FOOT + ANKLE SPECIALTY CENTERS

Patient Registration Form

Patient Name: _____ Date of Birth: _____ Sex: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed Social Security: _____-_____-_____

Ethnicity: _____ Race: _____ Primary Language: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Preferred Phone: _____ Secondary Phone: _____

Email: _____ Preferred Way to Confirm Appointments: ☐ Text ☐ Call

Emergency Contact: _____ Phone: _____ Relationship: _____

Advance Directive: ☐ Living Will ☐ Power of Attorney ☐ N/A Legal Forms Available: ☐ Yes ☐ No

Primary Care Physician / Facility: _____ Phone: _____

Referring Physician / Facility: _____ Phone: _____

How Did You Hear About Us? _____ Who Can We Thank? _____

Pharmacy: _____ Phone: _____ Fax: _____

Address: _____

Primary Insurance: _____ Policy ID / Number: _____

Claims Address: _____

Group Number: _____ Policy Holder: ☐ Self ☐ Spouse ☐ Other: _____

Date of Birth: _____ Social Security #: _____-_____-_____

Secondary Insurance: _____ Policy ID / Number: _____

Claims Address: _____

Group Number: _____ Policy Holder: ☐ Self ☐ Spouse ☐ Other: _____

Date of Birth: _____ Social Security #: _____-_____-_____

Worker's Comp Carrier: _____ Claim #: _____

Address: _____ Date of Injury: _____

Claim Representative: _____ Phone: _____

Employer: _____ Phone: _____

FOOT + ANKLE
SPECIALTY CENTERS

General Consent and Authorization for Treatment, Evaluation, and Information Release

This consent authorizes Foot + Ankle Specialty Centers, its physicians, and clinical staff to perform medically reasonable and necessary examinations, diagnostic testing, and treatment related to your care. This consent remains in effect unless and until it is revoked in writing. You have the right to refuse or discontinue services at any time.

I voluntarily request and authorize Foot + Ankle Specialty Centers, its physicians, and clinical staff to provide medical treatment and services to me, as deemed medically reasonable and necessary by my health care provider(s). I consent to medical examinations, evaluations, diagnostic testing, and treatment, which may include diagnostic, radiology and laboratory procedures. If invasive or interventional treatment is recommended, I understand that I will be informed of the nature, benefits, risks, and alternatives prior to the procedure, and that a separate, procedure specific informed consent form will be provided for my review and signature.

Release of Information I authorize the use and disclosure of my protected health information as described in the Notice of Privacy Practices provided to me. I authorize Foot + Ankle Specialty Centers, its physicians, and authorized staff to obtain and review my medication history and other relevant health care information whether verbally, in writing, or electronically as reasonably necessary for my treatment, care coordination, and healthcare operations. I further consent to the release of my health information to federal or state health plans, insurance carriers, third party administrators, collection agencies, employers or other entities responsible for payment, reimbursement, or related healthcare operations, as appropriate. I understand that this information may include, but is not limited to, details regarding my diagnosis, treatment, payment for services, and demographic information.

By signing below, I acknowledge that I have read and understand the consents and authorizations described on this form. I have had the opportunity to ask questions, and all questions have been answered to my satisfaction. I voluntarily agree to the terms outlined above.

_____	_____
Printed Name of Patient or Representative	Signature of Patient or Representative
_____	_____
Relationship to Patient	Date

FOOT + ANKLE
SPECIALTY CENTERS

Financial Policy

Foot + Ankle Specialty Centers is committed to the success of your medical treatment, and a mutual financial understanding is part of our relationship. Please review and initial each section to accept its terms.

Payment is due at the time of service: All co-payments, deductibles, coinsurance, and fees for non-covered services are due at the time of service unless you have made payment arrangements prior to your appointment. Patients with private insurance plans that include high deductible of $1000 or more will need to pay a $150.00 deposit at the time of service. You are responsible for any unpaid balance after your insurance has processed your claim. We accept cash, check, credit and debit cards.

We designate accounts "Self-Pay" under the following circumstances:

1. Patient does not have health insurance
2. Patient is covered by an insurance plan that our providers do not participate in
3. Patient does not have a current, valid insurance card on file

Initials _____

Referrals and Authorizations: It is your responsibility to verify that your assigned provider participates in your healthcare plan and obtain referral if your insurance requires one. If you are unable to obtain the referral prior to your appointment, your visit will be rescheduled, or you will be asked to pay for the visit in advance. The Practice may provide services that your insurance plan excludes or require prior authorization. If prior authorization is required, we will attempt to obtain authorization on your behalf. Ultimately, it is your responsibility to ensure that services provided are covered benefits and authorized by your insurance carrier.

Initials _____

Billing and Refunds: If we must send you a statement, the balance is due within 30 days of the statement date. If you have an outstanding balance over 120 days and failed to make payment arrangements (or become delinquent on an existing payment plan), your account may be turned over to a collection agency. You agree, in order to service your account or to collect any amounts you may owe, that we may contact you at any telephone number associated with your account. We may also contact you by text message or e-mail.

