FOOT & ANKLE
PHYSICIANS, P.A.

Welcome to our Practice

2350 Sunset Point Road Clearwater, FL 33765 P: 727-796-0565 F: 727-796-7464

PATIENT INFORMATION – PLEASE PRINT CLEARLY

First Name_____ M___ Last Name_____

Date of Birth_____ Gender___ Social Security #_____

Address_____

City_____ State _____ Zip Code_____

Phone#- Home_____ Work_____ Cell_____

Email_____

Ethnicity_____ Race_____ Preferred Language_____

Marital Status_____ Employment Status_____

Employer_____ Full time_____ Part Time_____

If patient is a minor- Provide name of parents or guardian_____

Address_____ Phone #_____

Referral Information- _____PCP_____ Other Specialist_____ Family Member _____Internet_____

_____Our Website _____Newspaper _____Phone Book ___ Other _____

Primary Care Physician_____ Phone#_____

Pharmacy Name_____Phone#_____

Emergency Contact:

Name_____ PH#_____

Preferred contact with our office ____Phone _____Text_____ Email_____

PODIATRIC HISTORY

Have you ever been to a podiatrist before? Yes ❍ No ❍

What is your **chief foot complaint** for which you came to be treated?

_____

_____

_____

When did it begin? _____

Did you receive treatment for this condition? Yes ❍ No ❍

If so, what type?

_____

_____

Circle the **degree of pain** you are currently experiencing:
Minimal 1 2 3 4 5 6 7 8 9 10 **Severe**

Have you ever had any of the following **foot conditions**? Please check all that apply:

❒Ankle Instability	❒Ingrown Toenails
❒ Arthritis	❒ Intoe – Out toe walking
❒ Back Pain	❒ Joint Pain
❒ Blisters	❒ Knee Pain
❒ Bone Spurs	❒ Limb Length Discrepancy
❒ Bunions	❒ Neuromas
❒ Burning Feet	❒ Numbness or tingling in foot or toes
❒ Corns/Calluses	
❒ Diabetic Evaluation	❒ Plantar Fasciitis
❒ Flat Feet	❒ Postural Fatigue
❒ Fracture	❒ Pronation
❒ Fungal Infections (skin/nail)	❒ Shin Splints
	❒ Sprains
❒ Gout	❒ Sweating/Odor
❒ Hammertoes	❒ Tendonitis
❒ Heel Pain	❒ Tired feet
❒ Hip Pain	❒ Ulcers
❒ Infections	❒ Warts

MEDICAL HISTORY

Have you ever been treated for any of the following conditions? Please ✓ all that apply to you;
Put an **M** if on your mother's side;
Put an **F** if on your father's side

_____Acid Reflux	_____Hypothyroidism
_____Anemia	_____Irritable Bowel Syndrome
_____Arthritis	_____Kidney Problems
_____Asthma	_____Liver Disease
_____Bleeding Disorders	_____Low Blood Pressure
_____Cancer	_____Nervous Disorder
_____Depression	_____Muscle or Joint Pain
_____Diabetes	_____Peripheral Arterial Disease
_____Epilepsy	_____Parkinson's Disease
_____Fatigue	_____Phlebitis
_____Fibromyalgia	_____Poor Circulation
_____Headaches	_____Respiratory Disease
_____Heart Condition	_____Rheumatic Fever
_____Hepatitis	_____Shortness of Breath
_____High Cholesterol	_____Seizure Disorders
_____HIV/Aids	_____Stomach Ulcers
_____Hypertension	_____Stroke
_____Hyperthyroidism	_____Varicose veins

MEDICATIONS

Are you currently on Blood Thinners? Yes ❍ No ❍

You can provide a printed list of your medications or list them below:

Name of Medication	Strength/Mg	Take how often?

Do you currently use: Cigarettes or Tobacco? Yes ❍ No ❍ Quit ❍

If yes, for how long? _____How many pks/day?_____

If quit, when? _____yrs _____months

Alcohol use? Yes ❍ No ❍ If yes, quantity _____daily _____weekly

SURGERIES

Please list all surgeries	Approximate Date

Name of MD/Family Physician _____

Address _____

Date of Last Visit _____

ALLERGIES

Have you ever had any adverse side effects or allergies to:	YES	NO		YES	NO
Adhesive Tape			Metal/Jewelry		
Anticoagulants			Novacaine		
Anti-inflammatory Meds			Peanuts		
Aspirin			Penicillin		
Codeine			Seafood		
Cortisone			Other antibiotics		
Iodine			Other pain medication		
Latex			Other		

If other, please explain _____

SIGNATURE ON FILE AND PERMISSION TO TREAT

- I understand that the information provided on this form is true and correct to the best of my knowledge.
- I request that payments of authorized benefits be made on my behalf for any services furnished by **Foot and Ankle Physicians, PA.**
- I authorize any holder of information about me to release any information needed to determine these benefits or the benefits payable to related services to the insurance agent.
- I recognize my financial obligation of any coinsurance, co-pays or deductibles and non-covered services that may be required.
- I hereby give permission to **Foot and Ankle Physicians, PA** and any qualified staff to evaluate, diagnose and treat my foot and/or ankle condition as may be deemed necessary.

