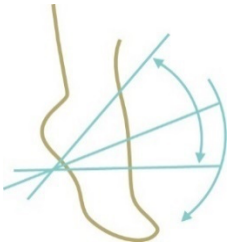
Ankle & Foot Center of Central Florida



New Patient Information

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

Address: _____ **City:** _____ **State:** _____ **Zip code:** _____

Home phone: _____ **Cell phone:** _____ **Email:** _____

Language: _____**Race:** _____ **Ethnicity:** Hispanic yes or no **Gender:** _____

SSN: _____ **Insurance Company Name:** _____

Name on Insurance Card: _____**Date of Birth of Policy Holder:** _____

Please answer the following questions in regards to your Social History

How did you hear about us?	Height and Weight
Describe in detail what brings you into the office.	Emergency Contact Name & Phone Number
Shoe size	Smoking Status: current, former, never, vape
Primary Care Doctor's First and Last Name	Pharmacy Name and Location
Last Visit to Primary Doctor	How long did you smoke?
Primary Care Doctor's Location	How much do you smoke?
HBA1C (Diabetics Only)	How much alcohol do you drink?
Date of last eye exam?	Illegal Drug Use? yes or no
Date of last colonoscopy	Marital status? married, single, divorced, widowed
You may discuss my health information with:	Occupation (include retired and disabled)

Please answer the following questions in regards to your Medical History

☐ AIDS/HIV	☐ Coronary Artery Disease	☐ Hepatitis	☐ Parkinson's
☐ Alzheimers or Dementia	☐ Depression/Anxiety	☐ High Cholesterol	☐ Polio
☐ Anemia	☐ Diabetes Type 1	☐ Hypertension	☐ Raynaud's Disease
☐ Arrhythmia	☐ Diabetes Type 2	☐ Kidney Disease	☐ Rheumatoid Arthritis
☐ Arthritis	☐ Dialysis	☐ Leg or Foot Ulcers	☐ Seizures/Epilepsy
☐ Artificial Joints	☐ Ear Problems	☐ Liver Disease	☐ Sleep apnea
☐ Asthma	☐ Fibromyalgia	☐ Lung Disease	☐ Stents
☐ Back Pain	☐ COPD	☐ Mental Illness	☐ Stroke
☐ Bipolar	☐ Foot Deformity	☐ Myocardial Infarction	☐ Thyroid Problems
☐ Bleeding Disorder	☐ GERD	☐ Neuropathy	☐ Tuberculosis
☐ Blind (legally)	☐ Gout	☐ OCD	☐ Varicose Veins
☐ Blood Clot	☐ Headaches	☐ Organ Transplant	☐ Venereal Disease
☐ Cancer	☐ Heart Disease	☐ Osteoporosis	
☐ Circulation problems	☐ Heart Problems	☐ Pacemaker	

Patient Name _____

Please answer the following questions in regards to your Surgical History.

☐ Amputation	☐ Foot Surgery	☐ Lower extremity bypass
☐ Ankle Surgery	☐ Gall Bladder	☐ Lung Surgery
☐ Appendectomy	☐ Hand Surgery	☐ Neck surgery
☐ Arthroscopic Surgery	☐ Heart surgery	☐ Pacemaker
☐ Back Surgery	☐ Hernia Surgery	☐ Plastic Surgery
☐ Cancer Surgery	☐ Hysterectomy	☐ Prostate surgery
☐ Cardiac bypass	☐ Joint Replacement	☐ Shoulder Surgery
☐ Carpal Tunnel Surgery	☐ Kidney Surgery	☐ Stent
☐ Cataract Surgery	☐ Knee Surgery	☐ Other _____

Please answer the following in regards to your Family History. Check Mother (M) or Father (F)

Family history of Autoimmune disease	☐ M	☐ F	Family history of High cholesterol	☐ M	☐ F
Family history of Blood Disorder	☐ M	☐ F	Family history of Hypertension	☐ M	☐ F
Family history of Cancer	☐ M	☑ F	Family history of kidney disease	☐ M	☐ F
Family history of Cardiovascular disease	☐ M	☐ F	Family history of Osteoporosis	☐ M	☐ F
Family history of foot deformity	☐ M	☐ F	Family history of Rheumatoid arthritis	☐ M	☐ F
Family history of Diabetes mellitus	☐ M	☐ F	Family history of Respiratory disease	☐ M	☐ F
Family history of Epilepsy	☐ M	☐ F	Family history of Tuberculosis	☐ M	☐ F
Family history of Glaucoma	☐ M	☐ F	Family history of stroke	☐ M	☐ F
Family history of Gout	☐ M	☐ F			

Please list all Medications you are on. (if you have a list please provide to front desk)

_____

_____

_____

_____

_____

Please list all your Allergies to medication. (Include Metal and Shellfish)

_____

_____

_____

_____

_____

Patient Consent

Patient Treatment Consent

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and preform such procedure upon me as the doctor deems necessary.

Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with front office staff.

- As our patient, you are responsible for all authorizations/referral needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept Visa, MasterCard, Discover, AMEX, CareCredit, cash or check. With your permission, your credit card information may be saved to process outstanding balances.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefit to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefit for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all-insurance changes and authorization/referral requirements. In the even the office is not informed, you will be responsible for any charges denied.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibly.
- There are elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to surgery.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.
- There is a service fee of $30.00 for all returned checks. There is a $25.00 no show fee. There is a fee of $20 fee for all disability paperwork.

