

**Total Podiatry**  
**Advanced Ankle & Foot Physicians & Surgeons**

**Patient Last Name:** \_\_\_\_\_ **First:** \_\_\_\_\_ **Middle:** \_\_\_\_\_

**Mailing address**

**Street Address: (If different from above)**

**Type of residence you live in:**  Private Home    Assisted Living Facility    Nursing Home    Group Home

**Home Ph#:** \_\_\_\_\_ **Cell Ph#:** \_\_\_\_\_

**OK to Leave a Message:**  YES    NO   **Email:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Social Security #:** \_\_\_\_\_ **Marital Status:** \_\_\_\_\_

**Race:** \_\_\_\_\_ **Ethnicity:** \_\_\_\_\_ **Language Preference:** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Contact Ph#:** \_\_\_\_\_ **Rel:** \_\_\_\_\_

**Pharmacy Information:**

**Pharmacy Name:** \_\_\_\_\_ **Pharmacy Ph#:** \_\_\_\_\_

**Location:**

**Seasonal Residents:**

**Northern Address:**

**Ph#** \_\_\_\_\_ **When do you go North:** \_\_\_\_\_

**Insurance Information**

**Primary Insurance:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**Subscriber ID:** \_\_\_\_\_ **Group Number:** \_\_\_\_\_

**Subscriber Name:**

**Subscriber SS#:** \_\_\_\_\_ **Subscriber Date of Birth:** \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**Subscriber ID:** \_\_\_\_\_ **Group Number:** \_\_\_\_\_

**Subscriber Name:**

**Subscriber SS#:** \_\_\_\_\_ **Subscriber Date of Birth:** \_\_\_\_\_

**Employer Information:**

**Employer Name:**

**Address:**

**Phone Number:** \_\_\_\_\_ **OK to leave message:**  YES    NO

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**AUTHORIZATION FOR COMMUNICATION WITH PHARMACY**

I hereby authorize the physician and / or representative to communicate via electronic submission with the pharmacy of my choice. This can and may include electronic submission of new prescriptions, authorizations of refills, and inquiry as to current medications.

\_\_\_\_\_  
Signature of patient or authorized person

\_\_\_\_\_  
Date

**PREGNANCY DISCLAIMER(FEMALE PATIENTS ONLY)**

I understand that if I am pregnant, I should not have any diagnostic x-rays or elective surgery without first checking with my obstetrician.

I am **NOT** pregnant. My last period was \_\_\_\_\_.

If during the course of my treatment I become pregnant, it is my responsibility to inform the doctor and avoid x-rays and elective surgery.

\_\_\_\_\_  
Signature of patient or authorized person

\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff Witness

\_\_\_\_\_  
Date

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I request the services of the Doctors of Total Podiatry, dully licensed physicians in the state of Florida, and all personnel, the consent to examination, diagnostic procedures and treatment which may need to be performed on my behalf. Also, I authorize the release of any medical information to any person or corporation, necessary to process my claim.

\_\_\_\_\_  
Signature of patient or authorized person

\_\_\_\_\_  
Date

**ASSIGNMENT OF BENEFITS**

I hereby authorize direct payment for all valid insurance benefits including all major medical benefits, be made on my behalf of Total Podiatry. I understand I will be financially and legally responsible for charge(s) not covered by assignment.

I certify that I have read the above authorization and understand and agree to same, and also certify no guarantee or assurance has been made as to the results that may be obtained.

\_\_\_\_\_  
Signature of patient or authorized person

\_\_\_\_\_  
Date

Please be aware that effective July 2018, Total Podiatry will have a new billing and collection policy.

As a patient, it is your responsibility to verify that we are indeed a participating provider with your insurance

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company/network and what services are covered.

\_\_\_\_\_(patient initial)

Please be advised that you are ultimately responsible for any and all balances incurred, regardless of insurance coverage. As a courtesy to you, our valued patient, our office will file to your primary and secondary insurance, as well as call your insurance carrier for eligibility verification and procedure pre-certification, when necessary. However, it is the responsibility of the patient to be aware of their insurance benefits. **It is our office policy to collect any co-pays and deductibles at the time of check in (Exception: Medicare deductible/Co-insurance if owed will be billed.)** Please be aware that a \$10.00 processing fee may be charged for each co-pay not paid at the item of service and/or your appointment rescheduled.

\_\_\_\_\_(patient initial)

Be advised that should you cancel your appointment with less than 24 hours notice or no-show for your appointment, it is up to the discretion of physician to reserve the right to assess a \$50.00 cancellation fee.

