Foot & Ankle Specialists, P.C.

Dr. Scott E. Hughes * Dr. Greg P. Vogt * Dr. Christine I. Tumele

PATIENT INFORMATION

Patient Name _____Date _____
Address _____ City _____State ____Zip_____
Birth date _____ Age _____Sex _____

Email to receive correspondence _____
SS# (required) _____
Home Phone _____Cell _____ Work _____

Do you wish to be contacted by phone (please circle) Y N

Occupation/Employer _____
Emergency Contact _____
Relationship _____ Phone _____

Your Preferred Pharmacy _____Address/City _____
Who referred you to our office: _____

INSURANCE INFORMATION

Person responsible for payment _____
Billing Address (if different) _____City _____ State__ Zip____
Birth date _____ SS# _____

Primary Insurance _____
Secondary Insurance _____
Other Insurance _____

****Please make sure that we have made a copy of your insurance card(s)****

****We are required to request this information by the Federal Government, but you are not required to answer****

Race: ☐ Native American ☐ Asian ☐ African American ☐ Caucasian

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Is your preferred language something other than English? (If yes, please specify)_____

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PATIENT INTAKE FORM

Patient Name _____ Date _____

Please fill out this form to the best of your knowledge. We can also assist you. This gives our doctors important information about your heath. We are interested to learn about you and this helps us to help you. Thank You.

REVIEW OF SYSTEMS: Please check if you are experiencing any of the following:

Constitutional:
__Change in thirst or appetite
__Chills
__Fatigue
__Fever
__Weight Change

Genitourinary:
__Frequent UTI's

Musculoskeletal:
__Uses an Assistive Device
__Back Pain
__Feet & Ankle Swelling
__Joint Pain
__Paralysis

Psychiatric:
__Chemical Dependency
__Emotional Problems
__Forgetfulness

Eyes:
__Eye or vision Problems

Cardiovascular:
__Chest Pain
__Cold Feet
__Cold Intolerance
__Heart Palpitations
__Racing Heart
__Slow Heartbeat

Dermatologic:
__Rash
__Skin Sores

Endocrine:
__Elevated liver enzymes

Hematologic:
__Bleeding tendency
__Cuts take long to heal
__Swollen Lymph Nodes

Ear/Nose/Throat/Neck:
__ Difficulty hearing

Respiratory:
__Breathing Difficulty
__Cough
__Shortness of breath

Gastro:
__Heartburn
__Nausea or Vomiting

Neurologic:
__Numbness
__Tingling
__Weakness

LIST ALL SURGERIES, THE DATE AND THE DOCTOR: Please write on back if more room is needed.

_____

_____

_____

PAST MEDICAL HISTORY: Please check the items if you've EVER been diagnosed as having and CIRCLE the associated disease that follows. Please write in any diseases not mentioned below that you suffer from.

__**Abuse of:** Alcohol, Narcotics, Cocaine, Heroin, Prescriptions
__**Anemia:** Folate, Iron deficiency, Sickle Cell, B12, Not sure
__**Angina:** Stable, Unstable, Not sure
__**Anxiety disorder:** PTSD, OCD, Panic, Manic Depressive
__**Arthritis:** DJD, Gout, Osteoarthritis, Joint Replacement Surgeries (list above in surgery section)
__**Asthma:** Mild, Moderate, Severe
__**Autoimmune Arthritis:** Lupus, MCTD, Scleroderma, Rheumatoid Arthritis, JRA, Psoriatic Arthritis
__**Back Injury:** Fracture, Disc Herniation, Sprain, Previous Back Surgery (list above in surgery section)
__**Back Pain:** Disc Disease, Sciatica, Arthritis, Previous Back Surgery (list above in surgery section)
__**Bleeding Disorder:** Platelet Dysfunction, Blood Thinner Medication, Bruise Easily
__**Bowel Problems:** Inflammatory Bowel Disease, Chron's, IBS, Ulcerative Colitis, Colostomy
__**Broken Bone:** Hand, Foot, Ankle, Leg, Arm, Hip, Shoulder, Neck, Back
__**Cancer:** Brain, Thyroid, Leukemia, Metastasis, Liver, Kidney, Lung