Patient or Authorized Signature**V**_____

If not patient, state relationship _____Date _____

FOOT & ANKLE
PHYSICIANS, P.A.

Patient's Name: _____ **DOB:** _____ **Date:** _____

Review of Systems: Please check any of the following symptoms that you are currently experiencing or have experienced in the last 7-10 day.

General
☐ Fatigue
☐ Fever
☐ Weight Gain
☐ Weight Loss

Cardiovascular
☐ Anemia
☐ Bleeding Problems
☐ Chest Pain
☐ High Cholesterol
☐ Leg Pain
☐ Leg Swelling
☐ Palpitations/Arrhythmia

Ear, Nose, & Throat
☐ Difficulty swallowing
☐ Hearing loss
☐ Nasal congestion
☐ Painful swallowing

Eyes
☐ Glasses
☐ Vision Changes

Gastrointestinal
☐ Abdominal/Stomach Pain
☐ Heartburn
☐ Indigestion
☐ Irritable Bowel Syndrome
☐ Ulcers

Genitourinary
☐ Urinating Problems

Skin
☐ Cancer
☐ Open Sores/Wounds
☐ Rash

Musculoskeletal
☐ Foot Deformity
☐ Joint Pain
☐ Muscle Ache

Neurologic
☐ Headache
☐ Seizures
☐ Tingling/Numbness

Psychiatric
☐ Anxiety
☐ Depression

Respiratory
☐ Cough
☐ Shortness of Breath

Anything else you want your doctor to be aware of?

_____

_____

Privacy Statement

Foot and Ankle Physicians, PA will use and disclose your health information for the following purposes: to treat you, to assist other health care providers in treating you, to allow insurance companies to process insurance claims for services rendered to you, to obtain payment for services rendered to you and for certain limited operational activities, such as quality assessment, licensing, accreditation and training of students. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization. If you have any questions, concerns or complaints regarding our privacy practices, please refer to the actual Notice of Privacy Practices provided to you for the person(s) whom you may contact.

Additional Disclosure Authority:

In addition to the allowable disclosures described in the State of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

Please circle your choice(s) below:

Any member of my immediate family	YES	NO
Spouse Only	YES	NO
Other (Please specify)	YES	NO

Acknowledgement of Receipt of Notice of Privacy Practices:
(Signature represents that I have been offered a copy of the policy)

I acknowledge that I was provided a copy of the Notice of Privacy Practices and have read (or had the opportunity to read if I so chose) and understood the Notice.

v_____ _____

Signature Date

_____

Patient Name or Authorized Representative (Print)

Financial Policy

Thank you for choosing Foot and Ankle Physicians, PA as your foot care provider. We are committed to providing you with quality and affordable health care. Please read the following office payment policy and feel free to ask us any questions that you may have. Once you accept this policy, kindly sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. This would also apply to 'follow up' visits when applicable. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some - and perhaps all - of the services you receive may be uncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. If required, obtaining the proper referral from your Primary Care Physician is your responsibility. Patients presenting to our office without a valid referral will be asked to pay in full. This payment will be held for 48 hours and will become non refundable if the proper referral is not obtained by then.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

7. Nonpayment. Invoices are sent out every 30 days. Your prompt payment will assist us in keeping the cost of healthcare down. If your account is over 60 days past due, you will receive a letter requesting immediate payment. A $10.00 rebilling fee will be charged for each additional invoice sent out after 30 days. Partial payments will not be accepted unless otherwise approved by our Billing Department. Please be aware that if a balance remains unpaid, we may refer your account to small claims court and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative podiatric care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. Missed appointments. Our policy is to charge $30.00 for missed appointments not canceled within a reasonable amount (more than 5 hours so we may appoint someone else who may be waiting to be seen) of time or for an understandable reason. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

9. Forms and Documents. It is our policy to charge for completion of forms, such as disability applications, FMLA, return to work clearance, etc. per occurrence. This will be $10.00 for the first page and $5.00 per page after that.

10. Fees. Our fees are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

√_____

_____

Signature of patient or responsible party

FOOT & ANKLE
PHYSICIANS, P.A.

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

I request and authorize _____ to release healthcare information to:

FOOT AND ANKLE PHYSICIANS, PA
2350 SUNSET POINT ROAD SUITE A
CLEARWATER, FL 33765

FAX: 727-796-7464

This request and authorization applies to: _____

☐ All healthcare information relating to the following treatment, condition, or dates: _____

_____

☐Other: _____

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION IS GOOD UNTIL PATIENT NOTIFIES IN WRITING OTHERWISE.