You will be charged a fee for returned checks according to the Fee Schedule. If you make an overpayment, we will issue a refund only if there are no outstanding balances for medical services on your account or any other account(s) with the same financially responsible party.

Initials _____

FOOT + ANKLE SPECIALTY CENTERS

Custom Products: I understand that custom durable medical equipment (DME), including but not limited to custom orthotics or specialty footwear, as well as dispensed items such as air casts, night splints, surgical shoes, and ankle braces, are non-returnable and non-refundable once ordered or provided. I further understand that insurance coverage is determined by my insurance plan, not by Foot + Ankle Specialty Centers. If my insurance denies coverage for any reason, I acknowledge that I am financially responsible for the cost of the DME items I have received.

Initials _____

Late, Cancelled and No-Show Appointments: We request 24-hour notice if you are unable to keep your appointment. You may be charged for each incident according to the Fee Schedule, where notice is not provided. These charges are your responsibility and will not be billed to your insurance. Patients who repeatedly "no-show" for appointments may be discharged from the practice. Foot + Ankle Specialty Centers strives to provide exceptional care to our patients. We ask that you schedule and keep all follow up appointments and participate in all treatments and diagnostic testing.

Initials _____

Fee Schedule

EVENT	FEE CHARGED
Failure to cancel your appointment within 24 hours	$50.00 per Clinic incident
Appointment "No-Show"	$50.00 per Clinic incident $100.00 per Procedure
Late Arrivals- if you arrive 15 minutes past your arrival time and we must reschedule your appointment	$50.00 per Clinic incident $100.00 per Procedure
Returned Check Fee	$25.00 per incident
Completion of Disability Forms (per each occurrence)	**FMLA**- $25.00 each completion **Short Term Disability Form**- $25.00 **Temporary Disabled Parking Permit**- $5.00
Legal Documents	$50–$150 per hour, based on scope of work

I acknowledge that I have read and understand the Financial Policy. My signature confirms my understanding that insurance coverage and payment are determined by my insurance plan. If my insurance denies coverage or payment for any reason, I accept full financial responsibility for all services rendered.

_____ _____

Printed Name of Patient or Representative Signature of Patient or Representative

_____ _____

Relationship to Patient Date

FOOT + ANKLE
SPECIALTY CENTERS

HIPAA Authorization for Use or Disclosure of Health Information

Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information and when we need your written authorization to do so. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

By signing this form, you consent to our use and disclosure of your health information for treatment, payment or health care operations. You have the right to request that we restrict how your health information is used or disclosed to carry out treatment, payment or health care operations. We are not required to agree with your requested restrictions; however, if we do agree to your restrictions, we are bound to follow them.

I understand that I can revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. Unless I revoke this authorization earlier, this consent for release of protected health information will remain in effect until terminated by me in writing.

_____	_____
Printed Name of Patient or Representative	Signature of Patient or Representative
_____	_____
Relationship to Patient	Date

Consent to Release Information to Family and Others

I hereby give my consent to release Protected Health Information from my medical and/or financial records from Foot + Ankle Specialty Centers to anyone specifically listed below.

Name	Relationship
_____	_____
_____	_____
_____	_____

☐ I specifically **DENY** permission to release to anyone.

_____	_____
Printed Name of Patient or Representative	Signature of Patient or Representative
_____	_____
Relationship to Patient	Date

FOOT + ANKLE SPECIALTY CENTERS

Health and Pain History Form

Patient Name: _____ **DOB:** _____

Pharmacy: _____ **Cross Streets:** _____

[ ] Male [ ] Female [ ] Right- handed [ ] Left-handed [ ] Ambidextrous

Height: _____ Weight: _____ Shoe Size: _____

Have you ever had custom Orthotics? [ ] Yes [ ] No

If yes, [ ] Currently Using [ ] Used in the Past When? _____

Reason for Visit

Location of problem: [ ] Foot [ ] Ankle [ ] Left [ ] Right [ ] Bilateral

Describe the foot/ ankle issue:

_____

Injury: [ ] Yes [ ] No Type: [ ] Work Injury [ ] Sports Injury [ ] Other: _____

Have you had previous imaging? [ ] Yes [ ] No Facility: _____ Date: _____

Previous treatment for this or any other foot/ ankle issues? [ ] Yes [ ] No Who? _____

What treatments? _____

Duration of problem? _____

How would you rate your pain on a scale of 0 (no pain) to 10 (worst pain)? _____

What makes the pain better? _____ Worse? _____

Do you get leg cramps after activity? [ ] Yes [ ] No Does your pain limit your activity? [ ] Yes [ ] No

Treatment History

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

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

Have you tried any of the following (select all that apply):

