CAROLINA FOOT & ANKLE ASSOCIATES, PLLC
WELCOME TO OUR OFFICE

Please take a few moments to answer the following questions so that we may get to know you better.

Patient Name: _____ **Appointment Date**: _____

Referring Physician (Name & Practice Location):_____

Preferred Pharmacy & Location:_____

1. **Describe your foot/ankle problem(s) (including left, right or both) :**

_____

_____

2. How long have you had this problem? _____
3. Are you experiencing pain? ☐ No ☐ Yes (if yes, please answer the following)

How long have you had pain? _____ days _____ weeks _____ months _____ years

Describe the type of foot pain: ☐Burning ☐Aching ☐Sharp ☐Stabbing ☐Throbbing ☐Pins/Needles ☐Numb

Pain severity 0 = none, 10 = very severe (please circle) 0 1 2 3 4 5 6 7 8 9 10

Exact location (if possible): _____

How frequent is the pain? ☐Constant ☐Most of the day ☐A few times per day ☐Weekly

Pain is often experienced with: ☐ Walking/Standing ☐ Resting ☐Certain Shoes ☐Pressure ☐With Activity

The pain is made worse by: _____

Do you feel numbness in your feet? ☐ Yes ☐ No Tingling? ☐ Yes ☐ No

Social History

4. Are you employed? ☐ Yes ☐ No Estimate the number of **hours each day** you spend on your feet: _____
5. Most of your hours are spent on which type of surface? ☐Concrete ☐ Wood ☐ Grass ☐ Other (describe) _____
6. Shoe style typically worn at work? _____ At home? _____ Shoe Size: _____

   Estimate the number of hours per day spent at home walking barefoot, in stocking feet or bedroom slippers: _____
7. If female, are you currently pregnant? ☐ No ☐Yes ☐ Maybe
8. Do you smoke cigarettes? ☐ No ☐Yes If so, for how many years? _____ How many packs per day? _____
9. Are you a former smoker? ☐ No ☐Yes If so, for how many years? _____ How many packs per day? _____
10. Do you drink alcoholic beverages? ☐No ☐Yes What kind and approximately how many each week? _____

PLEASE COMPLETE BOTH SIDES

11. **Past Medical History:** (Check those that **apply <u>to you</u>**) ☐ NONE

☐ Skin Cancer	☐ Thyroid Disorder
☐ Other Cancer (where?)	☐ Stomach Ulcer
☐ Vision Impairment	☐ Hiatal Hernia
☐ Hearing Loss	☐ GERD
☐ Lung/Respiratory Disorders	☐ Cirrhosis
☐ Mitral Valve Prolapse	☐ Kidney Disease
☐ Past Heart Attack (when?)	Do you receive kidney dialysis? ☐ Yes ☐ No
☐ Arrhythmia	☐ Diabetes
☐ Stroke	# Years:
☐ History of Blood Clots	☐ Gout
☐ Other Bleeding Disorders	☐ Rheumatic Fever
☐ High Blood Pressure	☐ Osteoarthritis
☐ Elevated Cholesterol	☐ Other Arthritis
☐ Anemia	☐ Seizure Disorder
☐ Depression or Mood Swings	☐ HIV/AIDS
☐ Fibromyalgia	☐ Hepatitis
☐ Neuropathy or Nerve Damage	☐ Tuberculosis
☐ Other:	☐ History of MRSA Infection

12. **If you have diabetes, please answer the following questions:**

Do you check your blood sugar at home? ☐ Yes ☐ No If so, how often? _____ Last result: _____

Last Hemoglobin A1C Value: _____ Date: _____ Drawn where? _____

Date of your last <u>dilated</u> eye exam: _____ Performed where? _____

Date of your last screening urine test: _____ Performed where? _____

13. **Surgical History: Have you ever had surgery?** ☐ No ☐ Yes (if yes, please continue)

Foot Surgery: ☐ Right ☐ Left Details: _____

Vascular: ☐ Stent ☐ Open Procedure Location: _____

Joint Replacement: ☐ Knee ☐ Hip ☐ Other: _____

Heart Surgery: ☐ Stent ☐ Open Heart ☐ Pacemaker ☐ Valve Repair

Gastric Bypass: ☐ Yes ☐ No If yes, date: _____

Please list any other surgeries: _____

14. **Family History** (Who in your family has had these medical problems?): ☐ NONE

☐ Diabetes _____ ☐ Heart Disease_____ ☐ Kidney Disease _____

☐ Hypertension _____ ☐ Stroke _____ ☐ Mental Illness _____

☐ Arthritis _____ ☐ Bleeding Disorder _____ ☐ Cancer_____

☐ Other Family History: _____

Patient Name: _____ **Appointment Date**: _____

15. **List all Medications/vitamins with dose & directions:** ☐ NONE ☐ I have attached a list

