GATEWAY FOOT&ANKLE CENTER

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Welcome to Gateway Foot & Ankle Center

Thank you for choosing us for all of your foot and ankle needs. We are dedicated to providing you with quality care in a very friendly, professional atmosphere. Please read carefully and sign at the bottom indicating your understanding and acceptance of our policies and procedures.

General, Financial and Insurance Polices

General Practice Policies

- Please give us at least 24 hours advanced notice if you need to cancel or reschedule your appointment. **All appointments that are canceled or rescheduled **without** 24 hour notice are subject to a $50.00 fee.*
- If your insurance requires a referral, it is your responsibility to keep track of the number of visits and request additional visits from your primary care physician if needed.

Financial Policy

- **Patients are responsible for all co-payments, un-met deductibles and any outstanding balance due on their accounts at the time of service**. There is a $25.00 charge for all returned checks.
- Payment for any non-covered podiatry supplies or procedures will be collected at the time of service.
- **Surgery:** A **$250.00 fee** will be assessed in the event you no-show or do not cancel/reschedule your surgery with at least 48 hours notice.
- **Forms:** There is a basic fee of $20.00 for each form we complete for you. Lengthy forms, letters, or paperwork may be subject to a higher fee.

Insurance

- **We file your insurance as a courtesy to you.** If we are not a provider with your insurance you will be responsible for the total cost of the office visit and any procedures performed at the time of service.
- **You are responsible for keeping up with your benefits that your insurance provides. In the event that your insurance denies your claim for any reason, you will be responsible for all services rendered.**

Thank you again for choosing our office.

Please Sign and date below indicating that you understand and accept our policy.

_____ _____

Print Patient Name Date

_____

Signature

David E. Smith, DPM
Matthew D. Truscello, DPM
Zachary A. Rohr, DPM

Adult Registration Form

How did you hear about us?

Last Name:	First Name:	Middle Initial:
Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	
Employer:	Work Phone:	

Preferred contact method? Cell Home Work Mail Email (Please Print Clearly): _____
Other:_____

Date of Birth:	Social Security #	Gender: Male Female

Marital Status (circle one): Single Married Widowed Divorced Separated

Race:	Ethnic Group:	Preferred Language:
Emergency Contact:		
Emergency Contact Phone #:		Relationship:
Referring Physician:		Phone:
Address:		Fax:
Pharmacy:		Phone:

Are you here for a workman's comp. problem? YES NO

As a result of an auto accident? YES NO

Are you involved in any legal action with regards to your health problem? YES NO

Primary Insurance:	ID #	
Secondary Insurance:	ID #	
Policy holder: (If other than patient)	SS #	Date of birth:

Please read all the information below and then sign and date this form.

I consent to treatment and request that payment of authorized Medicare/Commercial Insurance benefits be made to your provider at Gateway Foot & Ankle Center for any services furnished by that physician and his employees. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent or to my insurance company any information needed to determine these benefits payable for their related services.

I acknowledge full financial responsibility for all services rendered by your provider and the employees at Gateway Foot and Ankle Center and understand that payment of charges incurred is due at the time of service unless other financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of charges that I incur.

Signature:	Date:

GATEWAY FOOT&ANKLE CENTER

Please complete in BLACK or BLUE Ink ONLY.

WHAT IS THE REASON YOU ARE BEING SEEN AT GATEWAY FOOT & ANKLE CENTER TODAY?

_____

_____

_____

_____

PRIMARY PHYSICIAN'S NAME AND ADDRESS:

Name: _____
Address: _____
_____
Phone: _____
Fax: _____

OTHER PHYSICIAN'S NAME AND ADDRESS:

Name: _____
Address: _____
_____
Phone: _____
Fax: _____

Height: _____feet_____inches__ **Weight: _____lbs.___**

SYSTEMS REVIEW: (CHECK ALL THAT YOU HAVE HAD IN THE PAST 6 WEEKS) **CHECK BOX IF NONE OF THE BELOW APPLY** ☐

General:	☐Chills	☐Fatigue	☐Fever	☐Weight Change(loss or gain)	
Eyes:	☐Blurred Vision	☐Eye Pain	☐Sensitive to light		
Ears/Nose/Throat:	☐Ear pain	☐Congestion	☐Hoarseness	☐Dental problems	
	☐Runny nose	☐Nosebleeds	☐Hearing Problems		
Cardiovascular:	☐Edema	☐Chest pain	☐Palpitations	☐Rapid heartbeat	☐Short of breath lying down
Respiratory:	☐Cough	☐Shortness of breath	☐Coughing up blood		
Gastrointestinal:	☐Heartburn	☐Abdominal pain	☐Diarrhea	☐Constipation	☐Stool Changes
Hematologic/Lymphatic:	☐Easy bruising	☐Bleeding	☐Enlarged lymph nodes		
Genitourinary:	☐Blood in urine	☐Painful urination	☐Frequent urination		
Musculoskeletal:	☐Joint pain	☐Back pain	☐Muscle pain		
Integumentary (Skin):	☐Dry skin	☐Rashes	☐Fungal nail infection	☐Warts	
Neurological:	☐Dizziness	☐Headaches	☐Weakness	☐Numbness	
Endocrine:	☐Hair loss	☐Excessive thirst	☐Excessive hunger	☐Heat/Cold Intolerance	
Psychiatric:	☐Anxiety	☐Depression	☐Sleep disturbance		

SOCIAL HISTORY:

With whom do you live with? _____
Highest Level Education Completed: _____
Employment/Occupation: _____

Tobacco: ☐YES ☐NO How long? _____ How many packs per day? _____
If NO did you ever smoke? ☐YES ☐NO If so, how long? _____ Quit Date: _____
Alcohol: ☐YES ☐NO If so, how much? _____

FAMILY HISTORY (PLEASE LIST ALL FAMILY REQUESTED, IF APPLICABLE, NAMES NOT REQUIRED): ☐**UNKNOWN, ADOPTED**

	AGE:	MAJOR ILLNESS(S):	IF DECEASED, CAUSE OF DEATH:
Father:			
Mother:			
Brother(s):			
Sister(s):			

	AGE:	SEX:	MAJOR ILLNESS(S):	IF DECEASED, CAUSE OF DEATH:
Children:				

Patient Name: _____ DOB: _____

Please complete in BLACK or BLUE Ink ONLY.

PAST MEDICAL HISTORY: (CHECK ALL THAT APPLY) **CHECK HERE IF NONE APPLY** ☐

Gastrointestinal:		**Pulmonary:**	
☐ Irritable Bowel Syndrome	☐ GERD	☐ Pulmonary Embolism	☐ Asthma
☐ Pancreatitis	☐ Peptic Ulcer Disease	☐ COPD	☐ Sleep Apnea
☐ Hepatitis	☐ See: Other Information	☐ Pneumonia	☐ See: Other Information
☐ Crohn's Disease			
Cardiovascular:		**Renal/Genitourinary:**	
☐ Congestive heart failure	☐ Arrhythmia	☐ Renal Failure/Disease	☐ Renal Stones
☐ Heart Attack (MI)	☐ Hyperlipidemia	☐ Urinary Incontinence	☐ Ovarian Disease
☐ Deep Venous Thrombosis (DVT)	☐ Peripheral Vascular Disease	☐ Bladder disease	☐ Kidney Disease
☐ Hypertension	☐ Mitral Valve Disease	☐ BPH (Benign Prostatic Hypertrophy)	☐ See: Other Information
☐ Coronary Artery Disease	☐ See: Other Information		
Musculoskeletal:		**Endocrine:**	
☐ Fibromyalgia	☐ Osteoarthritis	☐ Diabetes type II	
☐ Chronic pain	☐ Rheumatoid Arthritis	☐ Hyperthyroidism	
☐ Gout	☐ Fractures	☐ Hypothyroidism	
☐ Lupus	☐ See: Other Information	☐ See: Other Information	
Immunology/Dermatology:		**Hematologic:**	
☐ Allergies	☐ Psoriasis	☐ Anemia	☐ See: Other Information
☐ Eczema	☐ Sinusitis (frequent)	☐ HIV (AIDS)	
☐ Immunodeficiency	☐ See: Other Information	☐ Blood clots	
Neurological/Genetic:		**Cancers:**	
☐ Alzheimer's disease	☐ Parkinson's disease	☐ Bone Cancer	☐ Pancreatic Cancer
☐ CVA	☐ Down Syndrome	☐ Lymphoma	☐ Renal Carcinoma
☐ Dementia	☐ Multiple Sclerosis	☐ Prostate Cancer	☐ Testicular Cancer
☐ Headaches	☐ See: Other Information	☐ Lung Cancer	☐ Thyroid Cancer
☐ Seizure Disorder		☐ Skin Cancer: Type_____	☐ See: Other Information
		☐ Location_____	
Other/Misc.:			
☐ Cataract	☐ Drug Abuse		
☐ Glaucoma	☐ Alcoholism		
☐ See: Other Information			

