Advanced Foot and Ankle of Indian River

Amberly Paradoa, DPM, FACFAS **Timothy Caballes, DPM, FACFAS** **Robby Caballes, DPM, FACFAS**

3735 11th Circle **13852 US Hwy 1**

Vero Beach, Florida 32960 **Sebastian, Florida 32958**

(772) 299-7009

Patient Name: _____ Date of Birth: _____/_____/_____

Age: _____ Phone:_____ Cell [ ] Home [ ] OK to leave a detailed message? Yes [ ] No [ ]

Address: _____

City, State, Zip: _____ SSN: _____

Email Address (For patient portal) patient will receive an email to register: _____

Name as Printed on Insurance Card: _____
Primary Insurance and ID #: _____
Secondary Insurance and ID #: _____
Insured Name and Date of Birth: _____

Guarantor for Minors:

Name: _____ Phone: _____

DOB: _____ Relationship: _____

Primary Care Physician: _____ **Date of Last Visit**: _____

Pharmacy (Location and Phone Number): _____

Emergency Contact:

Name: _____ Phone: _____

Relationship: _____

Name: _____ Phone: _____

Relationship: _____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I wish to give the following person(s) access to the use or disclosure of my health information, appointments and/or account information.

Name: _____ Phone Number: _____
Relationship: _____

Name: _____ Phone Number: _____
Relationship: _____

Name: _____ Phone Number: _____
Relationship: _____

Signature: _____ Date: _____

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Name: _____ DOB:_____ Date: _____
Current foot problem(s)_____Was this an accident? (circle) **Yes/No**
If yes, was it on the job? (circle) **Yes/No** (*If you answered yes, please inform the receptionist/call office immediately*)
Date of accident: _____ Has your employer been informed? (circle) **Yes/No**
Description of pain_____ How long have you had the pain/problem? _____
Where on foot/ankle: _____ Caused by_____
Aggravated by_____ Relieved by: _____ Prior treatment (circle) **Yes/No** If yes, what type of treatment and by whom? _____
Flu Vaccine: (circle) **Yes/No** When?_____ Pneumonia Vaccine: (circle) **Yes/No** When?_____
TDAP (Tetanus) Vaccine: (circle) **Yes/No** When?_____ Living Will or Power of Attorney: (circle) **Yes/No**
Height: _____feet _____inches Weight: _____ Occupation: _____Shoe Size: _____

Social History: Please CIRCLE

Tobacco Use:	Non-Smoker	Smoker ____packs per day	Smokeless Tobacco	Quit ____ Years ago.	Smoked____years.
Exercise:	None	Walking Everyday/Occasionally	Jogging/Running	Aerobic Activity ____ times per week.	Other:
Alcohol consumption:	None	Occasionally	Moderately	Heavy	Type:
Caffeine?	Yes	No	Recreational Drug use	Yes	No

Medical History: Please CIRCLE the box to the right that applies to YOUR Medical/Surgical History.

Diabetes Type I/Type II **(circle)** Date of diagnosis: Last A1c or BGL:		Arthritis **(type)**		Cancer **(type)**	
Heart Attack/Heart Disease **(circle)**		GERD/ulcer/Colitis **(circle)**		Depression/Anxiety	
High Blood Pressure		COPD/Asthma/Emphysema **(circle)**		HIV/AIDS	
Epilepsy/Seizures/Stroke **(circle)**		Neuropathy		PAD	
Bleeding Disorder		Gout		Hearing Aids	
Phlebitis/Blood clots/DVT **(circle)**		Liver Disease/Hepatitis A/B/C **(circle)**		Dentures	
Hypothyroidism		Wound current/history **(circle)**		Corrective Lenses	
Foot or Ankle injuries/surgery **(type)**		Vascular Surgery		Other Surgery:	

Family History. Please CHECK the box to the right if it applies to YOUR FAMILY (Blood Relatives Only)

