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 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 RELEAS 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 certify no guarantee or assurance has been made as to the result s that may be obtained.

_____

Signature of patient or authorized person Date

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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 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:** _____

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CONSENT TO USE AND DISCLOSE HEALTH INFORMATION
PRIVACY NOTICE ACKNOWLEGEMENT

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.

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 can 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: _____

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1. What is the problem/condition you are having? _____

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

3. How long have you been having this problem? _____

4. Have you seen a physician for this condition? Yes, No **If Yes,** Whom and when? _____

   Treatment: _____

5. Are you Diabetic? Yes, No **If Yes,** name of physician monitoring Diabetes: _____

   Controlled By: **Diet** **Oral Medications** **Insulin** **Last Blood Sugar:** _____

6. Current Medications & Dosage _____ _____ _____

   _____ _____ _____

   _____ _____ _____

7. Allergies & Reactions: _____ Reaction: _____

   _____ Reaction: _____

   _____ Reaction: _____

8. Surgical History & Dates _____ Date: _____

   _____ Date: _____

   _____ Date: _____

   _____ Date: _____

9. Prior Hospitalizations: _____

10. Current or Previous Primary Care Physician: _____ Phone:_____

11. Name of any Specialist you are currently under care with:

    Dr. _____ Phone:_____

    Dr. _____ Phone:_____

    Dr. _____ Phone:_____

12. Date of Last Flu Shot: _____ Shoe Size: _____

13. **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

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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

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	○ Living	○ Deceased	_____	☐	☐	☐	☐	☐	☐
Father	○ Living	○ Deceased	_____	☐	☐	☐	☐	☐	☐
Siblings	○ Living	○ Deceased	_____	☐	☐	☐	☐	☐	☐
Children	○ Living	○ Deceased	_____	☐	☐	☐	☐	☐	☐

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 ○ Yes ○ No

Hearing Loss ○ Yes ○ No

Burning / Tingling / Numbness ○ Yes ○ No

Blurred Vision ○ Yes ○ No

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Frequent Sore Throat	○ Yes	○ No	Infection	○ Yes	○ No
Ringing in Ears	○ Yes	○ No	Callous	○ Yes	○ No
Chest Pain	○ Yes	○ No	Wound	○ Yes	○ No
Foot/ Ankle Swelling	○ Yes	○ No	Rash / Itching	○ Yes	○ No
Heart Valve Problems	○ Yes	○ No	Change in Mole	○ Yes	○ No
Diarrhea	○ Yes	○ No	Deformed Nails	○ Yes	○ No
Loss of Appetite	○ Yes	○ No	Balance Problems	○ Yes	○ No
Nausea / Vomiting	○ Yes	○ No	Headaches	○ Yes	○ No
Weight Gain / Loss	○ Yes	○ No	Joint Stiffness	○ Yes	○ No
Shortness of Breath	○ Yes	○ No	Joint Pain	○ Yes	○ No
Chronic Cough	○ Yes	○ No	Weakness	○ Yes	○ No
Menopausal	○ Yes	○ No	Bowel / Bladder Problems	○ Yes	○ No
Nocturia	○ Yes	○ No	Frequency in Urination	○ Yes	○ No
Decreased Urine Stream	○ Yes	○ No	Fatigue	○ Yes	○ No

Past Medical History

Diabetic	○ Yes	○ No	Crohn's Disease	○ Yes	○ No
Heart Disease	○ Yes	○ No	Hiatal Hernia	○ Yes	○ No
Heart Murmur	○ Yes	○ No	Colitis	○ Yes	○ No
Mitral Valve Prolapse	○ Yes	○ No	Cirrhosis	○ Yes	○ No
Hypertension	○ Yes	○ No	Thyroid Problems	○ Yes	○ No
PVD	○ Yes	○ No	Liver Disease	○ Yes	○ No
Stroke	○ Yes	○ No	Carpal Tunnel	○ Yes	○ No
Raynaud's Disease	○ Yes	○ No	Neuropathy	○ Yes	○ No
Meniere's Disease	○ Yes	○ No	Cancer	○ Yes	○ No
Dialysis	○ Yes	○ No	Pancreatitis	○ Yes	○ No
Phlebitis	○ Yes	○ No	Multiple Sclerosis	○ Yes	○ No
Venous Insufficiency	○ Yes	○ No	Hypercholesterolemia	○ Yes	○ No
Respiratory Disease	○ Yes	○ No	Osteomyelitis	○ Yes	○ No
Alzheimer's Disease	○ Yes	○ No	Sciatica	○ Yes	○ No
Parkinson's Disease	○ Yes	○ No	Arthritis	○ Yes	○ No
Hepatitis	○ Yes	○ No	Fractures	○ Yes	○ No
Fibromyalgia	○ Yes	○ No	Hip Replacement	○ Yes	○ No
RSD / CRPS	○ Yes	○ No	Knee Replacement	○ Yes	○ No

