NoVa Foot and Ankle PLLC
PATIENT INFORMATION

DEMOGRAPHICS:

Today's Date: _____ Date of Birth ____/____/____ Age:_____ Sex: M F
First Name:_____ Middle _____ Last Name:_____
Home Address:_____ City:_____
State:_____ Zip: _____ Home Phone:_____
Cell Phone: _____ Email:_____
Marital Status: _____ Primary language: _____
Ethnicity: (Circle one) _ American Indian _Asian _ Black African American _ Native Hawaiian/Pacific Islander _ White _ Hispanic
Occupation:_____Employer:_____
Work phone: _____

FINANCIALLY RESPONSIBLE PARTY/GUARANTOR: (IF DIFFERENT FROM PATIENT)

First Name:_____ Last Name:_____
Relationship to patient:_____ Date of Birth_____/_____/_____
Home Phone:_____ Cell Phone:_____
Sex: M F Address:_____
City:_____State:_____Zip:_____

INSURANCE INFORMATION: (COPY OF CARD(S) REQUIRED)

Primary Insurance_____
Insured's Name_____
Secondary Insurance_____
Insured's Name_____

Emergency Contact Name : _____ Relationship:_____
Phone: _____

HOW DID YOU HEAR ABOUT US? (PLEASE CIRCLE)

Doctor Name:_____ Family/Friend Name:_____
Hospital/ER:_____ Insurance Plan YELP Google Other: _____

Pharmacy Name:_____Address:_____
City & Zip_____ Phone #: _____

FAMILY PHYSICIAN INFORMATION:

Did your Family Physician or other specialist refer you? Yes No
Did you independently come for an opinion? Yes If No, then who referred?_____
Physician Name :_____
Date last seen by doctor: _____
Address: _____ City/State_____Zip_____
Phone: _____

ALLERGIES (*CIRCLE* ALL THAT APPLY): NONE
Penicillin Sulfa Local Anesthetic Anti-inflammatory Medication Codeine Adhesive Tape Latex Iodine on Skin , IV Contrast Dye Cortisone Other_____

MEDICAL HISTORY (*CIRCLE* ALL THAT APPLY AND LIST): NONE
Anxiety Arthritis Asthma Ankle Swelling Blood Clot Bone /Joint Pain Cancer:_____
Cholesterol Depression Diabetes Heart Problems High Blood Pressure HIV
Kidney Disease Liver Disease Lung Disorders Poor Circulation Stroke Ulcers
OTHER:_____

MEDICATIONS YOU ARE TAKING:

_____

_____

SURGICAL HISTORY: (*CHECK* ALL THAT APPLY AND LIST OTHERS)
Hysterectomy ___ Cardiac(valve, pacemaker, graft, etc)__ Implant surgery (knee, hip, etc)__
Gallbladder removed:__ Vascular surgery lower extremity:__ Appendectomy:__
Tonsillectomy:__ Hernia repair:___ Cosmetic:___ Cancer Surgery:___
Other surgeries including any FOOT/ANKLE surgery:_____

_____
Complications with Anesthesia? (CIRCLE) Yes No

SOCIAL HISTORY: (CIRCLE AND LIST)
Do you drink alcoholic beverages? No Yes Socially Daily # Drinks/week_____
Do you smoke cigarettes? No, never No, I quit Yes currently Packs/Day_____#Years_____
Do you use "recreational" drugs? No,Never No,I quit
IF YES WHICH ONES? _____
FAMILY HISTORY: MOM LIVING DECEASED Medical issues:_____
DAD LIVING DECEASED Medical issues:_____
SIBLINGS LIVING DECEASED Medical issues:_____
REASON FOR VISIT : WHAT IS YOUR FOOT AND ANKLE ISSUE?
Location? (**Please circle**) **RIGHT LEFT FOOT ANKLE**
When did the problem begin? Date:_____
What started the pain:_____
Is the problem work related? Yes No
First visit to a doctor for this problem? Yes / No, who?_____
What is your foot/ankle problem?_____

_____
On a **scale of 0-10** with 10 being worst please rate your pain today: 0 1 2 3 4 5 6 7 8 9 10
Describe any previous treatment or home remedies, hospital/urgent care visists,doctor visits:

_____

_____
List any sports/activities:_____

Height:_____ Weight:_____ Shoe size:_____

OFFICE POLICIES

HMOs: All patients with HMOs are responsible for obtaining referrals from primary care physicians before seeing a specialist. Please ask your primary physician's office to obtain authorization numbers and specify possible treatment (when necessary) in order for NOVA Foot and Ankle to treat you. I hereby **authorize** NOVA Foot and Ankle to apply for benefits on my behalf for coverage of services rendered by them. I request payment to be made directly to NOVA Foot and Ankle and **authorize** the release of any necessary information to my insurance company. NOVA Foot and Ankle is a participating provider for many insurance companies. As a **courtesy** to our patients, this office may file claims with your insurance company. In most cases NOVA Foot and Ankle will accept the usual and customary fee approved by your insurance company. If referral is missing and insurance does not pay, balance will be the patient's responsibility. I understand that all balances are due at the time of the visit and that if **I have a deductible higher than $500, I will be asked to make a payment of $120. I understand that for any in-office procedures require a $250 deposit, for any outpatient surgery require a $500 deposit, custom orthotics require a $250 deposit, and any Durable Medical Equipment require a deposit ranging from $50-$100 (boot, night splint, ankle brace or air arch brace etc). I understand and agree that I am financially responsible for payment of any services rendered that are not paid by my insurance company. Interest will accrue on any unpaid balances after 30 days. I agree to pay a $50 no-show fee if I do not cancel my appointment within 24 hours of appointment time and it will be collected at my next visit.** I agree that any balance must be paid in full within 30 days, or an arrangement made in writing with this office. If I do not make timely payment of any amount owed on my account, NOVA Foot and Ankle may retain the service of any attorney and/or collection agency to assist with collection of any outstanding balance. In the event that my account is referred to any attorney or collection agency I authorize all my records may be released to them for use in collection of charges for services rendered. I agree to pay such cost that may be incurred in the collection of these charges, which are but not limited to collection agency fees of 30%, attorney fees of 30% and court costs. I understand that in order to obtain records copies of my medical records or have them sent, I will need to have a HIPAA release on file, I also understand that there may be a charge for the copy of my records.I understand that the office will not email me any records and that I will have access to my records through portal if I choose to give my email to the office.

Print Patient Name :_____

Signature:_____

Date:_____

Nova Foot and Ankle

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 healthcare 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.

Patient Name: _____

Relationship to Patient: _____

Signature:_____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date: _____ Initials: _____ Reason: _____

Informed Consent for Telehealth Services

Introduction:
Telehealth involves the use of medical information exchanged from one site to another via electronic communications. Providers provide services using an interactive audio and video telecommunication system that permits real-time communication to persons who are at some distance from the provider.
Privacy and Security: I understand that for this encounter, electronic systems used will incorporate security protocols as approved by Federal and State regulations, to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. I understand and acknowledge that security protocols could fail, causing a breach of privacy of personal medical information.
Nature of Telehealth Consultation: I consent the office of NoVA Foot and Ankle who explained to me how the video and conferencing technology will be used for the purposes outlined below:

1. Discuss and monitor examination/procedure/treatment
2. Diagnosis, follow-up and educational purposes
3. Photo recordings may be taken during the encounter
4. Non-medical technical personnel may be present in the telehealth area to aid in video transmission

Medical Records: I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth, and that no information obtained in the use of telehealth, which identifies me, will be disclosed to researchers or other entities without my consent.

Alternatives: I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My Provider has explained the alternatives to my satisfaction.

Risks and Consequences: The telehealth consultation will be similar to a routine medical office visit, except interactive video technology will allow you to communicate with a Provider at a distance. The use of video technology to deliver healthcare and educational services is a new technology and may not be equivalent to direct patient to Provider contact. Following the telehealth consultation, your Provider may recommend that you come in for an office visit or go to a Hospital for further evaluation.

Rights: I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment. I understand that I have the right to inspect all information obtained and recorded in the course of a telehealth interaction, and may receive copies of this information for a reasonable fee. I understand that it is my duty to inform my Provider of electronic interactions regarding my care that I may have with other healthcare providers.

I will have a direct conversation with the doctor, to ask questions concerning telehealth service, if I have any further questions. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand. All blanks or statements that required completion were completed before I signed this form.

I hereby consent to participation in a telehealth consultation.

_____ _____
Print Name of Patient Date

_____ _____
Signature Date