Patient Name: _____ **Date of Birth:** _____ **Sex:** ____M____F

Address: _____

Street Apt. No City State Zip

Home#: _____ **Work#**: _____ **Cell #:** _____

Email: _____ **Social Security No.** _____

Emergency Contact: _____Relation: _____ **Phone:** _____

Primary Language: _____ **Current Occupation:** _____

Ethnicity: _____ Marital Status (circle): Married Single Divorced Widowed Partner

PRIMARY CARE PHYSICIAN **Must be a doctor of Family Medicine, Primary Care, Internal Medicine, Endocrinology

Primary Physician Name: _____

Primary Physician Phone: _____ Date Last Seen: _____

***PLEASE NOTE: Medicare and Medicaid insurances require that a Primary Care Physician be listed for certain services to be paid. ***

ARE YOU IN HOSPICE CARE? ☐Yes ☐No If yes, facility: _____

ARE YOU IN SKILLED NURSING? ☐Yes ☐No If yes, facility: _____

TRANSPORTATION NAME & PHONE NUMBER: _____

INSURANCE INFORMATION

PRIMARY INSURANCE NAME: _____ Employer: _____

Policy Holders Name: _____ Social Security #: _____

Relationship to Patient: _____ Policy Holders Date of Birth: _____

SECONDARY INSURANCE NAME: _____ Employer: _____

Policy Holders Name: _____ Social Security #: _____

Relationship to Patient: _____ Policy Holders Date of Birth: _____

EXPLANATION OF PAYMENT POLICY & PRIVACY POLICY

I hereby authorize StrideCare to release medical information pertinent to the filing of insurance claims for me and file complaints regarding insurance on my behalf in pursuit of payment. I authorize my insurance carrier to pay benefits directly to StrideCare for any services filed on my behalf. I understand that I AM RESPONSIBLE for payment to StrideCare for charges for the above patient regardless of my insurance coverage. I also understand that StrideCare is not ultimately responsible for collecting my insurance or negotiating settlements of claims. I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read and understand the Notice and had opportunity to restrict access to my records. I also hereby give StrideCare permission to diagnose and administer treatment for my foot and/or ankle condition and authorize any release of information from my other physicians as required during the course of my treatment.

Patient's Signature: _____ Date: _____

StrideCare

Patient Name: _____ **Shoe Size:** _____ **Height**: _____ **Weight**: _____

Reason for your visit: _____ **Pain Level (1-10):** _____

Date symptoms started: _____ Injury description, if applicable: _____

What have you already tried to resolve it? _____

What makes the pain worse? _____

Preferred Pharmacy: _____ **Pharmacy Phone:** _____

Pharmacy Location and/or Address: _____

Are you currently experiencing any of these symptoms? ☐ Nausea ☐ Vomiting ☐ Fever ☐ Chills ☐ Night Sweats

If **diabetic**, which doctor handles your diabetes? _____ Phone #: _____

Last A1C? _____ Date Performed: _____ Doctor / Lab where done: _____

Do you have difficulty climbing stairs? ☐ Yes ☐ No Do you normally use: ☐ Walker ☐ Cane ☐ Wheelchair ☐ None

Caffeine Consumption ☐ Never ☐ Occasional ☐ Moderate ☐ Heavy

Alcohol Consumption ☐ Never ☐ Occasional ☐ Moderate ☐ Heavy

Smoking Status ☐ Never

☐ Current Tobacco User Packs per day _____ Years using _____

☐ Former Tobacco User Packs per day _____ Years using _____ Year quit _____

Type of Tobacco Use ☐ Cigarettes/ cigars ☐ E-cigarettes/ Vaping ☐ Chewing Tobacco/Snuff

Recreational Drugs used:

_____

_____

ALLERGIES

☐ NO KNOWN DRUG ALLERGIES ☐ Adhesive/Tape ☐ Anesthetics ☐ Aspirin ☐ Codeine ☐ Food Allergies

☐ Iodine ☐ Penicillin ☐ Latex ☐ Sulfa ☐ Other: _____

MEDICATION LIST (continue on back if needed; if you provided a list to be photocopied, write "see list")