\_\_\_\_\_(patient initial)

Please be aware that although your insurance carrier might state that some procedures are "eligible" for payment, or are a "covered benefit" that does not mean that there will be no financial obligation by you, the patient. Many items a deductible is withheld, or there may be a separate co-payment withheld, depending on your specific carrier. Again, it is ultimately the responsibility of the patient, to know and understand their individual policy.

\_\_\_\_\_(patient initial)

**All insurance companies state a disclaimer: There is no guarantee of payment. Every claim is subject to medical necessity and the terms of your contract at the time services are rendered.** Once we receive the "explanation of benefits" (EOB) we must abide by their payment and/or denial; therefore any remaining balance will be billed to you. Any disputes of the benefits should be addressed to your insurance company. Your account will be considered delinquent if payment is not made in a timely manner.

\_\_\_\_\_(patient initial)

In addition any co-insurance that is owed by you will be collected by the receptionist at subsequent appointments once your insurance carrier has processed the claim, or you will be sent a statement.

\_\_\_\_\_(patient initial)

By my signature below, the undersigned patient assigns the rights and benefits of insurance under the applicable insurance policy for any service and/or charges provided by the providers of Total Podiatry. I hereby direct the benefits to be paid directly to the physicians on my behalf for any services furnished to me by the providers of Total Podiatry. By my signature below I hereby certify that I have read and fully understand all the words and information contained in this form and reaffirm my consent to the examination, diagnostic procedure and/or care, treatment, therapy or remedy proposed.

By my signature below, I permit a copy/fax of this form to serve as an original signature of authorization.

Please feel free at any time to discuss any concerns or questions you may have with our Billing Specialists.

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Witness Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**CONSENT TO USE AND DISCLOSE HEALTH INFORMATION  
PRIVACY NOTICE ACKNOWLEDGEMENT**

**PATIENT NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_

By signing this consent, you authorize us to use and /or disclose your health information for treatment, payment, or health care operations. You have the right not to sign this consent. However, if you refuse to sign the consent, we have the right to refuse to treat you.

# Total Podiatry Advanced Ankle & Foot Physicians & Surgeons

**Your Rights with Respect to This Consent:**

- **Right to review notice of Privacy Practices** - You have the right to review a copy of our Privacy Practices before signing this consent. Our Notice of Privacy Practices details how we may use and disclose your health information. We may amend the Notice from time to time. A copy of the Notice is posted in your office. Any revisions made to the Notice will be posted as soon as feasible.
- **Right to Request Restrictions on Use/Disclosure** – You have the right to request that we restrict how we use and/or disclose your protected health information for the purpose of providing treatment, obtaining payment for our services, and/or conducting health care operations. Such requests must be made in writing. Please note that we are NOT required to agree to any restriction that you request. If, however, we decide to agree to a restriction you have request, we must restrict use and disclosure of your health information in the manner described in your request.
- **Right to Revoke Consent** -You have the right to revoke this consent at any time. Your revocation of this consent must be in writing. If you wish to revoke this consent, please contact the administrator of this practice to obtain the revocation form. Note that your revocation of this consent will not be effective for disclosures we have already made in reliance on your prior consent. We also have the right to refuse further treatment if you revoke this consent.
- **Right to Receive a Copy of This Consent Form** – You have a right to receive a copy of this consent after you sign it.
- **Effective Period** -This consent is effective unless and until you revoke it in writing.

**I give my authorization for my healthcare provider to discuss my care and treatment with the following individuals:**

1. Name: \_\_\_\_\_ Relation: \_\_\_\_\_
2. Name: \_\_\_\_\_ Relation: \_\_\_\_\_
3. Name: \_\_\_\_\_ Relation: \_\_\_\_\_

**I have an ADVANCED DIRECTIVE (LIVING WILL) and the following individual is able to make decisions regarding my healthcare if I am unable. (I will provide a copy of this for the office)**

Name of Individual: \_\_\_\_\_ Relation: \_\_\_\_\_

***I hereby authorize Total Podiatry to use and/or disclose my health information for treatment, payment, or healthcare operations.***

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**

**if a personal representative on behalf of the individual signs this authorization, please complete the following:**

Personal Representative Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Reason patient could not sign: \_\_\_\_\_

