Florida Foot and Ankle Group

[ ]Gary W. Chessman, DPM [ ] Luis J. Sanchez-Robles, DPM

Patient (Paciente) : **D.O.B (F.D.N)** _______________

Last Name (Apellido) First Name (Nombre) M.I (S.N.) Sex (Sexo): [ ]M [ ]F

Address (Dirrecion):

City (Cuidad) State (Estado) Zip Code (Codigo Postal)

Phone (Telefono):

Home(Casa) Cell Work (Trabajo)

Email (Correo Electronico): ____

Responsible Party (if a minor)
(Responsable de menor) :

Race	Ethnicity	Martial Status
[ ] Asian/Pacific Islander (Asiatico [ ] Black (Negro) [ ] Native American/Alaskan (Nativo) [ ] White (Blanco) [ ] Unknown (Desconocido) [ ] Other (Otro):_____________	[ ] Hispanic (Hispano) [ ] Haitian (Haitiano) [ ] Unknown(Desconocido) [ ] Other (Otro):_____________	[ ] Married (Casado/A) [ ] Divorced (Divorciado/A) [ ] Separated (Separado/A) [ ] Single (Soltero/A) [ ] Widowed (Viudo) [ ] Unknown (Desconocido)

Emergency Contact:

Name (Nombre): _________________________________
Relationship (Relacion) : __________________________
Phone (Telefono): ________________________________

Primary Insurance (Seguro Primario)

Name of Insurance (Nombre de Seguro) :			Member ID (ID de Miembro) :	
Address (Direccion):				
City (Cuidad):	State (Estado):	Zip Code (Codigo Postal) :	Group # (Num. Grupo)	Relationship to Insured (Relacion de Seguro) : [ ] Self (Solo) [ ] Spouse (Esposalo) [ ]Child (Hijo) [ ] Other: (Otro)

Secondary Insurance (Segundo Seguro)

Name of Insurance (Nombre de seguro):			Member ID (ID de Miembro):	
Address (Dirrecion):				
City (Cuidad):	State Estado:	Zip Code (Codigo Postal :	Group # (Num. Grupo)	Relationship to Insured (Relacion de Seguro): [ ] Self (Solo) [ ] Spouse (Esposalo) [ ]Child (Hijo) [ ] Other: (Otro)

Assignment of Benefits / Release Information

I hereby assign all insurance benefits to which I am entitles, including Medicare, Medicaid, private insurances, major benefits and any other health plans to the assigned physician. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all the charges whether or not paid by said insurance. I hereby authorize said assignee to release all information, including HIV, substance abuse, or psychiatric information which may be found in the record and is necessary to secure payment

Patient or Responsible Party (Paciente/ Cuidador) : ____________________________ Date (Fecha): ____________

Pharmacy Information (Informacion de Farmacia)

Name of Pharmacy (Nombre de Farmacia) :	Phone (Telefono0:		
Address (Direccion) :	City (Cuidad) :	State (Estado) :	Zip Code (Postal) :

Reason for visit (Razon de Visita):

____

____

____

Primary Care Physician (Medico de Atencion Primaria)

Name:			Phone:
Address:	City:	State:	Zip Code:

Height of Patient:__________ **Weight of Patient_________**

Smoking Status (Fumas): **Please circle one** Current / Previously / Never

Alcohol Use (Tomas Alcohol): **Please circle one** Daily / Weekly / Socially / Rarely / Never

Past Surgical History (Historia de Operaciones)

List any surgeries you have had (Ponda todas cirugias que a tenido)

Patient Name (Nombre de Paciente) :____ Date of Birth (F.D.N):________________________________

Known Medication Allergies (Alergias de Medicamentos)____

____

____

MEDICATIONS I TAKE (PRESCRIPTION, NON-PRESCRIPTION, VITAMINS, HERBALS)	
Medication Name (Nombre de medicamentos)	**Dose (Dosis)**

The accuracy of the information in this document depends on the accuracy and completeness of information provided by the patient at the time this document was prepared. The patient is responsible for advising the pharmacist of any change to these medications.

Patient Medical History (Historia de Salud)

Please mark the medical history that applies to you
(Por favo, margue el historial medico que se le aplica)

__Myocardial Infarction (Infarto de miocardio)
__Congestive Heart Failure (Insuficiencia cardiaca congestiva)
__ANGINA (Angina de pecho)
__Diabetes Miletus: Type 1 or Type 2
__High Blood Pressure (Presion alta)
__Hypercholesterolemia (Hipercolsterolemia)
__Stroke Syndrome (Ataque)
__Transient Ischemic attack (Isquemia transitoria transitorio)
__Cancer

__Asthma (Asma)
__Chronic Obstructive Pulmonary Disease (Enfermedad Pulmonar obstructiva conica)
__Peptic Ulcer Disease (La enfermedad de ulcera peptica)
__Thyroid Disease (Enfermedad de tiroides)
__Arthritis (Artritis)
__Psychiatric (Psiquatrica)
__Depression (Depresion)
__Tuberculosis
__HIV/ AIDS

Other (Otro) : ____

Please indicate which family member has or has had any history of the following illnesses. Using the following
(Por Favor indica que miembro de la familia tiene o ha tenido algun historial de las siguientes enfermedades, use las siguinetes)

(M) Mother (Madre) **(F)** Father (Padre) **(B)** Brother (Hermano) **(S)** Sister (Hermana)

___Myocardial Infarction (Infarto de miocardio)
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___Arthritis (Artritis)
___Psychiatric (Psiquatrica)
___Depression (Depresion)
___Tuberculosis
___HIV/ AIDS

Patient Authorization for Use and Disclosure of Protected Health Information

I, ____________________________________ hereby authorize Dr. Gary W. Chessman

to use and/or disclose to my primary care physician/other parties. The following specific protected health information: Medical Records, Lab Results, X-Ray, Operative Reports, and any/all paperwork pertaining to Medical History of patient. I understand that this authorization is valid until we receive a written notice to discontinue. I understand that the purpose of the discloser I am granting is for medical reason only. I expressly acknowledge that this authorization is voluntary. I understand that I may see and copy the information described in this form if I ask for it. This form was completely filled in before I signed it. I certify that all my questions were answered to my satisfaction and that I understand this authorization from and all its contents. This authorization is valid of ____/____/____.

____	____
Name of Individual (Print)	Signature
____	____
Signature of Legal Representative	Relationship

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