Welcome to our New Patients

Our practice is a division of the **InStride Foot & Ankle Specialists, PLLC**. We have divisions across North and South Carolina, and we operate under one tax ID number. As such, if you have seen any of the following physicians in the **past 3 years**, we need to know so that we will not file a new patient code for your visit today.

Please review the names of the divisions and podiatrists below and indicate if you have been seen at any of these divisions by putting a "X" on the line to the left of the practice name. Visits prior to 2017 do not need to be disclosed.

	DIVISION	PODIATRIST
	Alta Ridge Foot Specialists (Resigned 1/1/20)	Robert van Brederode, William Broyles, Thomas Verla
	Ankle & Foot Center of Charlotte **(Resigned 7/1/2017)**	Scott Basinger
	Brunswick Foot & Ankle Surgery, PA	Joseph Kibler
	Capital Foot and Ankle Centers	Eldon Peters (eff: 10/1/2018)
	Carmel Foot Specialists **(Resigned from group 1/1/20)**	Barbara Kaiser, Richard Lind, Richard Miller, Kevin Molan, Tori Simmons-Lewis
	Carolina Foot & Ankle Health Center	Millicent Brown
	Carolina Foot Care Associates, PLLC	Ashma Davidson, William O'Neill, Terry Donovan
	Carolina Podiatry Group	Brandon Percival, Julie Percival, William Harris, Katlin Jackson (eff:7/1/19), Robert Ezewuiro (eff:8/15/19)
	Central Carolina Foot & Ankle Associates	Melissa Hill, Gary Liao, Alan Sotelo
	Chapel Hill Foot & Ankle Associates, P.A.	Jane Andersen, Alan Bocko, Katherine Williams
	Charlotte Foot & Ankle Specialists, PLLC	Kristine Strauss **(resigned 8/1/2017)**
	Coastal Carolina Foot & Ankle	Thomas Hagan, Tyler Hagan
	Coastal Carolina Foot & Ankle Associates	Jeffrey Pupp (ret. 12/31/2019), Derek Pantiel, Kevin Bachman (eff: 1/1/2019)
	Crystal Coast Podiatry	Thomas Bobrowski
	Family Foot & Ankle Center, P.A.	Patrick Dougherty, Doug Smith
	Family Foot Care	Kevin McDonald, Neil Younce, Erin Younce (10/1/2019)
	Foot & Ankle Center of Durham	Eric Simmons
	Foot & Ankle of the Carolinas, PLLC	Eric Ward, Blaise Woeste
	Gaston Foot & Ankle Associates, P.A. **(resigned 12/1/19)**	David Kirlin, Ryan Meredith, Wagner Santiago, Randell Contento
	Greensboro Podiatry Associates, P.A.	Martha Ajlouny, N'Tuma Jah (resigned 12/21/17), **Jonathan Simpson (eff: 1/1/18) term 5/10/18**
	Hendersonville Podiatry	Russ Barone (ret. 2/2/18), Pam Stover
	James Mazur, D.P.M.	James Mazur, Erin Younce (eff: 12/19/2019)
	Kinston Podiatry	Dale Delaney
	Matthews Foot Care	Brian Killian, Kevin Killian, David Ellenbogen (termed 10/23/19), Wesley Jackson (eff: 7/1/19)
	Mt. Airy Foot & Ankle Center, PLLC	Thurmond Siceloff (term 10/23/2018) Jim Shipley, David Collard, Walter Falardeau, Jeffrey Hunter (eff: 7/1/19)
	Myers Podiatric Clinic	William Myers
	Piedmont Foot & Ankle Clinic **(Terming from Group 2/1/20)**	Rick Hauser, Rob Lenfestey, Jason Nolan, Joel Kelly, Elizabeth Bass, Daughtry, Jacob Panici, Brian Futrell
	Piedmont Podiatry Associates	Subodh Choudhary, Nicholas Canoutas, Cassandra Pike, Sarah Fitzgerald
	Queen City Foot & Ankle Specialists, P.C.	Roxanne Burgess, Alison Garten (termed 11/6/19), Wesley Jackson (eff: 7/1/19)
	Raleigh Foot & Ankle **(Resigned from Group 1/1/2018)**	Alan Boehm, Robert Hatcher, Jordan Meyers, Kirk Woelffer
	Roberson Foot Care, PC	Ainsley Rusevlyan (eff: 2/1/2019)
	Ryan Foot & Ankle Clinic	David Garchar, Jeff Glaser, Michael Ryan, Scott Whitman, Matthew Borns, Bradley Lind (eff:7/23/19)
	Salem Foot Care	Scott Matthews
	Summit Podiatry	Derek Pantiel, Kevin Bachman
	Upstate Foot Care	Hans Blaakman
	Wake Foot & Ankle Center	Mike Hodos, Jim Judge
	Wilson Podiatry Associates, PA	Kendall Blackwell

