Florida Foot & Ankle Group, P.A.

PATIENT INFORMATION *(Please Print)*

Date_____

Last Name_____ First_____ MI_____ Sex: ❑ Male ❑Female

Address_____

City_____ State_____ Zip_____

Date of Birth_____ Age_____ Home Phone # (_____)_____

CellPhone # (_____)_____ Email: _____

Employer_____ Work Phone # (_____)_____

If Minor, Responsible Party_____ Phone # (_____)_____

Emergency Contact_____ Phone # (_____)_____

Primary Physician (full name)_____ Phone # (_____)_____

Pharmacy (Name & location or phone number): _____

Marital Status: ❑ single ❑ married _ ❑ divorced ❑ widowed

Work Status: ❑ employed ❑ full-time student ❑ part-time student ❑ retired ❑ none

Referral Source: ❑ doctor ❑ friend/family ❑ phone book ❑ insurance book ❑ other

Preferred Language: _____ ❑ Declined

Race: ❑ White ❑ Black/African American ❑ Asian ❑Native American❑ Pacific Islander ❑Declined

Ethnicity: ❑ Hispanic ❑ Non-Hispanic ❑ Declined

INSURANCE INFORMATION

Primary Insurance_____

Address_____

_____

Phone # (_____)_____

Subscriber _____ Subscriber's Date of Birth_____

ID #_____

Group # _____ Subscriber's Employer_____

Relationship to Insured _____

Secondary Insurance_____

Address_____

_____

Phone # (_____)_____

Subscriber _____ Subscriber's Date of Birth_____

ID #_____

Group # _____ Subscriber's Employer_____

Relationship to Insured _____

Florida Foot & Ankle Group, P.A.

Patient Health History

Name_____ Age _____ Sex _____ Race _____

Reason for your visit today _____

Is this a work related injury? _____

Height _____ Weight _____ Shoe Size _____

Current Medical Conditions or Illnesses _____

Current Medications _____

_____

Allergies (drugs, iodine, tape, food) _____

List any hospitalizations or surgeries you have had _____

_____

Do any family members have: ___ Gout ___ Foot problems ___ Diabetes ___ High blood pressure
___ Blood or bleeding problems ___ Heart problems ___ Arthritis ___ Cancer

Do you have children? _____ Do you have pets?_____

Do you smoke cigarettes? _____ If yes, how much? _____ If no, have you ever smoked?_____

Do you drink alcohol?_____ If yes, how much?_____

Do you exercise? _____ If yes, what do you do? _____

Do you spend time on your feet at work? _____ What is your occupation? _____

Family Doctor/Internist:_____ Date last seen _____

Pharmacy name/address/phone number:_____

Do you have, or have you had, any of the following conditions or illnesses:

No	Yes		No	Yes		No	Yes	
___	___	Arthritis	___	___	Poor circulation	___	___	Lung or breathing problems
___	___	Cancer	___	___	Bleeding problems	___	___	Trauma to feet or legs
___	___	Gout	___	___	Poor healing	___	___	Cramping of feet or legs
___	___	Tuberculosis	___	___	Depression	___	___	Swelling of feet or legs
___	___	Diabetes Mellitus	___	___	Numbness in feet	___	___	Ear/eye/nose/throat problems
___	___	Rheumatic Fever	___	___	Low back pain	___	___	Infections/contagious disease
___	___	Heart problems	___	___	Weight loss/gain	___	___	Hepatitis, AIDS, STD
___	___	Stomach ulcers	___	___	High blood pressure	___	___	Blood transfusion
___	___	Phlebitis	___	___	Liver problems	___	___	Stroke
___	___	Anemia	___	___	Kidney problems	___	___	Other _____

The above information is complete and accurate to the best of my knowledge. I hereby give permission to Florida Foot & Ankle Group PA to examine, perform necessary diagnostic testing, and treat my foot or ankle condition. I authorize photographing my feet.

Patient/Parent/Guardian Signature_____ Date _____

V7/2013

FLORIDA FOOT & ANKLE GROUP, P.A.

Patient Consent For Use and Disclosure of Protected Health Information

With my consent, **Florida Foot & Ankle Group, P.A.**, may use and disclose Protected Health Information (PHI) about me to carry out Treatment and Payment Operations (TPO). Please refer to the **Florida Foot & Ankle Group, P.A.**, Notice of Privacy Practices (NPP) for a more complete description of such uses and disclosures.

I have the right to review the NPP prior to signing this consent. **Florida Foot & Ankle Group, P.A.**, reserves the right to revise its NPP at anytime. A revised NPP may be obtained by forwarding a written request to: **Florida Foot & Ankle Group, P.A., 925 Williston Park Point, Suite 1009, Lake Mary, FL 32746.**

With my consent, **Florida Foot & Ankle Group, P.A.**, may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results.

