NORTH FLORIDA
FOOT & ANKLE SPECIALISTS

Gainesville: 6420 W Newberry Rd. #210 Gainesville FL, 32605

Lake City: 456 SE Baya Drive Lake City FL, 32025

GENERAL PATIENT INFORMATION

PATIENT NAME: _____

First _____ Middle _____ Last _____

GENDER: Male Female Rather Not Say

DATE OF BIRTH: ____ / ____ / ____

SOCIAL SECURITY #: _____

PRIMARY LANGUAGE: _____

RACE: American Indian Asian African American White Pacific Islander Decline

ETHNICITY: Hispanic/Latino Not Hispanic/Latino Decline

REASON FOR VISIT: _____

CONTACT INFORMATION

EMAIL ADDRESS: _____ MAIN PHONE #: _____

PREFERRED PHARMACY: _____

PRIMARY ADDRESS: _____

Street _____

City _____ State _____ Zip Code _____

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EMERGENCY CONTACT INFORMATION

NAME: _____

First Middle Last

RELATIONSHIP: _____

PHONE #: _____

CURRENT MEDICATIONS AND DOSAGES (OTC, RX, SUPPLIMENTS)

ALLERGIES (LIST ALL FOOD, PHARMACEUTICAL OR ENVIRONMENTAL)

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ADDITIONAL INFORMATION

IS THIS VIIST DUE TO AN INJURY AT WORK OR CAR ACCIDENT? YES NO

NAME OF PRIMARY PHYSICIAN:

HOW DID YOU HEAR ABOUT US?

YES NO

MAY OUR OFFICE LEAVE VOICEMAILS THAT MAY CONTAIN SENSITIVE HEALTH INFORMATION?

PREFERRED METHOD OF COMMUNICATION:

LIST THOSE ALLOWED TO TALK TO THE PRACTICE REGARDING MEDICAL OR BILLING ISSUES

MEDICAL HISTORY (LIST ALL CURRENT OR PAST MEDICAL PROBLEMS)

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SURGICAL HISTORY (LIST ALL PAST SURGICAL PROCEDURES)

FAMILY MEDICAL HISTORY (LIST ALL FAMILY MEDICAL PROBLEMS)

SOCIAL HISTORY

MARITAL STATUS: Married Divorced Single

OCCUPATION:

HOW OFTEN DO YOU CONSUME ALCOHOL? Rarely Occasionally Socially Daily Never

IMMUNIZATIONS: FLU COVID-19 PNEUMONIA MENINGITIS

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PRIMARY INSURANCE INFORMATION

COMPANY:

PLAN NAME:

		Yes	No
INSURANCE ID #	GROUP #	Are you a current student?	

SECONDARY INSURANCE INFORMATION

COMPANY:

PLAN NAME:

		Yes	No
INSURANCE ID #	GROUP #	Are you a current student?	

PRINT NAME PATIENT OR RESPONSIBLE PARTY	SIGNATURE PATIENT OR RESPONSIBLE PARTY	DATE

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PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

PATIENT NAME: _____

First Middle Last

DATE OF BIRTH (MM/DD/YYYY): _____

Notice of Privacy Practice/clinics

_____**(Patient/Representative initials)** I acknowledge that I have received the Notice of Privacy Practice, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practice.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the familY members and others listed below:

Name	Relationship	Contact Number

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

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Communications about My Healthcare

I agree the Provider or an agent of the Provider or an independent physician's office may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the practice/clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

Consent to Email. Cellular Telephone. or Text Usage for Appointment Reminders and Other Healthcare Communications

If at any time I provide an email address or cellphone number at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email or text address I have provided or you or your EBO Servicer have obtained, at any text number forwarded, or transferred from that number. These instructions may include, but not be limited to: post-procedure instructions, follow-up instructions, educational information, and prescription information. Other healthcare communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care.

Note: You may opt out of these communications at any time. The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Note: This location uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated locations that share an electronic health record in which you have a relationship.

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PATIENT NAME:

First Middle Last

DATE OF BIRTH (MM/DD/YYYY):

Release of Information.

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation. If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary. Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

I certify that I have read and fully understand the above statements from all pages and consent fully and voluntarily to its contents.

PRINT NAME
PATIENT OR RESPONSIBLE PARTY

SIGNATURE
PATIENT OR RESPONSIBLE PARTY

DATE

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PATIENT CONSENT FOR FINANCIAL COMMUNICATIONS

Financial Agreement

- I acknowledge, that as a courtesy, NORTH FLORIDA FOOT & ANKLE SPECIALISTS LLC. may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand there is a fee for returned checks.

Third Party Collection. I acknowledge , NORTH FLORIDA FOOT & ANKLE SPECIALISTS LLC. may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

Assignment of Benefits. I hereby assign to , NORTH FLORIDA FOOT & ANKLE SPECIALISTS LLC. any insurance or other third-party benefits available for health care services provided to me. I understand , NORTH FLORIDA FOOT & ANKLE SPECIALISTS LLC. has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to , NORTH FLORIDA FOOT & ANKLE SPECIALISTS LLC., I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to , NORTH FLORIDA FOOT & ANKLE SPECIALISTS LLC.by the Medicare or Medicaid program.

Consent to Telephone Calls for Financial Communications. I agree that, in order for , NORTH FLORIDA FOOT & ANKLE SPECIALISTS LLC. or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that , NORTH FLORIDA FOOT & ANKLE SPECIALISTS LLC. or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or , NORTH FLORIDA FOOT & ANKLE SPECIALISTS LLC. or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

A photocopy of this consent shall be considered as valid as the original.

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PATIENT GENERAL CONSENT TO TREAT

I, the undersigned, hereby consent to the following;

- Administration and performance of general treatments
- Use of prescribed medications
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory test that may be considered medically necessary or advisable based on the judgment of my physician or their assigned designees.

I fully understand that this consent is given in advance of any specific diagnosis or treatment.

I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing (see revocation section below.)

I understand that NORTH FLORIDA FOOT & ANKLE SPECIALISTS LLC. may include consent at other satellite offices under common ownership.

A photocopy of this consent shall be considered as valid as the original.

I certify that I have read and fully understand the above statement and consent fully and voluntarily to its contents.

PRINT NAME PATIENT OR RESPONSIBLE PARTY	SIGNATURE PATIENT OR RESPONSIBLE PARTY CONSENT	DATE

OR

I hereby revoke my general consent to treat at North Florida Foot & Ankle Specialists

PRINT NAME PATIENT OR RESPONSIBLE PARTY	SIGNATURE PATIENT OR RESPONSIBLE PARTY REVOCATION	DATE

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LATE PATIENT, NO SHOW & CANCELATION POLICY ATTESTATION

We understand that there may be times when an appointment just does not work due to emergencies, obligations or unforeseen circumstances for work or family. Unfortunately this can have a large negative effect on our clinic schedule and take away from the time our specialists have to spend with each patient. In an effort to be as transparent as we can be if you are more than 1 hour late to your appointment, do not come to your appointment or we are not made aware of an appointment cancelation at least 24 hours in advance you will be charged a twenty-five dollar ($25) fee, which is not covered by insurance. Our clinic will also provide a one-time fee waiver if the appointment is rescheduled within a weeks time. Appointments missed by more than 15 minutes without advanced notice also are subject to rescheduling depending on availability.

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IF NOT DONE SO ALREADY PLEASE RETURN THIS PAPERWORK TO THE FRONT DESK WITH YOUR DRIVERS LICENSE AND INSURANCE CARD FOR OUR OFFICE TO COPY AND PLACE IN YOUR FILE