Foot and Ankle Specialists of Clearwater, LLC

First Name: _____MI: _____Last Name: _____

Mailing Address: _____ City: _____

State: _____ Zip Code: _____ Date of Birth: ____/____/_____

Social Security #: _____-____-_____

Gender: Male, Female or Unspecified

Employer: _____

Cell Phone #: (____) _____-_____ E-mail: _____

Home Number #: (____) _____-_____

Providing e-mail gives us permission to send

___ OK to leave message with detailed information appointment reminders and correspondence.

___ OK to text messages with coverage information

___ I DECLINE messages, leave call back number only

Primary Care doctor: _____ Date last seen: _____

Doctor's phone number: _____

Pharmacy: _____

Location: _____

How did you hear about our office?

_____

Were you referred by a physician? _____

If yes, which Doctor? _____

Is this visit pertaining to an auto accident or work-related injury? _____

Primary Insurance: _____ Secondary Insurance: _____

Are you the sponsor of this insurance? YES/NO Are you the sponsor of this insurance? YES/NO

If not, please provide the following: If not, please provide the following:

Spouse/ Parent Name: _____ Spouse/ Parent Name: _____

Date of Birth: _____/_____/_____ Date of Birth: _____/_____/_____

Shoe Size: _____

HEIGHT: _____ **WEIGHT:** _____

Smoker: (Please circle) Everyday Smoker OR Former Smoker OR Non-Smoker

Alcohol use: Never Occasional/weekends Regular If so, frequency/amount _____

Any recreational drug use: (Please list) _____

_____

Did you receive a Flu shot this season (October-March)? _____

If you are 65 years of age or older, have you received a Pneumonia vaccine? _____

Reason for your visit today:

_____

_____

How long has this been occurring:_____

Have you tried anything for this condition: _____

Has anything helped alleviate your pain:_____

Any past foot/ankle surgery or problems? If yes, please list:

_____

_____

_____

_____

_____

Please list your SURGERIES along with dates:

_____

_____

_____

_____

_____

_____

Family History of Medical Problems:

Mother: LIVING OR DECEASED

MEDICAL: _____

Father: LIVING OR DECEASED

MEDICAL: _____

Other Relatives (specify):

_____

_____

_____

Do you have diabetes? _____

If yes: TYPE I or Type II

Controlled By: Insulin/ Oral Medication/ Diet

Last blood sugar: _____ Last A1c: _____ (DATE of last A1c):_____

Current Medical Conditions:

Diabetes: (Y or N) _____

Blood pressure: (Y or N) _____

Heart conditions/ pacemaker: (Y or N) _____

All other conditions (please list all medical conditions):

_____

_____

_____

_____

_____

_____

_____

MEDICATIONS that you are taking WITH DOSAGES, if known:

Diabetic medications:

_____

_____

Blood pressure medications:

_____

_____

Blood thinners, including any aspirin or ibuprofen type products:

_____

_____

All other medications:

_____

_____

_____

_____

_____

_____

Consent for Medication History Data from Surescripts:

May we request a medication history review via Surescripts? This enables us to accurately document your medications, dosages, frequencies comprehensively without the errors that may occur by verbal documentation or partial history data. _____ YES _____ No

Signature: _____ **Date:** _____

Are you allergic to any medications? Please list medication and reaction:

_____

_____

Foot and Ankle Specialists of Clearwater, LLC Guidelines

Copays and balances are due at the time of service. We will bill to your insurance companies; however, you are ultimately responsible for all charges whether the insurance company paid for your claim or not. The insurance companies you place on this form are the carriers we will bill for your date of service.

I hereby authorize Foot and Ankle Specialists of Clearwater, LLC and staff to disclose my individually identifiable health information to the insurance carrier(s). Foot and Ankle Specialists of Clearwater, LLC will use and disclose my health information in order to obtain payment to the doctor for services rendered and allow insurance companies to process claims. I understand that this authorization is voluntary.

I hereby authorize the Physicians at Foot and Ankle Specialists of Clearwater, LLC to render treatment and/ or therapy to myself that they deem medically necessary in order to treat my condition(s). My signature confirms that I have given Foot and Ankle Specialists of Clearwater, LLC all past and current health information and that it is accurate to the best of my knowledge.

Signature of Patient/ Guardian:

_____ Date: _____

Foot and Ankle Specialists of Clearwater, LLC

Policy for REQUESTS FOR AUTHORIZATIONS FOR PROCEDURES/SURGERY BOOKINGS

In the course of your treatment, it may become necessary to complete imaging studies, procedures, or other interventions that require a pre-authorization from your insurance company. The pre-authorization process is a time-consuming process that requires staff to complete lengthy paperwork and phone communication with your insurance in order for your insurance to approve the procedure/treatment. No guarantees of insurance payments are made following completion of the authorization process. In order for us to process the authorization for certain procedures, the following fee schedule will apply when performed in our office and is not covered by your insurance:

MRI/similar imaging studies/FMLA/Disability	**125 per authorization/packet**
Forefoot surgery authorization/booking	**195 per authorization/booking fee**
Rearfoot/any reconstructive surgery authorization/booking	**495 per authorization/booking fee**

*****THE ABOVE FEES ARE NON-REFUNDABLE IN THE EVENT THAT ANY SURGERY/PROCEDURE IS CANCELLED BY THE PATIENT WITHOUT A DOCUMENTED MEDICAL REASON FOR THE CANCELLATION*****

I have read and understand the above policy on authorization fees and surgery booking/authorization fees:

SIGNATURE _____

Foot and Ankle Specialists of Clearwater, LLC

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

 Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

 Obtain payment from third-party payers.

 Conduct normal health care operations such as quality assessments and physician certifications. I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. (Please look on clipboard or in binder for copy of HIPAA) On occasion, it may be necessary to release clinical information to outside physicians, radiological institutions, laboratories, or physical therapy centers that you have been referred to, by Foot and Ankle Specialists of Clearwater, LLC, to aid in your coordination of care. We will not release your information to any third parties. Designation of Certain Relatives, Close friends and other Caregivers as my Personal Representative: I agree that the practice may disclose certain pieces of my health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my health care. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my healthcare.

Print Name: D.O.B._____

Patient/Guardian Signature/ Date:

_____