

**Florida Foot & Ankle Group, P.A.**  
**Patient Information Sheet**  
 Información del Paciente

Today's Date \_\_\_\_\_  
 Fecha \_\_\_\_\_

Name \_\_\_\_\_

Social Security # \_\_\_\_\_

Nombre \_\_\_\_\_

Seguro Social \_\_\_\_\_

Date of Birth \_\_\_\_\_

Sex  Male  Female Age \_\_\_\_\_

Fecha de Nacimiento \_\_\_\_\_

Sexo Masculino Femenino edad \_\_\_\_\_

Address \_\_\_\_\_

Dirección \_\_\_\_\_

City \_\_\_\_\_

Ciudad \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Estado \_\_\_\_\_

zip \_\_\_\_\_

Home Phone \_\_\_\_\_

(er) Telefono \_\_\_\_\_

Marital Status  Single  Married  Widow

Estado Civil Soltero Casado Viudo

Cell Phone \_\_\_\_\_

Pharmacy Phone \_\_\_\_\_

Employer \_\_\_\_\_

Empleador \_\_\_\_\_

Job position \_\_\_\_\_

Posicion \_\_\_\_\_

Family Physician \_\_\_\_\_

Medico Primario

Work Phone \_\_\_\_\_

Telefono del trabajo

Physician's Phone \_\_\_\_\_

Telefono del medico

primario

If minor, Rspnsible Party \_\_\_\_\_

Si es menor de edad, Persona responsable

Phone \_\_\_\_\_

Telefono

Emergency Contact \_\_\_\_\_

En caso de emergencia

Phone \_\_\_\_\_

Telefono

How were you referred to us?  Doctor  Friend / Family  Yellow Pages  Other

Como fue referido a nosotros Medico Amigo/familiar Páginas amarillas Otro

**PLEASE READ AND SIGN**

I understand that I am responsible for payment of devices provided to me or my dependent. I hereby authorize assign insurance benefits, otherwise payable to me/my dependent, to be paid directly to **FLORIDA FOOT & ANKLE GROUP,P.A.** I authorize any holder of medical information about me/my dependent to release to Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand that Medicare or my insurance company may deny payment for services rendered to me or my dependent (s) due to frequency or lack of medical necessity. I therefore, assume full financial responsibility for all non-covered services. My signature below authorizes the release of pertinent medical information to insurance carriers and authorizes my insurance benefits to be paid directly to the doctor.

I hereby give consent to **FLORIDA FOOT & ANKLE GROUP, P.A.** to provide whatever treatment the assign physician may deem necessary to the patient named below.

**POR FAVOR LEA Y FIRME**

Yo entiendo que soy responsable por pagos a servicios proveidos a mi o dependiente. Yo asigne beneficios de seguro, de otra manera pagadero a mi o mi dependiente a ser pagado directo a **FLORIDA FOOT & ANKLE GROUP, P.A.** y autorizo que cualquier informacion medica acerca de mi sea divulgada a "Health Care financial Administrator" y sus agentes y cualquier informacion necesitada con proposito de determinar beneficios pagaderos a servicios relativos.

Yo entiendo que Medicare o mi seguro medico puede negar pagos por servicios prestados a mi o mi dependiente debido a frecuencia de necesidad medica. Yo asumire completa responsabilidad financiera para todos los servicios no cubiertos por mi seguro medico. Mi firma autoriza el dar informacion pertinente a mi seguro medico y autorizo que mis beneficios de seguros sean pagados directo al medico asignado.

Yo doy consentimiento a **FLORIDA FOOT & ANKLE GROUP,P.A.** a proveer cualquier tratamiento asignado por el medico que sea necesario para el paciente.

Signature of Patient or Responsible Party / Firma del paciente o responsable

Date / Fecha

# Florida Foot & Ankle Group., P.A.

## Patient Health History

Historial de Salud del Paciente

\*\*\*Si necesita ayuda escribiendo en Ingles, porfavor dejenos saber\*\*\*

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Race: \_\_\_\_\_

Nombre

Edad

Sexo

Raza

Reason For Today's visit \_\_\_\_\_

Razón de la visita de hoy

Did your injury occur at work?

Ud. Se lastimó en su trabajo?

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Shoe Size: \_\_\_\_\_

Estatura

Peso

Tamaño de zapato

Current Medical Conditions or

Illnesses: \_\_\_\_\_

Condiciones Medicas al momento

Current Medications: \_\_\_\_\_

Medicamentos que toma al momento

Allergies (drugs, iodine, tape,  
food): \_\_\_\_\_

Alergias (Medicinas, comida, etc.)

List any hospitalizations or surgeries you have

had: \_\_\_\_\_

Lista de Hospitalizaciones u operaciones

Do any family members have:  Arthritis  High Blood Pressure  Diabetes  Cancer  Gout

Artritis Alta Presión Diabetes Cancer Gota

Algún miembro de su familia tiene  Blood or Bleeding Problems  Heart Problems  Foot Problems

Problemas de sangre o sangramiento Problemas del Corazón Problemas de los pies

Do you smoke cigarettes?  No  Yes \_\_\_\_\_

Ud. Fuma cigarillos?

Have you ever smoked?  No  Yes

Ud a fumado?

Do you drink alcohol?  No  Yes

Ud toma alcohol?

Do you exercise?  No  Yes

Ud se ejercita?

Do you spend time on your feet at work?  No  Yes

Ud trabaja parado?