Medication Name	Dosage (mg or mcg for example)	How often taken

Patient Name: _____

MEDICAL HISTORY

- ☐ Autoimmune Disease
- ☐ ADD/ADHD
- ☐ Amputation
- ☐ Accidents/Injuries
- ☐ Alzheimer's Disease
- ☐ Anemia
- ☐ Aneurysm
- ☐ Anxiety
- ☐ Artificial Joint _____
- ☐ Asthma
- ☐ Athlete's Foot
- ☐ Atrial Fibrillation
- ☐ Autism/Asperger's
- ☐ Bell's Palsy
- ☐ Bipolar
- ☐ Bleeding Disorder/ Hemophilia
- ☐ Blood Clots/ Phlebitis
- ☐ Blood Transfusion
- ☐ Brain Injury
- ☐ Chronic Heart Failure (CHF)
- ☐ COPD
- ☐ Cancer, Type: _____
- ☐ Cerebral Palsy
- ☐ Chicken Pox
- ☐ Coronary Artery Disease
- ☐ Crohn's Disease
- ☐ Deep Vein Thrombosis
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes Type: _____
- ☐ Dialysis
- ☐ Diverticulitis
- ☐ Ear/Nose/Throat Issues
- ☐ Eczema
- ☐ Ehlers-Danlos Syndrome
- ☐ Endocrine Disorder
- ☐ Epilepsy
- ☐ Fibroid Tumors
- ☐ Fibromyalgia
- ☐ Foot Deformities
- ☐ GERD
- ☐ Glaucoma
- ☐ Gout
- ☐ HIV/AIDS
- ☐ Hearing Issues
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ History Of Falls
- ☐ Intellectual Disability
- ☐ Kidney Disease
- ☐ Leg/Foot Ulcers
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Lupus
- ☐ Lyme Disease
- ☐ Lymphedema
- ☐ Macular Degeneration
- ☐ Multiple Sclerosis
- ☐ Nail Fungus
- ☐ Neuropathy
- ☐ Organ Transplant: _____
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinsons
- ☐ Pelvic Pain
- ☐ Peripheral Arterial Disease (PAD)
- ☐ Peripheral Vascular Disease (PVD)
- ☐ Polio
- ☐ Pregnant currently
- ☐ Psoriasis
- ☐ Raynaud's Disease
- ☐ Restless Leg Syndrome
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Shingles
- ☐ Spinal Cord Injury
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Under Pain Management Care
- ☐ Varicose Veins
- ☐ Vein Issues
- ☐ Venous Insufficiency

Family History: Please check any medical conditions that run in your family.

Diabetes:	☐ Mother	☐ Father	☐ Other family: _____
Gout:	☐ Mother	☐ Father	☐ Other family: _____
Heart Disease:	☐ Mother	☐ Father	☐ Other family: _____
High Blood Pressure:	☐ Mother	☐ Father	☐ Other family: _____

Fall Risk Assessment (age 65 and older please complete below)

Do you feel unsteady when standing or walking?
☐ No ☐ Yes

Do you worry about falling?
☐ No ☐ Yes

Have you fallen in the past year?
☐ No ☐ Yes

If you answered "Yes" to questions 3, please complete the following
How many times did you fall? # of falls: _____
Were you injured?
☐ No ☐ Yes

Surgeries: List all surgeries you have had. Begin with the most recent. Please include the year.

_____

_____

_____

_____

_____

Your understanding of our financial policies is an essential element of your care and treatment.
If you have any questions, please ask to discuss them with our supervisor.

**** PLEASE INITIAL that you have read each of the policies below regarding patient financial responsibility ****

_____ As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.

_____ Unless other arrangements have been made in advance by you or your health insurance carrier, payment for office services are due at the time of service. StrideCare accepts major credit cards, cash or check; some locations accept Care Credit.

_____ ASSIGNMENT OF BENEFITS: Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctors. In other words, by initialing this line, you authorize payment directly to StrideCare for services rendered by physicians employed by this clinic. If your insurance company does not pay the practice, you will receive a bill.

_____ All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for services or referrals; however, you remain responsible for charges from any service rendered. As your insurance company will not guarantee the quote of benefits they provide to us, we cannot guarantee our estimate; all final bills are determined by your insurance plan contract documents and claims processors. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

_____ You must inform the office of all insurance changes and authorization/ referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

_____ There are certain surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of these. In that event, payment will be due one week prior to the surgery or at the time of your pre-operative appointment. Cancellation of surgery with less than one week notice will result in a fee of $150.00.

_____ Patients who are 90 days past due on their balance will be sent to collections unless a payment plan on a valid credit/debit card has been put into place. Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due to the office. Defaulting on a payment plan will result in the account being sent to collections.

_____ There is a fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

_____ We understand that emergencies occur but repeated no shows or cancellations with less than 24-hours' notice may result in a fee of $25.00 or up to possible termination of the physician-patient relationship. You will be asked to pay any outstanding fees before you are seen by the doctor. Patients who arrive twenty minutes later than their scheduled appointment time might be asked to reschedule based on clinic volume at the time of arrival.