Authority of Personal Representative: \_\_\_\_\_

What is the problem/condition you are having? \_\_\_\_\_

1. Is the condition a result of an injury? Yes No **If yes, is this work related?** Yes No

How long have you been having this problem? \_\_\_\_\_

2. Have you seen a physician for this condition? Yes No **If Yes, Whom and when?** \_\_\_\_\_

Treatment: \_\_\_\_\_

3. Are you Diabetic? Yes No **If Yes, name of physician monitoring Diabetes:** \_\_\_\_\_

**Controlled By:** Diet Oral Medications Insulin **Last Blood Sugar:** \_\_\_\_\_

**Total Podiatry**  
**Advanced Ankle & Foot Physicians & Surgeons**

4. Current Medications & Dosage \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Allergies & Reactions: \_\_\_\_\_ Reaction: \_\_\_\_\_  
\_\_\_\_\_ Reaction: \_\_\_\_\_  
\_\_\_\_\_ Reaction: \_\_\_\_\_

6. Surgical History & Dates \_\_\_\_\_ Date: \_\_\_\_\_  
\_\_\_\_\_ Date: \_\_\_\_\_  
\_\_\_\_\_ Date: \_\_\_\_\_  
\_\_\_\_\_ Date: \_\_\_\_\_

7. Prior Hospitalizations: \_\_\_\_\_

8. \_\_\_\_\_ Current or Previous Primary Care Physician:  
\_\_\_\_\_ Phone: \_\_\_\_\_

9. Name of any Specialist you are currently under care with:  
Dr. \_\_\_\_\_ Phone: \_\_\_\_\_  
Dr. \_\_\_\_\_ Phone: \_\_\_\_\_  
Dr. \_\_\_\_\_ Phone: \_\_\_\_\_  
Date of Last Flu Shot: \_\_\_\_\_ Shoe Size: \_\_\_\_\_

**DO YOU HAVE A PACEMAKER OR DEFIBRILLATOR**      **Yes**      **No**      **If Yes, Date Placed:** \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Social History**

Do you use recreational drugs?       Yes       No

Do you exercise routinely?       Yes       No

**HIV / AIDS**       Yes       No

Do you use caffeine?       Yes       No      **If Yes, How much daily?** \_\_\_\_\_

Do you use tobacco?       Yes       No      **If Yes, How Long?** \_\_\_\_\_

Former user      **If Former, how long ago did you quit?** \_\_\_\_\_

Type of Tobacco:       Pipe       Cigar       Cigarettes       Chew

Amount:       Less than       1 pack per day       1 pack per day       More than 1 pack per day

# Total Podiatry

## Advanced Ankle & Foot Physicians & Surgeons

Have you had a drink containing alcohol in the past year?  Yes  No

If **YES**, How often did you have 6 or more drinks on one occasion in the past year?

Never  Less Than Monthly  Monthly  Daily or Almost Daily

How many drinks did you have on typical day when you were drinking in the past year?

1-2  3-4  5-6  7-9  10 or More

How often did you have a drink containing alcohol?

Never  Monthly  2-4 Times Per Month  2-3 Times Weekly  4+Times Weekly

### Family History

			Age	Diabetes	High BP	Heart Disease	Stroke	Mental Ill.	Cancer
Mother	<input type="radio"/> Living <input type="radio"/> Deceased	_____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="radio"/> Living <input type="radio"/> Deceased	_____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Siblings	<input type="radio"/> Living <input type="radio"/> Deceased	_____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Children	<input type="radio"/> Living <input type="radio"/> Deceased	_____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How many / age: Brother(s) _____ Sister(s) _____ Son(s) _____ Daughter(s) _____									

Have you had any falls in the past year?  Yes  No

If Yes, How many? \_\_\_\_\_

Any Injuries caused by falls?  Yes  No

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

### Do you have, or had in the past, any of the following?

Fever/ Chills <input type="radio"/> Yes <input type="radio"/> No	Burning / Tingling / Numbness <input type="radio"/> Yes <input type="radio"/> No
Hearing Loss <input type="radio"/> Yes <input type="radio"/> No	Blurred Vision <input type="radio"/> Yes <input type="radio"/> No
Frequent Sore Throat <input type="radio"/> Yes <input type="radio"/> No	Infection <input type="radio"/> Yes <input type="radio"/> No
Ringing in Ears <input type="radio"/> Yes <input type="radio"/> No	Callous <input type="radio"/> Yes <input type="radio"/> No
Chest Pain <input type="radio"/> Yes <input type="radio"/> No	Wound <input type="radio"/> Yes <input type="radio"/> No
Foot/ Ankle Swelling <input type="radio"/> Yes <input type="radio"/> No	Rash / Itching <input type="radio"/> Yes <input type="radio"/> No
Heart Valve Problems <input type="radio"/> Yes <input type="radio"/> No	Change in Mole <input type="radio"/> Yes <input type="radio"/> No
Diarrhea <input type="radio"/> Yes <input type="radio"/> No	Deformed Nails <input type="radio"/> Yes <input type="radio"/> No
Loss of Appetite <input type="radio"/> Yes <input type="radio"/> No	Balance Problems <input type="radio"/> Yes <input type="radio"/> No
Nausea / Vomiting <input type="radio"/> Yes <input type="radio"/> No	Headaches <input type="radio"/> Yes <input type="radio"/> No
Weight Gain / Loss <input type="radio"/> Yes <input type="radio"/> No	Joint Stiffness <input type="radio"/> Yes <input type="radio"/> No
Shortness of Breath <input type="radio"/> Yes <input type="radio"/> No	Joint Pain <input type="radio"/> Yes <input type="radio"/> No

