Beverly Hills Foot and Ankle, P.A.

Specializing in Wound Care, Trauma and Reconstructive Surgery of the Foot, Ankle and Leg
3404 North Lecanto Highway, Suite A, Beverly Hills, FL 34465
Phone: (352) 513-4867 **Fax**: 1 (888) 314-9873 **E-mail**: BeverlyHillsFootAnkle@gmail.com
Website: www.beverlyhillsfootankle.com

PERSONAL INFORMATION

First Name_____ Middle Initial_____ Last Name_____

DOB_____/_____/_____ Sex: M/F Race_____ Language_____

SSN_____ Marital Status_____ Pregnant? **Y** or **N**

Address _____

City_____ State_____ Zip_____

Home Phone_____ Work Phone_____

Cell Phone_____ Email _____

EMPLOYER INFORMATION

Name_____ Phone_____

Address _____

City_____ State_____ Zip_____

EMERGENCY CONTACT

Name_____ Phone_____

Address_____

City_____ State_____ Zip _____

Relationship to Patient _____

INSURANCE INFORMATION

Primary Insurance _____

ID#_____ Group#_____

Secondary Insurance _____

ID#_____Group#_____

☐ **PRIMARY CARE PHYSICIAN**

Name of Physician_____ Last Seen _____

Address_____

Phone _____ Fax _____

☐ **Preferred Pharmacy** _____ Phone _____

☐ **HEALTH HISTORY** [Check all that apply]

☐ Anemia	☐ Cholesterol, high	☐ Heart Burn	☐ Ulcers, Stomach
☐ Anxiety	☐ Dementia	☐ Heart Problems _____	☐ Ulcers, Foot
☐ Asthma	☐ Depression	☐ Joint Implants _____	☐ Urinary Tract Infection
☐ Arthritis, rheumatoid	☐ Diabetes	☐ Kidney Problems _____	☐ Seizures
☐ Arthritis, wear and tear	☐ Dialysis	☐ Leukemia	☐ Sickle Cell Disorder
☐ BPH	☐ Fibromyalgia	☐ Liver Problems	☐ Stents
☐ Back Problems	☐ Fungus	☐ Lung Disease _____	☐ Stroke
☐ Blood Pressure, high	☐ Glaucoma	☐ Migraines	☐ Thyroid problems
☐ Cancer _____	☐ Gout	☐ Osteoporosis	☐ Tuberculosis (TB)
☐ Coronary Artery Disease	☐ Hepatitis	☐ Pacemaker	☐ Varicose Veins
☐ CHF	☐ HIV/AIDS	☐ Pneumonia	☐ Alcohol Abuse
☐ COPD	☐ Heart Attack	☐ Psoriasis	☐ Drug Abuse

Other Medical Problems _____

☐ Smoke? **No** or **Yes** _____packs/_____years Former smoker? **No** or **Yes** Drink? **No** or **Yes** Frequency_____

☐ **Pneumonia vaccine?** __ No __ **Yes** Date: Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec 20_____

☐ **Influenza vaccine?** __ No __ **Yes** Date: Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec 20_____

☐ Height ___'___" Weight _____ pounds What date did you weigh yourself? _____ Last eye exam ___/___/_____

Have you seen a podiatrist in the past? Circle One: Yes or No. If Yes, please explain.

_____

☐ Allergies _____

Please Include What **Symptoms** You Experience

☐ Medications Currently Taking _____

Please Include **Dosage** and **Frequency** of Use

_____

_____

_____

☐ Past Surgeries (Please Include **Surgery Type**, **Doctor**, **Date** and **Place)**

_____

_____

_____

PROBLEM/REASON FOR VISIT [Check all that apply]

What specific problem(s) bring you to the office today? _____

_____

How long ago did the problem start? _____

How would you describe your pain? ☐ burning ☐ sharp ☐ dull ☐ aching
☐ stabbing ☐ radiating ☐ itching ☐ no pain
☐ other _____

If you have pain, would you rate your pain on a scale of 1 to 10? 0 = no pain, 10 = worst pain (Please circle)

0 1 2 3 4 5 6 7 8 9 10

Where is your pain located? Right: ☐ Lower leg ☐ Ankle ☐ Foot ☐ Heel ☐ Toe
Left: ☐ Lower leg ☐ Ankle ☐ Foot ☐ Heel ☐ Toe

Are you diabetic? **No** or **Yes** Blood sugar _____ Hemoglobin A1c _____ Last checked ___/___/_____

Do you have these problems in association with your diabetes? ☐ Kidney ☐ Eye ☐ Nerve ☐ Skin

☐ **FAMILY HISTORY** [Check all that apply] Please be as specific as possible in regards to your family history.