***OTHER INFORMATION:** _____

_____

_____

SURGICAL HISTORY: (CHECK and CIRCLE ALL THAT APPLY) **CHECK HERE IF NO SURGICAL HISTORY** ☐

☐ Appendectomy	☐ Cardiac Valve Replacement	☐ Arthroscopy: Location_____
☐ Tonsillectomy	☐ Hysterectomy (partial/total)	☐ Biopsy: Type _____
☐ Adenoidectomy	☐ Cataract Removal (right/left)	☐ Joint Replacement: Location_____
☐ Hernia repair	☐ Cholecystectomy (gall bladder removed)	☐ Fracture: Location_____
☐ Thyroidectomy	☐ Coronary Angioplasty	☐ Leg Bypass Surgery: Location_____
☐ Prostatectomy	☐ Pacemaker Implantation	☐ Leg Stent Placement: Location_____
☐ Coronary Artery Stent	☐ CABG (Coronary Artery Bypass Graft)	☐ See: Other Information

***OTHER INFORMATION:** _____

_____

_____

ANYTHING WE DID NOT ASK THAT YOU THINK WE SHOULD KNOW ABOUT. _____

_____

Patient Name:_____ DOB: _____

Please complete in BLACK or BLUE Ink ONLY.

GATEWAY FOOT&ANKLE CENTER

Name: _____ Date: ___/___/___

Date of birth: _____

MEDICATION AND ALLERGY LIST

Please list all medications you are currently taking, including vitamins, herbs, and natural supplements or Check None box below and sign at the bottom.

☐ NO MEDICATIONS

NAME	DOSAGE	HOW OFTEN

Please list all allergies or check box if no known drug allergies. ☐

Patient Signature: _____ Date: _____/_____/_____

GATEWAY FOOT&ANKLE CENTER

Do I Need a Test for PAD?

(Please complete questionnaire below.)

Peripheral Arterial Disease (PAD) is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain, or kidneys, become narrowed or clogged. It affects over 8 million Americans, most over the age of 50. It may result in leg discomfort with walking, poor healing of leg sores/ulcers, difficult to control blood pressure, or symptoms of stroke. People with PAD are at significantly increased risk for stroke and heart attack. Answers to these questions will determine if you are at risk for PAD and if a vascular exam will help us better assess your vascular health status.

Name: _____ **Date of Birth: ____/____/____**

Circle "Yes" or "No":

				Test for PAD
1.	Do you have foot, calf, buttock, hip or thigh discomfort (aching, fatigue, tingling, cramping, or pain) when you walk which is relieved by rest?	Yes	No	☐
2.	Do you experience any pain at rest in your lower leg(s) or feet?	Yes	No	☐
3.	Do you experience foot or toe pain that often disturbs your sleep?	Yes	No	☐
4.	Are your toes or feet pale, discolored, or bluish?	Yes	No	☐
5.	Do you have skin wounds or ulcers on your feet or toes that are slow to heal (8-12 weeks)?	Yes	No	☐
6.	Has your doctor ever told you that you have diminished or absent pedal (foot) pulses?	Yes	No	☐
7.	Have you suffered a severe injury to the leg(s) or feet?	Yes	No	☐
8.	Do you have an infection of the leg(s) or feet that may be gangrenous (black skin tissue)?	Yes	No	☐

Patient Signature: _____

Physician Signature: _____ **Date: ____/____/___**

HIPAA Regulations Privacy Documents

(Patient signature required at the bottom.)