__**Cancerous Tumors:** Breast, Cervical, Ovarian, Uterine, Prostate, Melanoma, Colon, Skin
__**Cardiac Arrhythmia:** Atrial Fibrillation, Slow or Fast Heartbeat, Pacemaker, Tachycardia, PVC's
__**Circulation Problems:** in hands, in legs, in feet
__**Dementia:** Alzeimer's, Alcoholic, Senile, Memory Loss
__**Diabetes:** Pregnancy Onset, Juvenile, Adult Onset, Diet Controlled, Controlled, Poor Control
__**Ear Problems:** Infection, Hearing Loss, Ringing
__**Eye Problems:** Glaucoma, Macular Degeneration, Retinopathy, Blindness
__**Headaches:** Tension, Stress, Migraine
__**Heart Condition:** Mitral Valve Prolapse, Valve Replacement, Heart Attack, Congestive Heart Failure, Murmur, Coronary Artery Disease
__**Hepatitis:** A, B, C, Not Sure
__**HIV or Aids**
__**High Blood Pressure:** Controlled, Uncontrolled
__**Kidney Disease:** Dialysis, Failure, Insuffiency, Infections, Arterial Stenosis
__**Liver Disease:** Cirrhosis, Fatty, Ascites
__**Menopause**
__**Neurologic Disease:** Multiple Sclerosis, Polio, Parkinson's Disease, Neuropathy, RSD
__**Venous Blood Clot or Phlebitis:** Superficial, Deep, Arm, Leg, Lung
__**Pinched Nerves:** Sciatica Right Leg, Sciatica Left Leg, Carpal Tunnel Syndrome
__**Psychiatric Care:** Depression, ADD, Bipolar, Delusional, Stress
__**Rash:** Eczema, Psoriasis
__**Reynaud's Syndrome**
__**Respiratory Condition:** History of Smoking, COPD, Bronchitis
__**Rheumatic Fever**
__**Seizure Disorder:** Epilepsy, Grand Mal, Focal, Partial
__**Sinus Conditions:** Seasonal Allergies, Infection, Sinusitis
__**Stomach Problems:** GERD, Diverticulitis, Constipation, Diarrhea, Polyps, Ulcers
__**Stroke:** TIA, CVA
__**Tuberculosis or TB:** Active Infection, Carrier, Treated, Positive Test Without Infection
__**Thyroid Disorder:** Hyperthyroidism, Hypothyroidism
__**Ulcers:** Legs, Feet
__**Other Diseases:**_____

FAMILY HISTORY:
Mother: ☐ Heart Problems ☐ Cancer ☐ Diabetes ☐ Arthritis ☐ Other: _____
Father: ☐ Heart Problems ☐ Cancer ☐ Diabetes ☐ Arthritis ☐ Other: _____
Sisters: ☐ Heart Problems ☐ Cancer ☐ Diabetes ☐ Arthritis ☐ Other: _____
Brothers: ☐ Heart Problems ☐ Cancer ☐ Diabetes ☐ Arthritis ☐ Other: _____
Children: ☐ Heart Problems ☐ Cancer ☐ Diabetes ☐ Arthritis ☐ Other: _____

SOCIAL HISTORY: Circle the proper answers for you
ALCOHOL USE:
I drink alcohol: 0 - 1 time weekly / 3 times a week / Daily / Special Occasions / I am a recovering Alcoholic
DIET:
I eat a: Regular Diet / Fast Food / Low Fat / Low Salt / Low Sugar / Weight Loss Diet
EMPLOYMENT:
My Employment requires: Prolonged Standing / Prolonged Walking / Prolonged Sitting / Other _____
EXERCISE:
__I exercise: 1-3 times per week / more than 4 times a week, by _____

__Sports I participate in :_____

DRUG HISTORY:
I use these illegal drugs: None / Cocaine / Heroin / Narcotics / Other_____

SMOKING HISTORY:
__I do not smoke
__I smoke ___packs of cigarettes every _____day(s) for _____years.
__I quit smoking, How long ago_____. I used to smoke _____packs per day for _____ years.

MEDICATIONS: Please LIST ALL NON-PRESCRIPTION AND PRESCRIPTION MEDICATIONS, vitamins, and herbs you take (include injections at home or from a doctor's office). We can make a photocopy of your medications list.

_____
_____
_____

ALLERGIES: Please list Allergies and types of Allergic Reactions.

__Adhesive tape	__Demerol	__Novocain	Other:_____
__Anticoagulants	__Eggs	__Peanuts	_____
__Aspirin	__Iodine	__Penicillin	_____
__Cipro	__IVP Dye	__Seafood	_____
__Codeine	__Latex	__Sulfa	_____

Are you pregnant? Yes / No / Not Sure Expected due date:_____

Name of Family Physician_____
Phone Number of Physician_____
Most Recent Date of Physical Exam_____
Are you currently under the care of this doctor? Yes / No
If yes, please state the reason_____

This form has been filled out to the best of my knowledge. I understand that any omissions may jeopardize my health and I cannot hold Foot & Ankle Specialists, P.C. responsible for any misinformation that I supplied.