Family	Arthritis	Cancer	Diabetes	Heart Problems	Stroke	High BP	Skin Disease	Foot Problems	Other
Father									
Mother									
Siblings									
Grandparents									
Children									
Spouse									

☐ **REVIEW OF SYSTEMS** [Check all that apply]

Constitutional	**Respiratory**	**Cardiovascular**	**Gastrointestinal**
☐ Chills	☐ Asthma	☐ Chest pain	☐ Abdominal pain
☐ Fatigue	☐ Bronchitis	☐ Extremity (Cool)	☐ Constipation
☐ Fever	☐ Cough	☐ Heart Attack	☐ Diarrhea
☐ Weakness	☐ Shortness of breath	☐ Palpitations	☐ Heartburn
☐ Nausea	☐ Sputum	☐ Leg Pain (Walking)	☐ Jaundice
☐ Vomiting	☐ Wheezing	☐ Swelling of Legs	☐ Liver problems
	☐ Tuberculosis	☐ Varicose Veins	☐ Excess thirst
		☐ Hair Loss on Legs	☐ Excess hunger
		☐ High Blood Pressure	☐ Hepatitis
Musculoskeletal	**Psychiatric**	**Skin**	**Neurological**
☐ Arthritis	☐ Anxiety	☐ Eczema	☐ Blackouts
☐ Joint pain	☐ Depression	☐ Itching	☐ Burning
☐ Gout	☐ Disorientation	☐ Nail problems	☐ Dizziness
☐ Back problems	☐ Hallucinations	☐ Dryness	☐ Fainting
☐ Deformities	☐ Disturbing thoughts	☐ Hives	☐ Headaches
☐ Joint Stiffness	☐ Excess stress	☐ Lumps	☐ Numbness
☐ Muscle cramps	☐ Memory loss	☐ Moles	☐ Strokes
☐ Muscle stiffness	☐ Mood changes	☐ Rashes	☐ Tingling
☐ Paralysis	☐ Nervousness	☐ Skin discoloration	☐ Tremors
☐ Weakness		☐ Skin ulcers	☐ Unsteady gait
☐ Gait problems			

REVIEW OF SYSTEMS [Check all that apply]

Endocrine	Hematologic	Allergic/Immunologic	Urinary
☐ Diabetes	☐ Anemia	☐ Coughing	☐ Blood in urine
☐ Weakness	☐ Bleeding easily	☐ Hives	☐ Burning
☐ Weight gain	☐ Blood clots	☐ Itchy eyes	☐ Incontinence
☐ Weight loss	☐ Bruising easily	☐ Itchy nose	☐ Infections
☐ Cold intolerance	☐ Swollen glands	☐ Runny nose	☐ Pain on urination
☐ Increased thirst	☐ Blood transfusion	☐ Sneezing	☐ Kidney stones
☐ Sweats		☐ Wheezing	☐ Urine discoloration
☐ Thyroid trouble			☐ Urine odor
☐ Excess urination			

Beverly Hills Foot and Ankle, P.A. Patient Financial Policy

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

- 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 to you or your health insurance carrier, payment for office services are due at the time of service.
- 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 doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We may have prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.
- If you have insurance coverage with a plan with which we do not have prior agreement, we will prepare and send the claim for you on unassigned basis. This means your insurer will send the payment directly to you. Therefore, all changes for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover same services. In the event your health plan determines a service to be “not covered” or you not have an authorization, you will be responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- By signing this form, you agree that if you are Out-of-Network, you will incur and pay any and all costs associated with your office visit that your insurance company does not pick up.
- 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 changes denied.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to surgery.
- 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 in this office.
- There is a service fee of $30.00 for all returned checks. Your insurance company does not cover this fee.
- A $25.00 fee will be charged for any missed appointment, cancellations require a 24 hour notice. This fee is not paid by insurance and is the patient’s responsibility to pay.