I, _____, hereby authorize Gateway Foot & Ankle Center to use and/or disclose my health information which specifically identifies me or which can be used to identify me to carry out my treatment, payment, and healthcare operations. I understand that while this consent is voluntary, if I refuse to sign this consent Gateway Foot & Ankle Center can refuse to treat me. I also grant permission to obtain a check of my medication history from all pharmacies and providers for medical reconciliation purposes.

I have notified that the Notice of Privacy Practices is available on request and also located in the waiting room of Gateway Foot & Ankle Center which contains a more complete description of the uses and disclosures of my protected information. I understand that this practice has the right to change the Notice of Privacy Practices periodically and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy.

I understand that I may request in writing that Gateway Foot & Ankle Center, restrict how my protected information is used and disclosed to carry out treatment, payment or health operations. I also understand that my provider is not required to agree with my request, but if this practice does not agree then I am bound to abide by written restriction.

I, _____, hereby give written consent to Gateway Foot & Ankle Center to disclose my protected health information including treatment, payment, and health care operations with the following person(s):

_____

Last Name **First Name** **Relationship to Patient**

_____

Address **City** **State** **Zip**

_____

Last Name **First Name** **Relationship to Patient**

_____

Address **City** **State** **Zip**

X_____

Signature of patient or patient's representative ***Date***

_____

Printed name of patient or patient's representative

_____

Relationship to patient

THIS FORM IS FOR YOU TO LIST FAMILY MEMBERS OR TRUSTED FRIENDS WHO YOU GIVE CONSENT TO TALK WITH YOUR PROVIDER OR TO PICK UP YOUR MEDICAL RECORDS IF YOU ARE UNABLE TO. IF YOU DO NOT LIST ANYONE, THEY CANNOT TALK WITH YOUR YOU DOCTOR

****PATIENT SIGNATURE REQUIRED**

GATEWAY FOOT&ANKLE CENTER

Patient Portal User Agreement

Patient Portal is a secure web portal that allows you, as a patient, to access certain electronic medical records. It can also be used to communicate with clinic staff directly via a secure messaging system. When using Patient Portal you have the opportunity to:

*View and print medication lists, allergies, lab/diagnostic results, and any pertinent medical history
*Request corrections to be made to demographic information
*Get answers to *non-emergency* questions
*Request/confirm/reschedule/cancel appointments online (although we are offering this service at this time, the best way to get the appointment you want, when you need it, is to give our office a call.)
*Request refills on medications

Please read the following policy carefully:

*We do not sell or give away any private information including email addresses, without your written consent, please read our HIPPA policy form for more information about private health information.
*We are offering Patient Portal as a courtesy to our established patients, however, if abuse or negligent usage of the portal persists, we reserve the right at our own discretion to suspend or terminate user access or modify services offered through Patient Portal as well as the right to discontinue its use.
*Since Patient Portal communicates with our staff through our electronic medical records, *it is only monitored during normal business hours.* It is unlikely we will "see" any messages sent after hours or on weekends. We will make every attempt to return portal messages within 1-3 business days starting on the date after the message was sent. Please do NOT use the portal for emergencies or urgent matters. You must call our office at (931) 245-1920 if you have an urgent matter to discuss.
*If you are not receiving emails from us, please check your JUNK or SPAM folder before contacting our office.
*By using the Patient Portal, you agree to protect your password from unauthorized individuals. It is your responsibility to notify us in the event that your password is stolen. You agree to not hold Gateway Foot and Ankle Center responsible for any network infractions beyond our control.

Please remember that Patient Portal is a relatively new feature of electronic records, and as such, runs the risk of having some imperfections. Feel free to browse your Patient Portal and get acquainted with the features it has to offer. We, at Gateway Foot and Ankle Center, welcome the opportunity to offer you personalized care.

Name: _____

☐ Yes, I would like to use the Patient Portal
☐ No, I decline use of the Patient Portal or do not have an email address at this time

Signature: _____ **Date:** _____

Email Address (required for use): _____

By signing this consent, you are activating your Patient Portal. A message will be sent to the email address provided with instructions on how to create your log in information. For further instructions see the “Portal Instructions for the Patient,” information sheet. Your Patient Portal User for 12 months. At the end of 12 months an email will be sent to you to re-register your account. If the log in is not re-registered it will be considered inactive.