ Noted masses
Chest:	☐ Shortness of breath	☐ Wheezing	☐ Cough	☐ Spitting up blood
Heart:	☐ Chest pains	☐ Palpitations	☐ Fainting	☐ Breathlessness
Abdomen:	☐ Difficulty Swallowing	☐ Appetite change	☐ Vomiting	☐ Bowel habit changes ☐ Tarry Stool ☐ Pain
Neurologic:	☐ Weakness	☐ Tremor	☐ Seizures	☐ Changes in mentation ☐ Lack of muscle control
Psychiatric:	☐ Depressive symptoms	☐ Change in sleep habits		☐ Changes in thought content

COASTAL PODIATRY CENTER
FEDERAL HEALTH PRIVACY RULE

CONSENT FORM

PRIVACY RULE

The Federal Government has developed regulations in an attempt to ensure the health care privacy of patients. This means that we cannot use or disclose health information for the purposes of treatment, payment, or health care operations without your written consent. As part of these regulations, we are required to inform you how this office utilizes, shares, and protects the health care information that we collect. Attached is a copy of our office policy and further detail regarding the Federal Health Privacy Rule.

You may revoke this consent at any time, or you may request additional restrictions on how your health care information is used and disclosed for treatment, payment, and health care operation purposes.

I agree with the Health Care Privacy Compliance utilized by this office.

PATIENT PRINTED NAME: _____ **DATE:** _____

PATIENT SIGNATURE: _____

EMAIL: _____

DO YOU HAVE: LIVING WILL: Y or N SURROGATE DECISION MAKER: Y or N

AUTHORIZATION for RELEASE of MEDICAL INFORMATION

I hereby authorize Coastal Podiatry Center to furnish my medical records consisting of, but not limited to consultation notes, diagnostic test results, progress notes, operative reports, and other medical information to named individual below. This release is in effect for o e year from the date noted _____

1. _____ **Relation:** _____

2. _____ **Relation:** _____

I HEREBY GIVE MY PERMISSION TO THE PHYSICIANS OF COASTAL PODIATRY CENTER TO ADMINISTER TREATMENT AND TO PERFORM SUCH PROCEDURES AS MAY BE NECESSARY BASED ON MY DIAGNOSIS AND/OR TREATMENT.

COASTAL PODIATRY CENTER

DISCLOSURES & FINANCIAL POLICY: PLEASE INITIAL EACH BELOW

_____ **INSURANCE BENEFITS AND COVERAGE:** Verification of coverage and eligibility IS NOT a guarantee that payment will be made by your insurance company. That is determined by your insurance company at the time the claim is submitted and reviewed. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Benefits may not be clearly defined during our research in your insurance coverages. If you ever have any questions regarding your coverage, please contact your insurance using the number presented on the back of your card. Ultimately, YOU are responsible for all costs uncured during treatment, apart from contractual adjustments and provider write-offs. **UNINSURED PATIENTS:** FULL Payment is due at the time of service. We accept cash, check, or credit cards.

_____ **BILLING FOR SERVICES:** Our office bills your insurance in accordance with predetermined fee schedules. It is the patient's responsibility to provide accurate, up to date insurance information so that billing may be done correctly. Once services fees are billed to your primary insurance, remaining costs will be billed to your secondary insurance automatically when applicable. If you have not met your deductible, you may be asked to make a payment to the office at the time of your visit. Any services that are clearly not covered by any insurances will be discussed prior to treatment so an upfront cash price can be agreed upon. A denial of coverage for services by your insurance may require you as the patient working with our billing team to appeal these types of decisions. Any balances due after insurance determinations will be billed to patients by mail. Patients are welcome to contact the billing team of Foot Ankle Specialty Centers to make payments or set up a payment plan. There is a $25.00 fee assessed for returned checks.

_____ **REFERRALS / AUTHORIZATIONS:** It is the patient's responsibility to obtain all referrals if your insurance requires one. If one is not obtained prior to yo appointment, you may be responsible for that appointment cost.

_____ **PAYMENT:** Payment is expected at the time of your visit. Patients with private insurance plans that include high deductibles of $1000 or more will need to pay a $150.00 deposit at the time of service. Our office accepts cash, check, and credit card. Payment will include any unmet deductible, coinsurance, copayment, and non-covered charges from your insurance company. If you are not able to pay your balance in full, you must contact out billing office to discuss a payment plan. Statements will be sent monthly.

_____ **DELINQUENT ACCOUNTS:** After 90 days of non-payment accounts will incur a "**Rebilling**" fee of $15.00. This will be repeated each month. If you have difficulty making a payment, you MUST contact us PRIOR to the due date to avoid these fees. A courtesy call will be placed before the account is subject to our collections process.

_____ **NONCOVERED BENEFITS:** We realize unforeseen circumstances may arise or that some insurance companies may not cover some medically necessary services (i.e., orthotics, nerve testing, diabetic foot care). In these instances, a payment plan may be available. These will be evaluated on a case-by-case basis. While we try to accommodate all our patients, we do maintain strict guidelines regarding payment plans. Failure to adhere to the payment schedule will result in a revocation of the payment plan agreement.

_____ **ADMINISTRATIVE SERVICES:** You will be charged a fee of $25.00 for disability or FMLA paperwork to be completed. The fee is payable upon presentation of the forms. The forms will NOT be completed until the $25.00 fee is received. Completion of legal forms can range from $50-$150 per physician's discretion. If you require a hard copy of medical records, a $10 fee will be charged.

_____ **CUSTOM PRODUCTS**: I understand that if a custom DME product is ordered for me, such as orthotics or special shoes, or I receive an air cast, night splint, surgical shoe, and/or ankle brace, that they are non-refundable and non-returnable. If my insurance denies them for any reason, I understand it is ultimately my responsibility and I will pay for the product(s) I have received.

_____ **NO SHOW / CANCELLED APPOINTMENT POLICY**: A missed, or cancelled, appointment leaves an open appointment that could have been used by a patient in need of medical care. A no-show appointment occurs when a patient, parent/legal guardian fails to give adequate notice, 24 hours, that the appointment cannot be kept. Foot Ankle Specialty Centers reserves the right to charge for a missed appointment. Failure to cancel or reschedule an appointment within 24 hours of the scheduled appointment will result in $50 fee, which is NOT covered by your insurance. If two (2) no- shows are incurred during a calendar year (January – December) a $50 fee will be applied to your account for each missed appointment. Habitually missed appointments could lead to a patient being discharged from the practice.

_____ **LATENESS**: If you are late for our appointment time, please call to inform the staff. They will review the schedule to determine if the appointment will need to be rescheduled to another day or work an appointment behind other scheduled appointments. After the 2nd late show a $50 fee will be applied to your account.

I, _____, have read the ***Disclosures & Financial Policy***, understand it, and agree to its terms.

Signature_____ Date:_____