Signature_____ Date _____

It is the policy of our practice that all doctors and staff preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its doctors and staff have the necessary medical and PHI to provide the highest quality care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. Our practice and its doctors and staff will:

- Adhere to the standards set forth in the Notice of Privacy Practices.
- Collect, use and disclose PHI only in conformance with state and federal laws and current patient covenants and/or authorizations, as appropriate. Our practice and its doctors and staff will not use or disclose PHI for uses outside of practice's TPO (Treatment, Payment and Health Care Operations), such as marketing, employment, life insurance applications, etc. without an authorization from the patient.
- Use and disclose PHI to remind patients of their appointments unless they instruct us not to.
- Recognize that PHI collected about patients must be accurate, timely, complete and available when needed. Our practice and its doctors and staff will:
- Implement reasonable measures to protect the integrity of all PHI maintained.
- Recognize that patients have a right to privacy. Our practice and its doctors and staff respect the patient's individual dignity at all times. Our practice and its doctors and staff will respect patient's privacy to the extent consistent with providing the highest quality medical care possible and with the efficient administration of the facility.
- Act as responsible information stewards and treat all PHI as sensitive and confidential. Consequently, our practice and its doctors and staff will:
- Treat all PHI data as confidential in accordance with professional ethics, accreditation standards and legal requirements.
- Not disclose PHI data unless the patient (or his or her authorized representative) has properly authorized the release or law otherwise authorizes the release.

Recognize that, although our practice "owns" the medical records, the patient has a right to inspect and obtain a copy of his/her information is accurate or incomplete. Our practice and its doctors and staff will:

- Permit patients access to their medical records where their written request is approved by our practice. If we deny their request, then we must inform the patients that they may request a review of our denial. In such cases we will have an on-site healthcare professional review the patients' appeals.
- Provide patients an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.

All doctors and staff of our practice will maintain a list of certain disclosures of PHI for purposes other than TPO for each patient and those made pursuant to an authorization as required by HIPAA (Health Insurance Portability and Accountability Act). We will provide this list to patients upon request.

All doctors and staff of our practice will adhere to any restrictions concerning the use or disclosure of PHI that patients have requested and have been approved by our practice.

All doctors and staff of our practice must adhere to this policy. Our practice will not tolerate violations of this policy is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions in accordance with our practice's personnel rules and regulations.

Our practice recognizes and respects the fact that the patient has the right to inspect and obtain a copy of his/her Protected Health Information (PHI).

Privacy Procedures to accomplish this Privacy Policy include:

- The Privacy Officer will provide the front office staff with an original form for patients to complete when the patient desires to inspect and copy his/her PHI.
- The front office staff will photocopy and make available to patients the form to inspect and copy PHI.

- The front office staff will respond to patients' request and questions concerning inspecting and copy their PHI. In addition, the front office staff will distribute the form to the patients' upon their request.
- Once the patient completes the form, the front office staff should forward the form to the Privacy Officer for review.
- Once the patient has submitted his/her request in writing (using the practice's form is optional), the front office staff must verify the patient's signature matches his/her signature on file.
- The Privacy Officer must review the patient's request and respond to the patient within 30 days from the date of request. The Privacy Officer can request an additional 30-day extension as long as the request is made to the patient in writing with the reason for the delay clearly explained.
- The Privacy Officer should agree to all reasonable requests. If access is denied, the Privacy Officer must provide the patient with an explanation for the denial as well as a description of the patient's review appeal.
- When the patient has requested to inspect their PHI and his/her request has been accepted, the Privacy Officer or other authorized practice representative should accompany the patient to a private area to his/her records and remain with the patient during the inspection. After the patient inspects the records, The Privacy Officer will note in the record the date and time of the inspection, and whether the patient made any requests for amendments or change to the record.
- When the patient signs this form, Beverly Hills Foot and Ankle, P.A., its doctors and office staff will requisition your past prescription history through the electronic medical records. All records will remain confidential and within the electronic medical records system (EMR).
- When the patients request to copy his/her PHI has been accepted, the front office staff should copy his/her records within 10 days at a charge of $1.00 per page.
- Alternatively, patient is able to request access to their Health Fusion (EMR) personal patient portal so that they may view their medical records electronically. Patient must submit this request in person to the Privacy Officer so that the login and password information is disseminated to the correct individual. Please note that the Privacy Officer and/or support staff reserve the right to ask for proof of identification and verification of demographic information while this request is made.
- Please note that while the email is HIPAA COMPLIANT, texting is not. If you decide to initiate text regarding your patient information, please understand that you are accountable for the information that is disseminated.
- By signing this form you agree to photographic documentation of your feet, ankles and/or legs below the knee taken for evaluation of treatment purposes.

Signature_____ Date _____

How did you hear about Dr. Krishnan and Beverly Hills Foot and Ankle, PA?

__ Internet Search __ Newspaper Ad __ Friend
__ Family Member __ Magazine Ad __ Doctor Referral
__ Other _____

Office Use Only

Spoke with patient about possibility of _____ insurance policy not covering visit despite prior authorization from insurance company. Patient understands and complies with the above Financial Policy. Initialing indicates patient's understanding and compliance regarding financial responsibility. _____
Office manager/staff initials _____ Date _____