_____I attest that I have been seen in the above indicated division of the InStride since 0**1/01/2017.**

_____I attest that to my best recollection; I have not been seen by any of the above divisions/physicians since **01/01/2017.**

Signature of patient:_____Date: _____

InStride Comprehensive Foot and Ankle Center, PA

Acknowledgement of Receipt
Of Notice of Privacy Practices

Patient Name & Address: _____

_____

I have received a copy of the Notice of Privacy Practices for the above-named practice.

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason:

  _____

- ❑ Other: _____

  _____

Prepared By _____

Signature _____

Date _____

InStride Comprehensive Foot and Ankle Center, PA

Chart # _____
Date: _____

Patient Name: _____
(First) (Middle) (Last)

Address: _____

City: _____ State: _____ Zip Code: _____

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

Date of Birth: _____ Sex: ☐ M ☐ F Social Security Number: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed E-mail: _____

Do we have your permission to leave a voice message (i.e. appointment reminders) at the contact number? ☐ Yes ☐ No
Do we have your permission to leave a voice message for normal test results at the contact number? ☐ Yes ☐ No

Insurance Information:

Primary insurance: _____ Secondary: _____

Policy holder's Name (**ONLY if different from Patient**) _____

Policy holder's DOB: _____ Policy holder's SS#: _____

Policy holder's Employer: _____

Contact Information:

Emergency Contact: _____ Phone#: _____

Patient's Employer: _____ Phone#: _____

Primary Care Physician: _____ Phone#: _____

Referring Physician: _____ Phone#: _____

If patient is under the age of 18 who is the legal guardian:

Name: _____ Phone Number: _____

Are you here as a result of an injury? ☐ Yes ☐ No

Work related? ☐ Yes ☐ No Date of injury: _____

Auto/Vehicle Accident: ☐ Yes ☐ No Date of accident: _____

AUTHORIZATION FOR TREATMENT: I hereby authorize such examination, x-rays, treatments, medications, physical therapy and minor surgical procedure as may be prescribed by Comprehensive Foot & Ankle Center.

_____ _____

Patient or Responsible Party's Signature **Date**

InStride Comprehensive Foot and Ankle Center, PA

Please initial on line before each paragraph acknowledging understanding of our policies even if at this time it does not apply to your situation.

_____**For patients with Insurance**, **Co-payments, co-insurance, unmet deductibles and non-covered services or supplies are due at the time of service**. If your insurance fails to respond to the claim within **60 days,** CFAC reserves the right to collect full payment from the patient.

_____**If you have Medicare and have changed to an HMO Insurance Policy (Medicare replacement plan)** you must provide this information to the front desk. **Co-payments, co-insurance, unmet deductibles and non-covered services or supplies are due at the time of service.** If we do not participate with your HMO plan, you may be responsible for payment in full if there is not an out of network benefit. If you fail to disclose correct insurance information to us, you will be responsible for payment.

_____**For patients without insurance, or on a plan we do not participate with:** Comprehensive Foot and Ankle Center (CFAC) financial policy requires payment in full at time of service. **If you do not have your insurance card with you and we are unable to verify benefits, you will be responsible for paying at the time of service.**

_____If you are unable to pay your balance in full when due, you need to **contact our billing supervisor immediately.** Failure to make payment on your account as required every 30 days will require further action to collect the balance in full and your credit rating will be affected. If regular monthly payments are not received, and no payment arrangements have been made, we will no longer be able to extend credit to you for future visits. **An additional collection fee of 30% will be added to the outstanding balance at the time of transfer to collection agency.**

Medicare/Medicaid Patient's Certification: I certify the information given by me in applying for payment under Title XVIII and XIX of the Social Security Act is correct. I request payment be made directly to **Comprehensive Foot & Ankle Center**. I authorize **Comprehensive Foot & Ankle Center** to release any medical information including complete medical records, test results and billing information to my insurance company, and to other medical professionals and medical care institutions that I may be referred to for treatment. I understand that this information will be used to review, investigate or make payment of a claim and to review records for quality improvement initiatives, audit compliance, utilization management and complaint resolutions.