HIPAA/Privacy Policy

YOUR RIGHTS: As a patient of the Ankle and Foot Center of Lake County, you have a right to:

- Request an electronic or paper copy of your medical record and other health information, which shall be provided to you within thirty (30) days at a reasonable cost-based fee;
- Request that updates and corrections be made to your health information;
- Request that confidential communications be conveyed to you in a specified, reasonable manner;
- Request that certain treatment you receive, payments you make, or operations you undergo be shared with other entities, unless approving your request would adversely affect your care;
- Request a list of individuals and entities with whom we have shared your health information for the last five (5) years, at a reasonable, cost-based fee;
- Request a paper copy of this privacy notice; Request a medical power of attorney; and
- File complaints with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C., 20201 or by calling 1-877-696-6775, or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

YOUR CHOICES: As a patient of the Ankle and Foot Center of Lake County, you may request that we:

- Share your information with your family, close friends, and others involved in your care, or during a disaster relief situation;
- Require written consent in order to use your health information for marketing purposes, the use of psychotherapy notes, or for sale; and
- That we discontinue contacting you for fundraising efforts.

USES AND DISCLOSURES: The Ankle and Foot Center of Lake County shall use or share your health information to:

- Treat you; Run our practice, improve your care, and contact you when necessary;
- Procure payment for services rendered;

- Aid public health and safety concerns in preventing disease, helping with product recalls, reporting adverse effects to medications, reporting abuse, neglect or domestic violence, or in preventing or reducing serious threats to anyone's health or safety;
- Further health information research;
- Comply with federal and state laws;
- Respond to organ and tissue donation request;
- Work with a medical examiner or funeral director;
- Further worker's compensation claims and other government requests; or
- Respond to lawsuits and court proceeding requests.

OUR PROMISES TO YOU: We promise and ensure that:

- Pursuant to privacy and security law, we shall maintain and protect your health information
- We will inform you if a breach occurs that potentially comprises the privacy and security of your information
- We shall follow the privacy practices and duties delineated in this notice; and
- We will not use or share your information without your written consent, and at any time, you may change your mind, provided you do so in writing.

This notice is subject to changes, which shall apply retroactively to all information we have about you. Any changes will be reflected in the most current version of this notice, which you may request a copy of.

I acknowledge that I have read and fully understand this Notice of Privacy Practices and consent to all practices contained herein.

Authorization for Release of Health Information

ANKLE & FOOT CENTER OF LAKE COUNTY LLC uses SureScripts, Inc., a prescription system that allows prescriptions and related information to be exchanged between my providers and the pharmacy. The information sent between these systems may include details of any and all prescription drugs I am currently taking and/or have taken in the past. This information will be utilized to ANKLE & FOOT CENTER OF LAKE COUNTY LLC.

This authorization may include disclosure of prescription information related to alcohol and drug abuse, mental health treatment, and/or confidential HIV related information by SureScripts, Inc. to ANKLE & FOOT CENTER OF LAKE COUNTY LLC

I have the right to revoke this authorization at any time by writing to ANKLE & FOOT CENTER OF LAKE COUNTY LLC. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

Information disclosed under this authorization might be re-disclosed by the recipient, and this re-disclosure may no longer be protected by state or federal law.

This authorization expires one year from the date of my signature below.

THIS AUTHORIZATION DOES NOT AUTHORIZE ANKLE & FOOT CENTER OF LAKE COUNTY LLC TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THOSE PERMITTED UNDER APPLICABLE LAW.

****Please sign and date the item below*****

Acknowledgement and Authorization

I have read and understand the HIPAA/Privacy Policy for ANKLE AND FOOT CENTER OF LAKE COUNTY LLC.I hereby assign my insurance benefits to be paid directly to the healthcare provider**.** I authorize ANKLE AND FOOT CENTER OF LAKE COUNTY LLC to release medical information required to process my insurance claim. I have read and understand the Financial Policy for ANKLE AND FOOT CENTER OF LAKE COUNTY LLC**.** I authorize ANKLE AND FOOT CENTER OF LAKE COUNTY LLC to obtain/have access to my medication history All the information provided on my health history forms is true. I authorize my provider's office to contact me by phone, email, text, and mail. I have read and understand the Patient Treatment Consent.

Print Name of Person Signing _____

Relationship to Patient _____

Signed _____

Date _____

Consent for Care, Treatment and Payment

I, _____, for myself or for _____, if I am signing as a Personal Representative, consent to enter into a Patient Relationship with my Physician's office. I understand that my provider and associates (physicians and medical assistants) may also terminate the relationship with proper written notice to me. I agree that you may release information regarding my treatments and services provided to me to third party payers for billing purposes, unless such services are paid for in full out of pocket. I understand that such "treatment services" may include but not limited to:

- Nails and Skin care
- Sudoscan nerve test
- MLS Laser Therapy
- ABI Arterial Study
- Nails and Skin biopsy
- Wound culture
- Wound Care
- Radiological x-rays
- Surgical debridement of wound, skin, nails
- Durable medical supply (walking boots, surgical shoes, orthotics, braces, pads, taping, compression garments)
- Over the counter medication and products (Skin, nail, joint and neuropathy)
- Regenerative medicine products/injections – hyaluronic acid, platelet rich plasma (PRP)
- Surgical suite, set up, supplies and environmental costs used for private in office surgeries including Minimal Incisions Surgical (MIS) procedures such as: MIS bunions, hammertoes, soft tissue procedures, osteotomies (Bone procedures), tenotomies (tendon procedures).

The services and products may or may not be fully covered by my insurance and therefore agree to be responsible for payment of such items offered in the office.

I also understand and agree that she may use my information for your internal and confidential health care operation.

_____ _____

Patient Signature Date