Las Vegas Foot and Ankle Center

2649 W. Horizon Ridge Pkwy Suite 100
Henderson, NY 89052
Phone (702) 565-6641

825 N. Gibson Road Suite 430
Henderson, NV 89011
Fax (702) 565-9249

PLEASE FILL OUT ALL SECTIONS COMPLETELY

Patient Information

First Name: _____ Last: _____ MI: _____

Email Address: _____

Patient's Street Address: _____

City: _____ State: _____ Zip: _____

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

Please check primary number where you can be reached at for medical reason: ☐ Home Phone ☐ Cell Phone ☐ Business Phone

Date of Birth: _____ Social Security #: _____ Marital Status: _____ Gender: ☐ M ☐ F

Employer: _____ Employer Phone: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Primary Insurance Information

Responsible Party First Name: _____ Last: _____ MI: _____

Social Security #: _____ Date of Birth: _____ Employer: _____

Insurance Company: _____

Policy Number: _____ Group Number: _____

Insured relationship to patient: _____ Insurance Co-payments $ _____

Secondary Insurance Information

Responsible Party First Name: _____ Last: _____ MI: _____

Social Security #: _____ Date of Birth: _____ Employer: _____

Insurance Company: _____

Policy Number: _____ Group Number: _____

Insured relationship to patient: _____ Insurance Co-payments $ _____

Guarantor Information – If same as patient, do not complete.

First Name: _____ Last: _____ MI: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Date of Birth: _____

Social Security #: _____ Employer: _____ Relationship to Patient: _____

Was this an accident? ☐ Yes ☐ No Is this a workers compensation claim? ☐ Yes ☐ No

Name of an Emergency Contact person not living with you: _____

Phone: _____ Relationship to patient: _____

LAS VEGAS FOOT & ANKLE CENTER

LasVegasFootandAnkle.com

FINANCIAL RESPONSIBILITY POLICY

I further understand that balances not paid within 90 days form the date they are deemed your responsibly will be referred to an outside collection agency, and I will be responsible for any attorney's fees, collection expenses and interest. I also understand that this account may be listed with local and national credit bureaus.

Insurance may pay all or part of your financial obligation to Las Vegas Foot and Ankle Center. However, you are responsible to see that all accounts are completely paid within 90 days. It is very important for you to understand that it is impossible for our office to know what your particular insurance plan will cover, what it will allow, or what it will pay for services we render to you. Many times, we will not know this information until after we receive the Explanation of Benefits (EOB) from your insurance company. Therefore, by becoming a patient of Las Vegas Foot & Ankle Center YOU assume complete and total responsibility for all charges.

I understand and accept financial responsibility for payment of all accounts with Las Vegas Foot & Ankle Center.

Signature of Patient or responsible party _____

Patient's name (Printed) _____ **Date:** _____

IF PATIENT IS UNDER 18 YEARS OF AGE: I hereby authorize treatment for the minor whose name appears above as "patient".

Signature of patient or responsible party _____

Relationship: _____ **Date:** _____

PLEASE GIVE INSURANCE CARDS AND A PHOTO I.D. TO RECEPTIONIST

WHEN YOU COMPLETE THIS FORM.

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MEDICAL HISTORY FORM - (This form is CONFIDENTIAL)

PLEASE FILL OUT ALL SECTIONS COMPLETELY

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Occupation: _____

Current Height: _____ Weight: _____ Shoe Size: _____

Preferred Language: _____ Ethnicity & Race: _____

Name of Primary Care Physician/Referring Physician: _____ Phone #: _____

Last Visit with Physician: _____ Has he/she requested you be seen in our office? ☐ Yes ☐ No

What is your FOOT or ANKLE problem? PLEASE BE SPECIFIC. Where does it hurt? How long has it been bothering you? Is the pain sharp, dull, deep or superficial, stabbing or burning? Does it ache or tingle? Is there any numbness? Have you had any previous treatment(s)?

_____

_____

LIST CURRENT MEDICATIONS - List dosage and why you are taking each medication. Attach a separate list if necessary.

Pharmacy Name _____ Phone #: _____

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

ALLERGIES: ☐ Penicillin ☐ Sulfa ☐ Codeine ☐ Other _____

LIST PREVIOUS SURGERIES OR HOSPITALIZATIONS

_____

_____

_____

PATIENTS HISTORY - Do you have any of the following?

☐ Heart Disease ☐ Diabetes ☐ Kidney Disease ☐ Liver Disease ☐ Lung Disease ☐ High Blood Pressure

☐ Thyroid Disease ☐ Cancer Type ☐ Other medical problems _____

WHO IN YOUR FAMILY HAS?