Diabetes TYPE I/TYPE II		Heart Attack/Heart Disease		High Blood Pressure		Adopted/No Knowledge	

Please list all Medications you are currently taking:

MEDICATION NAME	DOSAGE	HOW MANY TIMES A DAY

Allergic to (circle) Penicillin, Sulfa Drugs, Aspirin, Codeine, Iodine, Tape, Cortisone, Local Anesthesia, Other:_____

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Dear Patient:

We look forward to seeing you in our office. Thank you for giving us the opportunity to care for your medical needs. In order for us to provide you with the best care possible, we must follow a few guidelines and government regulations. **This information is for your convenience and is provided to help you understand and give consent to our financial and office policies.**

Office hours:

Monday – Thursday: 9:00- 5:00
Friday: 9:00- 12:00
By appointment only

By law we are required to have a copy of your Insurance card(s) & Photo ID on file.

- Dr. Paradoa, Dr. T. Caballes, and Dr. R. Caballes use Medical Billing Connection as an outside billing company.
- **Insurance co-pays, deductibles, and any co-insurance are due at the time of services rendered. If payment is not received, there will be a $15.00 administration fee added to your balance.** Any balances due beyond 30 days are subject to interest of 1.5%, which accumulates each month thereafter, in addition to the $15.00 administrative fee for balances not paid in full at the time of services rendered. **If a minor, whomever signs the paperwork is ultimately responsible for all outstanding balances.**
- **Medicare:** Dr. Paradoa/Dr. T. Caballes/Dr. R. Caballes are providers for Medicare. Your secondary insurance will be filed as a courtesy. However, if your secondary insurance has not made payment within 90 days of Medicare payment you will be responsible for any remaining balance. You will be responsible to sign and review the Advanced Beneficiary Notice (ABN), for services non-covered or deemed not Medically Necessary by Medicare. If the patient has no secondary insurance, you will be responsible for the 20% co-insurance. **It is your responsibility to know your policy and if we participate with your Medicare Advantage plan, and if you require a referral**.
- **Commercial Insurance Plans:** Dr. Paradoa/Dr T. Caballes/Dr. R. Caballes are providers of BC/BS. Any co-pay or deductible will be due at time of service. **It is your responsibility to know your policy and if we participate with your Commercial Insurance plan, and if you require a referral**.
- **Self-Pay or Non-Participating Insurance:** Dr. Paradoa/Dr. Caballes/Dr. R. Caballes require payment in full at time of service. $200.00 will be collected upon check-in and the remainder will be collected upon checking out.
- **Collections:** All unpaid balances will be sent to an outside collection agency or small claims court, after all practice efforts have been exhausted. Any & all small claims & collections cost will be the patient's responsibility.
- **Return Check fee:** A fee of $45.00 will be charged to any patient account for a returned check.
- **Appointment No Call/No Show:** A fee of $45.00 will be charged to any patient account for a missed appointment.
- **Fee for completing paperwork:** A fee of $40.00 will be collected from the patient at time of service for forms including but not limited to disability, FMLA, or insurance forms.
- **X-ray Policy:** X-ray CDs are $11.00 each and require a 48-hour notice. If you decide not to pick up the disc your account will be charged for the $11.00 fee regardless.
- **Other Entities:** During your course of treatment, you may be referred to other institutions for treatment. These referrals are based solely on medical necessity and our affiliations with these institutions are based on providing our patients with the highest quality and medical care possible. Advanced Foot and Ankle of Indian River will make every effort in sending you to a participating facility through your insurance, but it is ultimately the patients' responsibility.