Assignment of Benefits: I hereby authorize payment directly to **Comprehensive Foot & Ankle Center** for all medical or surgical benefits otherwise payable to me under terms of my insurance.

_____ _____

Patient or Responsible Party's Signature Date

Thank you for complying with these policies so that we can keep your costs as low as possible.

****

We recognize how difficult it is to understand many of the points in today's insurance policies, with new plans and companies emerging constantly. Our office staff will make every attempt to follow the guidelines required by your insurance company. However, please understand the **contract is made between the insurance company and the patient.** Therefore, it is the **patient's responsibility** to know and understand the details of his/her specific coverage.

Thank you for choosing us as your foot care provider.
Discover, MasterCard, Visa, Debit Cards and Checks Accepted
($35 return check fee will be charged)

InStride Comprehensive Foot and Ankle Center, PA

Medical History

Chart # _____
Date: _____

Name: _____

Date of Birth: _____ **Age:** _____ **Sex:** _____ **Height:** _____ **Weight:** _____ **Shoe Size:** _____

Allergies to Medication: ☐ None Known ☐ _____

Referring Physician: _____ **Pharmacy Name & Address:** _____

Reason for today's visit: _____

Have you ever been treated for any of the following? (Please check below)

☐ Diabetes	☐ High Blood Pressure	☐ Kidney/Bladder Disease	☐ Fibromyalgia
☐ Heart Disease	☐ Anemia	☐ Hepatitis/Liver Disease	☐ History of Gout
☐ Nerve Disorders	☐ Stomach Problems	☐ Osteoporosis	☐ History of Ulcers
☐ Stroke/Seizures	☐ Thyroid Disease	☐ Back Pain or Injury	☐ Mental Health Disorders
☐ Cancer/Tumor	☐ Bleeding Disorder	☐ Respiratory Disease	☐ Drug/Alcohol Abuse
☐ Arthritis	☐ Circulation Trouble	☐ Emphysema/Asthma	☐ HIV/AIDS
☐ High Cholesterol	☐ History of Blood Clots	☐ Rheumatoid Arthritis	

Family History: (parents, grandparents, and siblings) **(Please check below)**

☐ Diabetes	☐ Heart Disease	☐ Cancer/Tumors	☐ Liver Disease
☐ Stroke/Seizures	☐ High Blood Pressure	☐ Kidney/Bladder Disease	☐ Arthritis/ Rheumatoid Arthritis
☐ Nerve Disorders	☐ Osteoporosis	☐ Bleeding Disorders	☐ History of Gout

☐ Family history unknown

Medications: (please list only current medications)

_____ _____ _____

_____ _____ _____

_____ _____ _____

Surgical History: (Please list all surgeries**)**

_____ _____ _____

_____ _____ _____

Social History:

Do you smoke ☐ YES ☐ NO If yes, packs/day_____ Former smoker ☐ YES ☐ NO If yes, year quit _____

Do you drink ☐ YES ☐ NO If yes, drinks/day_____ Pregnant ☐ YES ☐ NO Nursing ☐ YES ☐ NO

Review of Systems: Check all that apply to you: (recent/current symptoms only**)**

CON ☐ fever ☐ recent weight loss
HEAD ☐ headache
EYE ☐ worsening vision ☐ seeing double images ☐ blurry vision
ENT ☐ loss of hearing ☐ hoarseness
CV ☐ chest pain or discomfort ☐ palpitations
RS ☐ difficulty breathing ☐ chronic cough
GI ☐ decrease in appetite ☐ difficulty swallowing ☐ heartburn ☐ nausea
☐ Vomiting ☐ abdominal pain w/anti-inflammatory medicine ☐ blood in stool
GU ☐ pain during urination ☐ urinary frequency increased ☐ blood in urine
END ☐ excessive thirst ☐ temperature intolerance
SK ☐ dry skin ☐ skin lesions ☐ skin rash
HEM ☐ easy bleeding ☐ easy bruising
NEU ☐ dizziness ☐ convulsions
PSY ☐ sleep disturbances ☐ drug/alcohol addiction ☐ depression