[ ] Injections	[ ] Physical Therapy
[ ] Medications	[ ] Wound Care
[ ] Orthotics or Bracing	[ ] None

Are you Diabetic? [ ] Yes [ ] No If yes, how long? _____ What type? _____

Most Recent A1C? _____ Date: _____

Do you currently have a Pacemaker or an AICD? [ ] Yes [ ] No

Are you currently taking Anticoagulants/Blood Thinners? [ ] Yes [ ] No

If yes, what type?
[ ] Arixta [ ] Aspirin [ ] Eliquis [ ] Heparin [ ] Lovenox [ ] Plavix [ ] Pradaxa [ ] Warfarin/Coumadin

[ ] Herbals (Garlic, Ginko, Ginseng, Vitamin E, Fish Oil) [ ] Other: _____

Physician managing blood thinner? _____

Reason for taking blood thinner? _____

Current Medications (Attach a list if necessary)

	Name	Dose	How Often
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

Allergies [ ] Yes [ ] No (if yes, indicate below and reaction)

Allergy	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

Surgical History

Surgery	Date	Surgery	Date
1._____	_____	4._____	_____
2._____	_____	5._____	_____
3._____	_____	6._____	_____

Past Medical History

Select all that apply:

[ ] Arthritis
[ ] Asthma
[ ] Autoimmune Disease
[ ] Balance Problems
[ ] Bleeding or Clotting Disorder
[ ] Cancer Type:_____
[ ] Chronic Skin Infections
[ ] COPD
[ ] Edema
[ ] Frequent Falls
[ ] Hepatitis Type: _____
[ ] High Blood Pressure
[ ] High Cholesterol
[ ] HIV/AIDS
[ ] Kidney Disease
[ ] Liver Disease
[ ] MRSA
[ ] Neuropathy
[ ] Osteoporosis
[ ] Psychiatric Disorder
[ ] Sciatica
[ ] Sleep Apnea
[ ] Stroke or TIA
[ ] Thyroid Disorder
[ ] Varicose Veins
[ ] Vascular Disease
[ ] Other:_____

Family History

Select all that apply:

[ ] Cancer: Relationship: _____
[ ] Diabetes: Relationship: _____
[ ] Heart Disease: Relationship: _____
[ ] Hypertension: Relationship: _____
[ ] Neurological: Relationship: _____
[ ] Psychiatric: Relationship: _____
[ ] Stroke: Relationship: _____
[ ] Unknown

Social History

Employed: [ ] Yes [ ] No [ ] Part-time [ ] Full-time Occupation: _____

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Significant Other

Do you use caffeine? [ ] Yes [ ] No If yes, # of drinks/day _____ How many years? _____

Do you use Tobacco? [ ] Yes [ ] No [ ] Former If yes, # of packs/day _____ How many years? _____

Do you use Alcohol? [ ] Yes [ ] No If yes, # of drinks/day _____ How many years? _____

Do you use illicit substances? [ ] Yes [ ] No If yes, please describe: _____

Are you sexually active? [ ] Yes [ ] No

Review of Systems

Select only current or very recent symptoms:

General: [ ] Chills [ ] Fatigue [ ] Fever [ ] Loss of Appetite [ ] Weakness [ ] Weight Changes
Cardiovascular: [ ] Pain/Angina [ ] Palpitations [ ] Peripheral Edema [ ] Shortness of Breath
Endocrine: [ ] Cold/Heat Intolerance [ ] Excessive Sweating [ ] Excessive Thirst [ ] Excessive Urination
Gastrointestinal: [ ] Abdominal Pain [ ] Constipation [ ] Diarrhea [ ] Nausea [ ] Vomiting
Genitourinary: [ ] Blood in Urine [ ] Difficulty Urinating [ ] Loss of Bladder Control [ ] Painful Urination
HEENT: [ ] Blurry/Double Vision [ ] Difficulty Swallowing [ ] Headaches [ ] Hearing Changes [ ] Sinus Pain

Review of Systems Cond.

Musculoskeletal: [ ] Joint Redness [ ] Joint Stiffness [ ] Joint Swelling [ ] Muscle Cramps
Neurological: [ ] Dizziness [ ] Fainting [ ] Gait Difficulties [ ] Numbness [ ] Tremors [ ] Weakness
Psychiatric: [ ] Anxiety [ ] Depression [ ] Memory Loss [ ] Sleep Disturbances [ ] Suicidal Ideation
Respiratory: [ ] Cough [ ] Hemoptysis [ ] Shortness of Breath [ ] Wheezing
Skin: [ ] Changes in Hair or Nail [ ] Changes in Skin Color [ ] Dry Skin [ ] Itching [ ] Recurrent Rashes

I certify that my Medical History is complete and accurate to the best of my knowledge and ability.

_____	_____
Printed Name of Patient or Representative	Signature of Patient or Representative
_____	_____
Relationship to Patient	Date