Foot and Ankle Wellness Center

Patient's name____
(First) (MI) (Last)

SS# __________________ Date of Birth _________________ Age ____________

___ Male ___ Female ___ Single ___ Married ___ Widowed ___ Divorced

Street Address ____

City/State/Zip Code ____

Email ____

Mobile phone # ___________________ Home phone # _____________________

Pharmacy name and phone # ____

Employer ____________________ Occupation ____________________________

Work phone # ____

Emergency contact name ____

Phone # ____________________ Relationship to patient ____________________

PCP's name and phone # ____

Who can we thank for referring you? ____________________________________

I hereby authorize the payment of medical health benefits to Foot and Ankle Wellness Center, LLC for services rendered. I understand I am financially responsible for any services not covered by my insurance carrier. I further agree to pay all costs, attorney fees, and other collection costs that my be incurred to enforce collection of any outstanding amounts. I hereby authorize Foot and Ankle Wellness Center, LLC to release any medical information necessary to complete and process insurance claims. I, the undersigned, request that payments of authorized Medicare benefits be made on my behalf to Foot and Ankle Wellness Center, LLC for any services furnished to me by the physician. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and it's agents any information to determine these benefits payable for related services. I authorize Foot and Ankle Wellness Center, LLC to treat me and use my personal health information for healthcare operations. I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information.

____ _______________________

Patient's Signature (legal guardian, if a minor) Date

Medical History

Reason for today's visit ____

Shoe size _________ Height _____________ Weight _____________

Do you smoke? ______________ Do you drink alcohol? ____________

Past tobacco use? ___________

Females, Are you pregnant? _______________ Nursing? _______________

Have you had past foot or ankle surgery? _________________________

Allergies:

Penicillin __ Iodine __ Aspirin __ Adhesive tape __ Sulfa __ Codine __

Seafood/Shellfish __ Local anesthetics __ Latex __ Other ___________

Current medications ____

____

____

Prior surgeries ____

Illnesses:

Anemia __ Arthritis __ Asthma __ Back Pain __ Bleeding Disorders __

Diabetes __ Gout __ Heart Disease __ Hepatitis __ HBP __

Kidney Problems __ Liver Disease __ Neck Pain __

Numbness in feet __ Poor Circulation __ Stroke __ Cancer __ HIV/Aids __

Blood clots __ Other _____________________

I hereby give my permission to the providers at Foot and Ankle Wellness Center, LLC to perform diagnostic, therapeutic and/or operative procedures as may be deemed necessary in diagnosis and/or treatment of my feet and/or ankles.

____ ______________________

Patient's signature (legal guardian, if a minor) Date

Cancelled/Missed appointment fee: If you cannot keep your appointment time, please call our office at least 24 hours prior to your scheduled appointment time. There may be a $50 fee for any appointment cancelled without 24 hour notice. If you miss 3 or more appointments, you may be required to pay a $50 deposit to hold any future appointment time slots. If you arrive more than 10 min late for an appointment, you may need to be rescheduled. You will bear the complete financial responsibility for any fee(s) incurred. Repeated missed or late appointments may result in dismissal from our practice.

Collections fee: You will be sent up to three notices for your financial responsibility (co-insurance, deductible, etc) after payment and/or EOB is received from your insurance company/companies. After the third and last notice, your account will be forwarded to our collection agency, and a 25% fee will be added to your account. You bear complete responsibility for any fee(s) incurred. In the even that your insurance company sends payment to you, the patient, it should be forwarded to our office to be applied your balance.

Privacy practices/HIPAA: By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices/HIPAA and that I have (or had the opportunity to read it if I so choose) and understand the Notice and agree to it's terms.

May we phone, email, or text you to confirm appointments? ______________________

May we leave a message on your machine or voicemail? _________________________

May we discuss your medical condition with any member of your family? __________

If yes, please name the members allowed ______________________________________

____ ________________________

Patient's signature (legal guardian, if a minor) Date