Signature of Patient_____Date_____

FAS Initials_____ Date_____

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OFFICE POLICY AGREEMENT

INITIAL REGISTRATION AND UPDATES

Please fill out the registration forms as completely as possible. Be sure to read and sign the "consent for treatment" section. If there is ever a change in your name, health insurance, address or phone number, please notify our front desk. Your Medical history will be reviewed and updated as needed at each appointment.

INSURANCE

Present your insurance card to our receptionist at your first appointment. We must have complete and accurate information to file your claim. Benefits will be verified through your insurance carrier prior to being seen by the doctor. Please be aware that you have final responsibility for payment of services rendered. Any amount not covered or not paid by your insurer will be billed to you directly.

PAYMENT AT TIME OF SERVICE

Payment for all deductibles, copayments, and non-covered services is due at the time of treatment, unless previous arrangements have been made with our billing department. For your convenience, we accept cash, personal checks, Mastercard, Visa, and Discover. There is a $30 fee for checks returned by your bank.

COLLECTION POLICY

Statements will be sent monthly for any balance due on your account. If no extended payment arrangements have been made, we expect full payment for services rendered within 15 days. You can mail your payment, call and pay with a credit card over the phone, or pay online from your patient portal.

If an account balance has not been paid in full within 90 days, no additional appointments will be scheduled until the balance is paid. Accounts may then be referred to a collection agency. You will be responsible for any collection and/or court costs incurred during the collection process.

The responsibility for payment of services rendered to dependent children rests with the parent who seeks treatment for the child. Any court ordered responsibility judgement must be handled between the individuals involved, without the inclusion of our office.

APPOINTMENT POLICY

As a courtesy, our office will attempt to contact you the day before your scheduled appointment. However, the responsibility for keeping appointments is yours. If it is necessary to reschedule an appointment, please give us as much notice as is possible so we can schedule another patient during that time.

It is our hope that the above office policies will allow us to provide quality care to our valued patients. If you have any questions or need clarification of any of these policies, please do not hesitate to ask.

My signature below indicated that I have read the statements above, understand, and agree to comply with this policy.

_____ _____

Patient Signature Date

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AUTHORIZATION FOR TREATMENT AND INSURANCE PAYMENT

Patient Name_____Date_____

ASSIGNMENT AND RELEASE

- I, the undersigned certify that I (or my dependant) have insurance coverage with:

  _____

- I assign directly to Foot & Ankle Specialists, P.C. all insurance benefits, if any, otherwise payable to me for services rendered.
- I understand that ultimately, I am financially responsible for all charges whether or not they are paid by insurance.
- I hereby authorize the Foot and Ankle Specialists, P.C. to release all information necessary to secure the payment of benefits.
- I authorize the use of this signature or its copy on all insurance submissions.

Patient Signature_____Date_____

Parent or Authorized Rep_____

Relationship to insured_____

MEDICARE AUTHORIZATION (For Medicare or Medicare HMO patients only)

- I authorize payment to be made on my behalf to Foot & Ankle Specialists, P.C.
- Information to process a claim on my behalf may be released to my insurance company.
- I am responsible for my 20% co-pay and yearly deductible for covered services.
- I will be notified prior to treatment if services are not covered by Medicare.

Beneficiary Signature_____Date_____

AUTHORIZATION FOR TREATMENT

I certify that the information I have provided concerning my health and medical history is complete, true and correct to the best of my knowledge. I give permission to the doctors of Foot & Ankle Specialists, P.C. to administer and perform services and/or procedures as may be deemed necessary in the diagnosis and treatment of my feet, ankles, or hands.

Signature_____ Date_____

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Acknowledgement of Receipt of Foot & Ankle Specialists, P.C.'s Notice of Privacy Practices

I acknowledge that I will be provided a copy of the Notice of Privacy Practices if I desire, that I have read (or had the opportunity to read) and understood the Notice.

_____ _____

Patient Name (Please Print) Date

Authorization to Use or Disclose Protected Health Information

I authorize Foot & Ankle Specialists, P.C. to discuss and/or disclose my Private Health Information (PHI) to the following individual's as described below:

____Spouse_____
____Adult Child(ren)_____
____Parent(s)_____
____Other_____

Expiration: This authorization will stay in effect unless I set an expiration date, or it is otherwise revoked.

_____

_____ _____

Signature Date

_____

Witness