Heart Disease? _____ High Blood Pressure? _____ Cancer? _____

Stroke? _____ Other Family Related Medical Problems _____

HAVE YOU EVER SMOKED? ☐ Yes ☐ No When did you quit? _____

DO YOU SMOKE NOW? ☐ Yes ☐ No How many packs a day? _____ For how many years? _____

DO YOU DRINK ALCOHOL? ☐ Yes ☐ No How much a day? _____ A week? _____

MARK ALL THAT APPLY

CONSTITUTION

☐ Good general health ☐ Recent weight change ☐ Fever ☐ Fatigue

EYES

☐ Eye disease or injury ☐ Blurred vision ☐ Double vision ☐ Glaucoma ☐ Wear glasses/contacts

EARS, NOSE, MOUTH AND THROAT

☐ Hearing loss ☐ Tinnitus ☐ Earaches ☐ Sinus problems ☐ Nose bleeds ☐ Mouth sores
☐ Bleeding gums ☐ Sore throat ☐ Voice changes ☐ Swollen neck glands

CARDIOVASCULAR

☐ High blood pressure ☐ Heart disease ☐ Heart attack ☐ Chest pain ☐ Angina ☐ Palpitations

RESPIRATORY

☐ Coughs ☐ Lung disease ☐ Spitting up blood ☐ Shortness of breath ☐ Asthma

GASTROINTESTINAL

☐ Loss of appetite or change in bowel movements ☐ Nausea ☐ Vomiting ☐ Diarrhea
☐ History of rectal bleeding ☐ Abdominal pain ☐ Heartburn ☐ History of stomach ulcer

MUSCULOSKELETAL

☐ Joint Pain ☐ Stiffness ☐ Muscle weakness ☐ Muscle cramps ☐ Back pain ☐ Difficulty with walking

INTEGUMENT/SKIN

☐ Rash ☐ Itching ☐ Change in skin color ☐ Change in nails

NEUROLOGICAL

☐ Frequent/recurring headaches ☐ Light headedness ☐ Dizziness ☐ Convulsions ☐ Seizures
☐ Numbness ☐ Tingling sensations ☐ Tremors ☐ Paralysis

PSYCHIATRIC

☐ Memory Loss ☐ Nervousness ☐ Depression ☐ Insomnia

ENDOCRINE

☐ Glandular problems ☐ Hormone problems ☐ Thyroid disease ☐ Diabetes ☐ Heat intolerance
☐ Cold intolerance

HEMATOLOGIC/LYMPHATIC

☐ Slow to heal after cuts ☐ Bleeding tendencies ☐ Anemia ☐ Phlebitis ☐ Past transfusions
☐ Enlarged glands

IMMUNOLOGICAL

☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C ☐ HIV ☐ Tuberculosis

Notice of Privacy Practices for Health Information Acknowledgement Form

The law require that Las Vegas Foot & Ankle Center must provided to the patient a copy of our Notice of Privacy Practices for Health Information. By Signing below, the patient acknowledges receipt of such, or if you are the patient's legal representative or authorized agent, you acknowledge receipt of such.

I hereby give permission for Las Vegas Foot & Ankle Center to examine and render medical and / or surgical treatment. I also agree to follow ALL prescribed treatment. I authorize photographs to be taken for medical education purposes. I also authorize the release of any information required during examination or treatment. Las Vegas Foot & Ankle Center agrees to provide podiatric medical services for the patient whose name appears below.

Signature of patient or responsible party _____

Patient's name (Printed) _____ **Date:** _____

Please indicate who we are allowed to release any information to other than yourself

_____

_____

_____

I have attempted to provide the patient a copy of our NPP, but was unable to do so for the following reasons:

_____

_____

_____

Signature of Doctor's representative: _____ **Date:** _____

Print Name: _____

OFFICE POLICY FOR LAS VEGAS FOOT and ANKLE CENTER

Thank you for choosing Las Vegas Foot & Ankle Center. In Order to expedite your visit and to ensure that we are accessible to all of our patients, we have put together some guidelines for you.

Cancellation Policy: **We require *24 hour notice* for all cancelled appointments, Naturally there will be unexpected circumstances where this would be overlooked such as a family emergency, but we would like to keep our schedules efficient.**

Disability Forms: **We are happy to complete any paperwork for our patient's; however, there is a fee for this and we should receive this up front. We would like at least *2 Weeks* to complete them.**

Fees are incurred for the following services:

Missed appointments	$35.00
Copy of X-Rays (Digital)	$25.00
Disability Forms/Short Term Disability	$30.00
Copy of Medical Records Per Page	$ .60

IMPORTANT NOTICE:

None of these fees are billable to your insurance company. They are not considered covered services by any insurance company.

Please Initial _____

LAS VEGAS FOOT & ANKLE CENTER NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION.

PLEASE REVIEW CAREFULLY.

LAS VEGAS FOOT & ANKLE CENTERS LEGAL DUTY

LAS VEGAS FOOT & ANKLE CENTER is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

LAS VEGAS FOOT & ANKLE CENTER uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care we provide. For example; LAS VEGAS FOOT & ANKLE CENTER may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives, or other health related benefits that could be of interest to you.

LAS VEGAS FOOT & ANKLE CENTER may use or disclose your personal health information without prior authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time..

For any other situation, LAS VEAGS FOOT & ANKLE CENTER'S policy is to obtain your written authorization before disclosing your personal health information. If you provide us with written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

LAS VEGAS FOOT & ANKLE CENTER may change its policy at any time. When changes are made; a new Notice of Privacy of Practices will be posted in the waiting room and patient exam areas; and will be posted; and will be provided on your next visit. You may also request an updated copy of our Notice of Privacy of Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other then treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law or in an emergency circumstance. LAS VEGAS FOOT & ANKLE CENTER will consider all such requests on a case by case basis but is not legally required to accept them.