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

16. **Do you take the following?** ☐ Tylenol ☐ Advil, Ibuprofen, Aleve or Motrin

If so, how much? _____ How often? _____

17. **Allergies** (If yes, what type of reaction?) ☐ NONE

☐ Penicillin _____
☐ Other Antibiotics (which ones?) _____
☐ Aspirin _____
☐ NSAIDS (Ibuprofen/Aleve): _____
☐ Pain Medication (which ones?): _____
☐ Latex _____
☐ Sulfa Drugs_____
☐ Nickel/Other Metals _____
☐ Surgical Implants _____
☐ X-ray Contrast Dye _____
☐ Other _____

18. **FLU VACCINE** Have you received the flu vaccine this year? ☐No ☐Yes If yes, when? _____

19. **VITAMIN D LEVEL** Have you had your Vitamin D Level checked? ☐Yes (☐ normal ☐ abnormal) ☐No ☐Unsure

To be used by Carolina Foot & Ankle Staff:

BP (sitting): _____/_____ Pulse _____/min (Reg. Irreg.) Resp. _____/min Temp: _____°F

Height _____ Weight_____

PLEASE COMPLETE BOTH SIDES

CAROLINA FOOT & ANKLE ASSOCIATES, PLLC

Please check any of the following that you are currently experiencing or have recently experienced:

Constitutional			
☐ Fever	☐ Chills	☐ Sweats	☐ Weight Change
Head, Eyes, Ears, Nose and Throat			
☐ Vision Impairment (Glasses, Contacts)	☐ Cataract	☐ Sore Throat	
☐ Double Vision	☐ Neck Pain	☐ Ringing in the Ears	
☐ Difficulty Swallowing	☐ Dentures		
☐ Nosebleeds	☐ Dizziness		
Cardiovascular			
☐ Chest Pain / Discomfort	☐ Cardiovascular Symptom	☐ Heart Murmur	
☐ Swelling lower extremity	☐ Leg Pain with Exercise	☐ Palpitations	
Hematologic/Lymphatic			
☐ Bleeding Problem	☐ Swollen Glands		
☐ Anemia	☐ Skin Lump - Location		
Respiratory			
☐ Difficulty Breathing	☐ Wheezing	☐ Previous Pulmonary Disease	
☐ Exposure to TB	☐ Cough		
Gastrointestinal			
☐ Nausea	☐ Vomiting	☐ Diarrhea	
☐ Decrease in Appetite	☐ Abdominal Pain	☐ Constipation	
Endocrine			
☐ Often Thirsty	☐ Frequent Urination	☐ Prior Kidney Disease	
☐ Urinary Symptoms	☐ Thyroid Disease		
Musculoskeletal			
☐ Musculoskeletal symptoms	☐ Feeling weak	☐ Joint Pain	
☐ Weakness of limbs	☐ Prior Fracture		
Nervous System			
☐ Ataxia	☐ Speech Difficulties	☐ Headache	
☐ Neuropathy	☐ Confusion/ Disorientation	☐ Fainting	
☐ Seizures			
Skin			
☐ Rash	☐ Ulcer	☐ Infections	☐ Cracking
☐ Color Change	☐ Growth	☐ Hair Loss	
☐ Eczema	☐ Lesions	☐ Sun Sensitivity	
Allergic, Immunologic History			
☐ Dermatitis	☐ Rheumatoid Arthritis	☐ Lupus	☐ Collagen Vascular
Psychiatric			
☐ Anxiety	☐ Depression		

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

Signature: X_____ **Date:** _____

Patient or Personal Representative

CAROLINA FOOT & ANKLE ASSOCIATES, PLLC
DEMOGRAPHICS

Patient's Last Name: _____ **First:** _____ Middle Int: _____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Gender: _____ **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated

Race: ☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ Native American ☐ Other: _____

Ethnicity: ☐ Hispanic ☐ Non Hispanic **Preferred language:** _____

Social Security: _____ **Date of Birth:** _____

Home Phone: _____ **Work Phone**: _____ **Cell Phone:** _____

Primary Care Doctor's Practice Name: _____

Email Address: _____

Primary Insurance: _____ **Secondary Insurance:** _____

Who carries the insurance? ☐ The patient ☐ Other (Name): _____ DOB: _____

How did you hear about our practice? _____

Is the patient in a facility (ex: nursing home)? Name: _____ Phone: _____

Responsible Party

If someone (other than the patient) is responsible for the patient's bill, please complete the following:

Responsible Party's Name: _____ Relationship to patient: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

In case of emergency, whom do we contact?: _____

Home: _____ Cell: _____ Work: _____

I authorize the release of any medical information necessary to process my insurance claim and request payment of benefits to the doctor. I hereby give permission to the doctor to administer treatment and to perform any minor procedures as may be needed in the diagnosis and/or treatment of my foot and ankle condition. I understand that services rendered should be paid for at the time of service unless other arrangements have been made.