Family Doctor / Internist: \_\_\_\_\_ Date last seen: \_\_\_\_\_

Medico de cabecera

Fecha

Do you have or have had any of the following conditions or illnesses:  
 Ud tiene o a tenido alguna de las siguientes condiciones o enfermedades:

Arthritis Artritis	<input type="checkbox"/> No <input type="checkbox"/> Yes	Poor circulation Pobre circulación	<input type="checkbox"/> No <input type="checkbox"/> Yes	Lung or breathing problems Problemas de pulmones / respiratorios	<input type="checkbox"/> No <input type="checkbox"/> Yes
Cancer Cancer	<input type="checkbox"/> No <input type="checkbox"/> Yes	Bleeding Problems Problemas de sangramiento	<input type="checkbox"/> No <input type="checkbox"/> Yes	Trauma to feet or legs Trauma en los pies o piernas	<input type="checkbox"/> No <input type="checkbox"/> Yes
Gout Gota	<input type="checkbox"/> No <input type="checkbox"/> Yes	Poor healing Problemas curandose	<input type="checkbox"/> No <input type="checkbox"/> Yes	Cramping of feet or legs Calambres en los pies o piernas	<input type="checkbox"/> No <input type="checkbox"/> Yes
Tuberculosis Tuberculosis	<input type="checkbox"/> No <input type="checkbox"/> Yes	Nerve problems Problemas de nervios	<input type="checkbox"/> No <input type="checkbox"/> Yes	Swelling of feet or legs Hinchazon de los pies o piernas	<input type="checkbox"/> No <input type="checkbox"/> Yes
Diabetes Mellitus Diabetes Melitus	<input type="checkbox"/> No <input type="checkbox"/> Yes	Numbness in feet Adormecimiento de los pies	<input type="checkbox"/> No <input type="checkbox"/> Yes	Ear/eyes/nose/throat problems Problemas de oidos/ojos/nariz o garganta	<input type="checkbox"/> No <input type="checkbox"/> Yes
Rheumatic Fever Fiebre reumatica	<input type="checkbox"/> No <input type="checkbox"/> Yes	Low back pain Dolor de espalda baja	<input type="checkbox"/> No <input type="checkbox"/> Yes	Infections/contagious disease Infecciones/ enfermedades contagiosas	<input type="checkbox"/> No <input type="checkbox"/> Yes
Heart problems Problemas de corazón	<input type="checkbox"/> No <input type="checkbox"/> Yes	Weight loss/gain Gano / perdida de peso	<input type="checkbox"/> No <input type="checkbox"/> Yes	Hepatitis, AIDS, VD Hepatitis, SIDA, Enfermedades venereas	<input type="checkbox"/> No <input type="checkbox"/> Yes
Stomach ulcers Ulceras en el estómago	<input type="checkbox"/> No <input type="checkbox"/> Yes	High blood pressure Alta presión	<input type="checkbox"/> No <input type="checkbox"/> Yes	Blood Transfusion Trasfusión de sangre	<input type="checkbox"/> No <input type="checkbox"/> Yes
Phlebitis Flebitis	<input type="checkbox"/> No <input type="checkbox"/> Yes	Liver problems Problemas del hígado	<input type="checkbox"/> No <input type="checkbox"/> Yes	Stroke Stoke	<input type="checkbox"/> No <input type="checkbox"/> Yes
Anemia Anemia	<input type="checkbox"/> No <input type="checkbox"/> Yes	Kidney problems Problemas de los riñones	<input type="checkbox"/> No <input type="checkbox"/> Yes	Other Otro	<input type="checkbox"/> No <input type="checkbox"/> Yes

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

La siguiente información esta completa a lo mayor de mi entender. Autorizo a Florida Foot & Ankle Group, P.A., a examinar y hacer cualquier procedimiento necesario para tratar la condición de mi pie o mi tobillo. Autorizo que tomen fotos mis pies.

Patient/Parent/Guardian Sinature \_\_\_\_\_

Date \_\_\_\_\_

Firma del Paciente / Padres / Enacargado

Fecha

# 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

**HIPAA OMNIBUS RULE  
 PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES  
 AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM**

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: \_\_\_\_\_

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITY'S IN THE FUTURE.**

\_\_\_\_\_  
 Please print your name

\_\_\_\_\_  
 Please sign your name

\_\_\_\_\_  
 Legal Representative

\_\_\_\_\_  
 Description of Authority

Your comments regarding Acknowledgements or Consents: \_\_\_\_\_

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:  
 First Name Only     Proper Sir Name     Other \_\_\_\_\_

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:  
 (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION VIA:

- Cell Phone Confirmation                       Text Message to my Cell Phone
- Home Phone Confirmation                       Email Confirmation
- Work Phone Confirmation                       Any of the Above

I AUTHORIZE INFORMATION ABOUT MY HEALTH BE CONVEYED VIA:

- Cell Phone Confirmation                       Text Message to my Cell Phone
- Home Phone Confirmation                       Email Confirmation
- Work Phone Confirmation                       Any of the Above

I APPROVE BEING CONTACTED ABOUT SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO on behalf of this Healthcare Facility via:

- Phone Message                                       Any of the Above
- Text Message                                         None of the above (opt out)
- Email

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- It was emergency treatment \_\_\_\_\_
- I could not communicate with the patient \_\_\_\_\_
- The patient refused to sign \_\_\_\_\_
- The patient was unable to sign because \_\_\_\_\_
- Other (please describe) \_\_\_\_\_

\_\_\_\_\_  
 Signature of Privacy Officer