Print Name: _____ Date: _____

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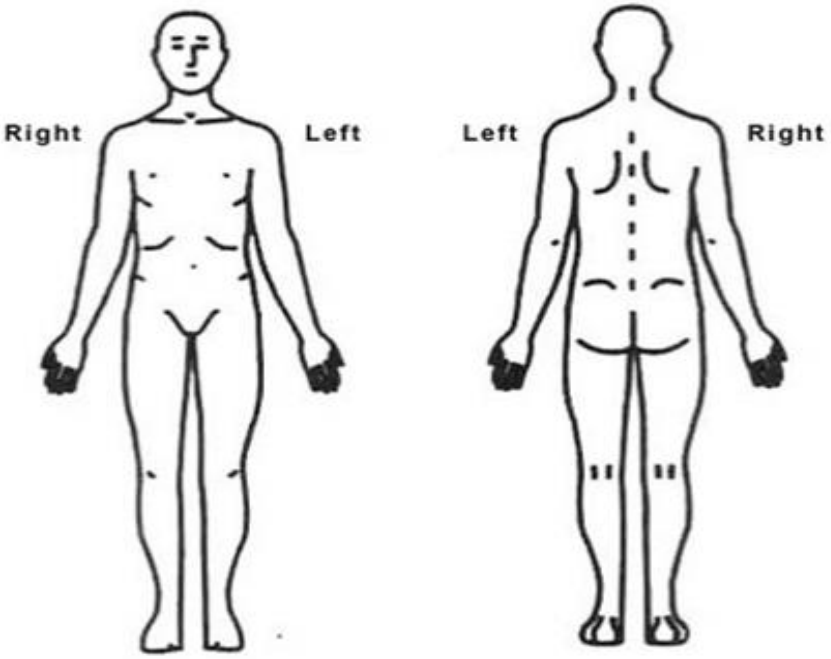
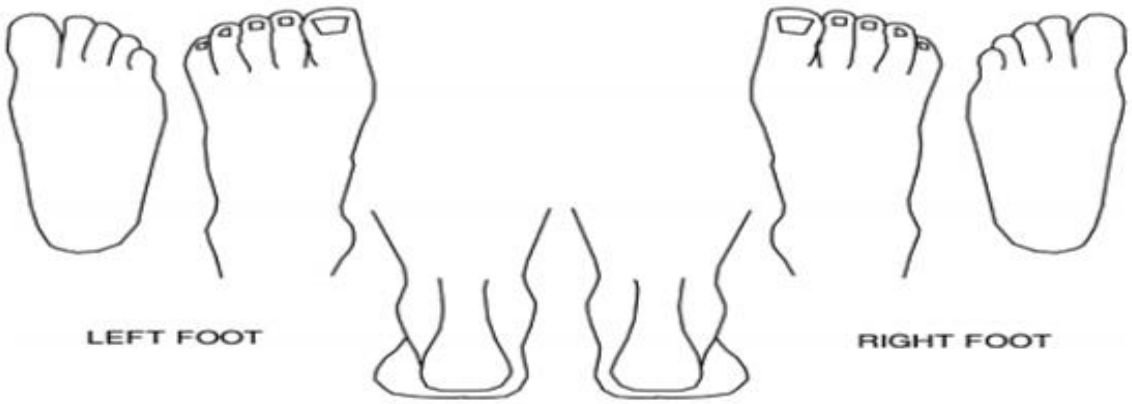
Please mark an X indicating the area of injury or discomfort on the chart below.





0 1 2 3 4 5 6 7 8 9 10

No Pain Moderate Pain Worst Possible

Current pain level:_____ Worst pain level:_____

Patient Name:_____ Date:_____