I authorize payment of insurance benefits to the doctor. This authorization applies to all dates of service until revoked.

Signature: _X_____ **Date:** _____

Patient or Personal Representative

CAROLINA FOOT & ANKLE ASSOCIATES, PLLC
AUTHORIZATION TO RELEASE INFORMATION TO FAMILY/FRIENDS

Patient Name: _____ **Date of Birth:** _____

Carolina Foot and Ankle is authorized to release protected health information about the above named patient to the entities named below:

Choose each item that is subject to this authorization:

☐ Leave information on the voice mail ☐ Give information to spouse

☐ Give information to the following persons: _____

Description of information to be released:

☐ Financial Information ☐ Results from tests or x-rays

☐ Medical information as follows: _____ ☐ Other information: _____

I prefer appointment reminder calls via: ☐ Phone ☐ Text Message ☐ Email

Rights of the Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Carolina Foot and Ankle. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by a federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization. This authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

Signature: X_____ **Date:** _____
Patient or Personal Representative

_____

Description of Personal Representative's Relationship and Authority (attach necessary documents)

Notice of Privacy Practices

Our notice of privacy practices provides information about how we may use and disclose protected health information about you. It also provides information about your rights as a patient of our practice and whom you may contact at our office to ask questions about our privacy practices. By signing below, you are agreeing that you have had the opportunity to read our notice of privacy practices.

Signature: X_____ **Date:** _____
Patient or Personal Representative

CAROLINA FOOT & ANKLE ASSOCIATES, PLLC
FINANCIAL POLICY

Patient Name: _____ **Date of Birth:** _____

YOUR INSURANCE

Our relationship is with you, not your insurance company. If we are a participating provider with your insurance, we will file your claim for you. We do not; however, file third party payer claims for motor vehicle, worker's compensation, or other accidents. If you do not have your insurance card at the time of service, it may be necessary for you to pay for your visit in full.

According to our insurance contracts, we are obligated to collect the patient's responsibility at the time we provide services. Therefore, any applicable co-pays, coinsurance, or deductible amounts must be paid at each visit. In the case of high deductible plans (including HRAs and HSAs), the contracted amount will be due from the patient at the time of service. If you require a procedure, a member of our staff will contact your insurance company to confirm eligibility and gain an estimate of your benefits. Prior to the procedure, you are required to pay in full for your estimated out-of-pocket expense related to the procedure. Patients with a history of not paying these fees may be discharged from our practice and their insurance carrier will be notified. Payment must be made in full for any services considered by your insurance as "non-covered" or "not reasonable or necessary".

Some insurance companies may require a pre-certification or pre-authorization for certain services. While we will gladly assist you with this process, the final responsibility to insure that any such requirements are completed prior to treatment is yours. Denied charges due to lack of proper pre-certification/pre-authorization will be billed to you.

IF YOU DO NOT HAVE INSURANCE

A minimum deposit of $150 is due at check in for all self-pay patients. Charges for follow up visits will be due at the time of service.

NO SHOWS

Please try to give our office 24 hours advance notice of cancellation so we may offer the appointment to another patient. Repeatedly missing appointments without adequate notice may lead to dismissal from the practice.

RETURNED CHECKS

There is a $25 service fee for all checks returned for non-sufficient funds. A third party service will attempt to have the check clear your account twice before returning it to us as uncollectable. Patients who have written returned checks will be required to pay for subsequent visits using cash or a credit card.

COLLECTIONS

If you are unable to pay your account in full as billed, please contact our office to make other financial arrangements. Overdue accounts with inactivity after 90 days may be assigned to a collection agency for follow up. Regrettably, patients referred to collections will be dismissed from our practice.

PATIENT REFUNDS

After all insurance balances have been settled, we will issue patient refund checks for credit amounts over $10. Checks are written once per month. Due to administrative costs, credit balances under $10 will be held on account for a return appointment.

MEDICAL RECORDS

In order that we may keep your information up to date, please inform us of any changes, including insurance, address or phone number.

We are happy to complete disability, FMLA etc. forms for our patients. Before leaving the form with us, please make sure you have filled in the patient portion. There will be a $15 fee for your first form and a $5 fee for any related follow up form. Please allow five business days for processing. Due to HIPAA regulations, we are not able to fax forms to your employer.

Upon your request, copies of x-rays and medical records may be made available for your pick up by giving us a 48 hour notice. As a courtesy, the first two x-ray films are free. Each film thereafter is $10. X-ray discs are $5 each. There will be a minimum charge of $10 for medical record copying; however, with your written authorization we are happy to fax your medical records directly to another physician at no charge.

By signing below I acknowledge that I have read the above financial information and agree to adhere to the policies outlined.

Signature: X_____ **Date:** _____

Patient or Personal Representative