With my consent, **Florida Foot & Ankle Group, P.A.**, may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, **Florida Foot & Ankle Group, P.A.**, may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that **Florida Foot & Ankle Group, P.A.**, restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to **Florida Foot & Ankle Group, P.A.**, to the use and disclosure of my PHI to carry out TPO. I certify that all of my questions were answered to my satisfaction and that I understand this authorization form and all of its contents. I understand that, upon my request, I may view or receive a copy of the information referenced above, and a copy of this form after I sign it.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign the consent, **Florida Foot & Ankle Group, P.A.**, may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Patient's Name

_____

Print Name of Patient of Legal Guardian

SIGNATURE ON FILE FORM

FLORIDA FOOT & ANKLE GROUP, P.A.

I hereby give consent to **Florida Foot & Ankle Group, P.A.** to provide whatever treatment the assigned physicians may deem necessary to the patient named below.

I understand that I am responsible for payment of services provided to me. I hereby assign insurance benefits, otherwise payable to me, to be paid directly to **Florida Foot & Ankle Group, P.A.** for Professional Physicians fees and authorize release of information for insurance purposes. I understand I am responsible for charges not covered by my insurance policy and will pay balances in full within 30 days of the first billing statement. A rebilling fee of $10.00 will be added for each additional billing statement sent. All collection fees incurred by **Florida Foot & Ankle Group, P.A.** will be my responsibility.

I hereby request payment of authorized Medicare benefits and/or any other insurance benefits to be made either to me or on my behalf to **Florida Foot & Ankle Group, P.A.** for any services furnished me by **Florida Foot & Ankle Group, P.A.** I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to process the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned claims, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Name of Responsible Party:_____

Signature:_____ Date:_____

(Form revised 11/04)

Florida Foot & Ankle Group, P.A.

FINANCIAL POLICY

Thank you for choosing Florida Foot & Ankle Group, P.A., as your foot care provider. The following information discusses our current financial policy and procedures.

1. It is your responsibility to provide accurate demographic and insurance information and a picture ID at the time of your visit. If you do not have insurance or do not present a valid insurance card, you will be responsible for payment at the time of service. A copy of our billing form will be provided if requested.

2. If your insurance plan requires a referral, it is your responsibility to obtain the referral prior to being seen by our physicians. Failure to provide a referral may necessitate rescheduling of your appointment.

3. It is your responsibility to ensure that our physicians are in your insurance network.

4. Copayments are due at the time of your visit. Also, co-insurance, unmet deductibles and outstanding balances are due at the time of your visit or prior to scheduled surgeries and procedures. We accept cash, checks and credit/debit cards. Post-dated checks are not accepted.

5. We will bill your insurance company on your behalf. You agree to assign payment to Florida Foot & Ankle Group and authorize Florida Foot & Ankle Group to bill your insurance plan in accordance with your insurance benefits in place at the time services are rendered.

6. Your insurance plan may not cover all services and/or supplies provided to you during your visit. These "non-covered" charges will be your responsibility, and due at the time of your visit or upon receipt of a billing statement.

7. You are ultimately responsible for payment of charges for services you receive from our office.

8. Cancellations for office appointments and procedures must be received at least 24 hours prior to the scheduled appointment. Cancellations for scheduled surgery must be received at least five days prior to the scheduled surgery date.

9. A $50 **no-show** fee will be charged for failure to cancel any appointment. A $25 fee will be charged if cancelled **less than 24 hours in advance** of appointment. A $100 fee will be charged for surgeries cancelled less than **5 days prior** to the scheduled surgery.

10. **The returned check fee is $30.**

11. Medical records requests must be received in writing at least 72 hours prior to the date needed. Fees for medical records are set in accordance with allowable amounts as defined by the State of Florida, and must be received prior to record delivery. No more than five pages may be faxed.

12. X-ray copy requests must be received at least one week prior to the date needed. There will be a **$15 fee for each x-ray copied.**

13. There will be **a prepaid fee of $25** for completing individual medical leave forms, disability forms, work restriction forms, employer forms, school forms, insurance forms, etc. All form requests require 5 to 7 business days to process.

14. Durable medical equipment (DME) consists of items such as crutches, surgical shoes, and removable casts. Once dispensed, these items cannot be returned or exchanged.

15. Over-the-counter products and medical supplies purchased from our office cannot be returned or exchanged.

Your signature certifies that you have read the foregoing policy and accept its terms.

_____ _____

Patient or Patient's Representative or Responsible Party Date

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of the Notice of Privacy Practices (see link on website) and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature

PRIVATE HEALTH INFORMATION CONSENT

Patient's Name:_____
DOB:_____

I,_____, authorize Dr. Cindy M. Watson, or Dr. Walter E. Roth III, or any member of the staff of Florida Foot & Ankle Group, P.A., to speak with any persons listed below regarding my Private Health Information. I understand this consent will be in effect for the duration of my care with Dr. Watson or Dr. Roth. If I choose to end this consent I will speak with your office staff to terminate this agreement. I understand Private Health Information means my medical records, financial records, treatment options, and/or any other information that is related to me.

Name of Person	Relationship to Patient	Contact Phone #

_____

Patient's Signature Date