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Today's Date: _____

HIPAA COMPLIANCE PATIENT CONSENT FORM

The Health Insurance Portability and Accountability Act of 1996 allows for the use of your information for treatment, payment, or healthcare operations. You have the right to restrict how your protected health information is used and disclosed. If the terms of this notice change, you will be notified at your next visit to update your signature.

By signing this form, you consent to our use and disclosure of your protected healthcare information as follows:

- Protected health information may be disclosed as indicated in the privacy policy.
- Information may be shared with your pharmacy, your Primary Care Physician or other doctors, or insurance company.
- This privacy policy may be changed by the practice, when necessary, as required or allowed by law.
- You have the right to revoke this consent in writing at any time and non-authorized disclosures will cease from that date forward. This privacy policy will stay in effect until the time that it is revoked by the patient or changed as required by law.

PLEASE INDICATE YOUR PREFERENCES REGARDING YOUR PERSONAL HEALTHCARE INFORMATION:

Health Notifications:	____ E-mail	____ Phone	____ Text message
Prescription Notifications:			____ Text message only
Appointments:	____ E-mail	____ Phone	____ Text message
Announcements:	____ E-mail	____ Phone	____ Text message
Billing & Payments:	____ E-mail	____ Phone	____ Text message

I consent to have my medication history obtained from pharmacies and my insurance company. This is to help keep medication lists up to date and accurate.

☐ Yes ☐ No

Please list any family members or friends (including ALL CUSTODIAL PARENTS FOR MINOR PATIENTS) with whom we can share your information? ☐ None Allowed

_____ Relationship to patient _____

_____ Relationship to patient _____

_____ Relationship to patient _____

_____ Relationship to patient _____

Any limitations to WHAT you allow us to share with the above individuals? _____

_____

Notice of Physician Ownership and Coordination of Care

Dear Patient,

We are committed to providing you with high-quality, coordinated healthcare services. As part of this commitment, we want to inform you about the relationships our physicians have with various service lines within our organization. Please take a moment to review the following information.

Physician Ownership and Financial Interests

Some of our physicians have an ownership interest in StrideCare (Interventional Partners, PLLC) which owns and operates multiple specialty practices and healthcare service providers, including but not limited to:

- Various Specialty Medical Practices
- Ambulatory Surgery Centers (ASCs)
- Pathology Labs
- Diagnostic Imaging Services

This means that our physicians may benefit financially from referrals to these services.

Coordination of Care

Our physicians strive to provide you with comprehensive and coordinated care by referring you to the appropriate service lines within our organization. This coordination helps ensure that you receive seamless and integrated healthcare tailored to your specific needs.

Your Right to Choose

You have the right to choose your healthcare providers. While our physicians may recommend services within our organization for your convenience and coordinated care, you are not obligated to use these services. You may seek care from any provider of your choice.

Transparency and Patient Rights

We believe in transparency and want you to be fully informed about the potential financial relationships between our physicians and the services they may recommend. If you have any questions or concerns about these relationships or your care options, please feel free to discuss them with your physician or a member of our staff.

Acknowledgement of Disclosure

I have read and understand the information provided above regarding physician ownership and the coordination of care within StrideCare (Interventional Partners, PLLC). I acknowledge that I have been informed about my right to choose my healthcare providers and the potential financial interests of my physicians.

_____ _____

Print Patient Name Date of Birth

_____ _____

Patient (or Patient Representative) Signature Today's Date

_____

Print Patient Representative Name

_____

Relationship to Patient

Electronic Communication Consent Form

I consent that Stride Healthcare can provide their services and communicate with me via mobile phone, messages, e-mail and any kind of online communications, provided that these communications comply with privacy regulations. I am aware there may be risks associated with electronic communications, such as unencrypted text or email. I understand I have the right to request communications by alternative means or at alternative locations at any time.

Appointment Reminders, Reschedules and Cancellations

I understand that Stride Healthcare can reach me any time to remind me of my appointments or let me know in case of any change about my appointments. I also understand that Stride Healthcare may employ and use a third-party automated system to contact me for the purpose of confirming, rescheduling or cancelling an appointment.

Telemedicine Appointments

For telemedicine, I understand the appointments will be held via electronic environments.

Contact Information Change

I accept that I am responsible for notifying Stride Healthcare when my contact information changes.

Consent Cancellations

I know that I can revoke this consent at any time by contacting Stride Healthcare.

I consent to the use of mobile phone communications, including calls and text messages (please check one).

☐ Yes ☐No

I consent to receive electronic notifications for confirming, rescheduling or cancelling my appointments (please check one)

☐ Yes ☐No

_____

Print Patient Name

_____

Patient (or Patient's Representative) Signature

_____

Print Patient Representative Name

_____

Relationship to Patient