Patient Signature: _____ Date: _____

HIPAA: I agree to allow Dr. Paradoa/Dr. T. Caballes/Dr. R. Caballes to use or disclose the protected health care information of the listed patient to carry out treatment, payment, or health care operations.
I have been informed of the Privacy Notice. The notice is a more complete description of the uses and disclosures of protected health information that may be made, and of my rights with respect to protected health information. I understand that I have the right to request a restriction on how protected health information is used or disclosed in order for Dr. Paradoa/Dr. T. Caballes/Dr. R. Caballes to carry out treatment, payment, and health care operations. Further, I understand that this request for restriction must be in writing and if the health care provider agrees to the restriction, the restriction is binding. However, the health care provider is not required to agree to the requested restriction. I also understand that the office may call my home to confirm information, and will mail statements to the address I have listed, which is part of the health care operations of Amberly Paradoa DPM, FACFAS.
I understand that I have the right to revoke this consent at any time. The revocation must be in writing.
This consent meets the requirements of the Health Information Portability and Accountability Act of 1996 (HIPAA)

Patient Signature: _____ Date: _____

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Medical Records Release: Authorization for Use or Disclosure of Protected Health Information for Treatment, Payment, Or Healthcare Operations.

Patient Name: _____

Date of Birth: _____

Address: _____

Phone: _____

The information requested may be used for purposes of my continued health care. I hereby authorize the release or use of my protected health information and medical record information by Advanced Foot and Ankle of Indian River to carry out treatment, payment, or healthcare operations. You may request a copy of the practice's Notice of Privacy Practices for a complete description of the potential release and use of such information, and you have the right to review such notice prior to signing this consent form.
We reserve the right to change the terms of this Notice of Privacy Practices at any time. If we do make changes to the Notice of Privacy Practices, you may obtain a copy of the revised Notice.
You retain the right to request restrictions on how your protected health information is used or released regarding treatment, payment, or healthcare operations. Our office is not required to agree with such restrictions. However, if we agree with such restrictions, then those restrictions are binding on Advanced Foot and Ankle of Indian River.
I acknowledge and agree that Advanced Foot and Ankle of Indian River may disclose my protected health information and medical record information to the individuals who are either my family members, legal representatives, guardians, health care surrogates, or have power of attorney on my behalf.

I authorize the records release of the following information.
** Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/ alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

All medical records Restrictions:_____
Laboratory/pathology reports
X-rays/radiology records
Pharmacy/prescription records
Billing records
Office Visit and General Notes

Please send the requested records to:

Address: 3735 11th Circle Suite 201
Vero Beach, Florida 32960
Phone: (772) 299-7009
Fax: (772) 562-7138

_____ _____
Signature of Patient Date

Refusal to sign: Your insurance may request Advanced Foot and Ankle of Indian River to send medical records on your behalf to determine financial obligation. By refusing to sign this form you acknowledge that you accept the responsibility for any payment associated with the denial of claims from your insurance company. **Initial:** _____

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CONSENT FOR TRANSFER OF BIOLOGICAL SPECIMEN

Florida law (Section 817.5655, Florida Statutes) prohibits the sale of transfer of a person's biological specimen from which DNA can be extracted to a third party without the express consent of such person.

During the course of your care at Advanced Foot & Ankle of Indian River, it may be medically necessary to obtain a blood, urine, stool, tissue or other type of biological specimen for analysis. This analysis **will not** involve the examination of your DNA to identify the presence and composition of genes in your body. After the analysis has been performed and the sample is no longer needed, it will be stored as medical waste and then transferred to a third party for disposal in accordance with all local, state, and federal requirements.

It may also be the case that a biological specimen (such as blood, urine, hair, bodily fluids, etc.) from you may be deposited on medical instruments, bedding, clothing, or other objects. These objects may then be transferred to a third party for cleaning or disposal.

By signing this document, you affirmatively state that it is your intention decision to consent to the transfer of any and all biological specimens collected by or deposited with Advanced Foot & Ankle of Indian River to a third party as set forth above. This consent does not authorize the sale or transfer of a biological specimen for the purpose of DNA analysis.

_____
Signature of Patient

_____
Printed Name of Patient

_____/_____/_____
Date