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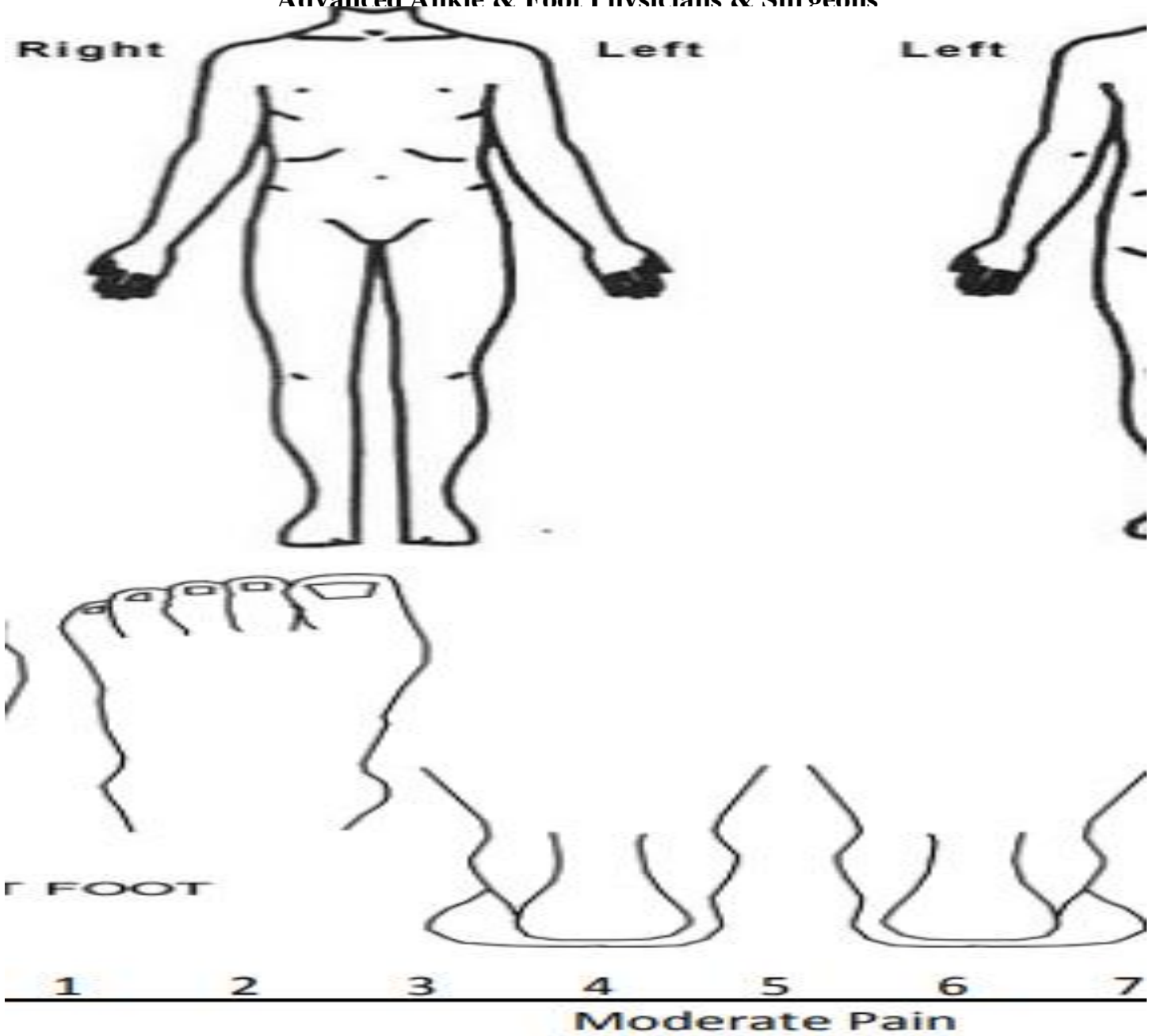
<p>Chronic Cough      <input type="radio"/> Yes   <input type="radio"/> No</p> <p>Menopausal        <input type="radio"/> Yes   <input type="radio"/> No</p> <p>Nocturia            <input type="radio"/> Yes   <input type="radio"/> No</p> <p>Decreased Urine Stream   <input type="radio"/> Yes   <input type="radio"/> No</p> <p>Diabetic            <input type="radio"/> Yes   <input type="radio"/> No</p> <p>Heart Disease      <input type="radio"/> Yes   <input type="radio"/> No</p> <p>Heart Murmur      <input type="radio"/> Yes   <input type="radio"/> No</p> <p>Mitral Valve Prolapse   <input type="radio"/> Yes   <input type="radio"/> No</p> <p>Hypertension      <input type="radio"/> Yes   <input type="radio"/> No</p> <p>PVD                <input type="radio"/> Yes   <input type="radio"/> No</p> <p>Stroke              <input type="radio"/> Yes   <input type="radio"/> No</p> <p>Raynauds Disease   <input type="radio"/> Yes   <input type="radio"/> No</p> <p>Minieres Disease   <input type="radio"/> Yes   <input type="radio"/> No</p> <p>Dialysis            <input type="radio"/> Yes   <input type="radio"/> No</p> <p>Phlebitis           <input type="radio"/> Yes   <input type="radio"/> No</p> <p>Venous Insufficiency   <input type="radio"/> Yes   <input type="radio"/> No</p> <p>Respiratory Disease   <input type="radio"/> Yes   <input type="radio"/> No</p> <p>Alzheimers Disease   <input type="radio"/> Yes   <input type="radio"/> No</p> <p>Parkinsons Disease   <input type="radio"/> Yes   <input type="radio"/> No</p> <p>Heaptitis           <input type="radio"/> Yes   <input type="radio"/> No</p> <p>Fibromyalgia        <input type="radio"/> Yes   <input type="radio"/> No</p> <p>RSD / CRPS         <input type="radio"/> Yes   <input type="radio"/> No</p>	<p><b>Past Medical History</b></p>	<p>Weakness            <input type="radio"/> Yes   <input type="radio"/> No</p> <p>Bowel / Bladder Problems   <input type="radio"/> Yes   <input type="radio"/> No</p> <p>Frequency in Urination      <input type="radio"/> Yes   <input type="radio"/> No</p> <p>Fatigue              <input type="radio"/> Yes   <input type="radio"/> No</p> <p>Crohn's Disease        <input type="radio"/> Yes   <input type="radio"/> No</p> <p>Hiatal Hernia         <input type="radio"/> Yes   <input type="radio"/> No</p> <p>Colitis                <input type="radio"/> Yes   <input type="radio"/> No</p> <p>Cirrhosis              <input type="radio"/> Yes   <input type="radio"/> No</p> <p>Thyroid Problems      <input type="radio"/> Yes   <input type="radio"/> No</p> <p>Liver Disease         <input type="radio"/> Yes   <input type="radio"/> No</p> <p>Carpal Tunnel         <input type="radio"/> Yes   <input type="radio"/> No</p> <p>Neuropathy           <input type="radio"/> Yes   <input type="radio"/> No</p> <p>Cancer                <input type="radio"/> Yes   <input type="radio"/> No</p> <p>Pancreatitis           <input type="radio"/> Yes   <input type="radio"/> No</p> <p>Multiple Sclerosis     <input type="radio"/> Yes   <input type="radio"/> No</p> <p>Hypercholesterolemia   <input type="radio"/> Yes   <input type="radio"/> No</p> <p>Osteomyelitis         <input type="radio"/> Yes   <input type="radio"/> No</p> <p>Sciatica              <input type="radio"/> Yes   <input type="radio"/> No</p> <p>Arthritis              <input type="radio"/> Yes   <input type="radio"/> No</p> <p>Fractures             <input type="radio"/> Yes   <input type="radio"/> No</p> <p>Hip Replacement      <input type="radio"/> Yes   <input type="radio"/> No</p> <p>Knee Replacement      <input type="radio"/> Yes   <input type="radio"/> No</p>
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Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Please mark an X indicating the area of injury or discomfort on the chart below.**

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