FOOT AND ANKLE WELLNESS CENTER
DR. LEONARD E. VEKKOS

NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____
STREET APT# CITY STATE ZIP

HOME # (_____) _____WORK# (_____) _____CELL# (_____) _____

E-MAIL:_____ PREFERENCE: HOME:☐ CELL:☐: E-MAIL ☐

AGE: _____DATE OF BIRTH: _____SS NO.:_____ MALE ☐ FEMALE ☐

OK TO LEAVE MESSAGES WITH: PATIENT ONLY:☐ SPOUSE:☐ OTHER:☐ NAME: _____

YOUR OCCUPATION: _____EMPLOYER: _____

EMPLOYER'S ADDRESS: _____EMPLOYER PHONE (_____) _____

EMERGENCY CONTACT:_____ PHONE (_____) _____

MARITAL STATUS: S:☐ M:☐ W:☐ D:☐ PRIMARY LANGUAGE: _____

ETHNICITY: HISPANIC OR LATINO:☐ NON-HISPANIC OR LATINO:☐

RACE: AMERICAN INDIAN OR ALASKAN NATIVE:☐ ASIAN:☐ BLACK OR AFRICAN AMERICAN:☐
NATIVE HAWAIIAN OR PACIFIC ISLANDER:☐ WHITE:☐

PRIMARY INSURANCE: _____ ID #:_____GROUP #:_____

SUBSCRIBER: _____DOB: _____ SS#:._____

HMO ☐ PPO ☐

SECONDARY INSURANCE: _____ ID #:_____GROUP #:_____

SUBSCRIBER: _____DOB: _____ SS#:._____

HMO ☐ PPO ☐

PRIMARY CARE PHYSICIAN_____ PHONE (_____) _____

PHYSICIAN'S HOSPITAL AFFILIATION _____ DATE OF LAST VISIT _____

WHO REFERRED YOU TO OUR OFFICE? _____

WHAT IS YOUR FOOT PROBLEM? _____

HOW LONG HAVE YOU HAD THIS PROBLEM? _____ HAVE YOU BEEN TREATED FOR IT? YES ☐ NO ☐

BY WHOM? _____

IS YOUR FOOT PROBLEM THE RESULT OF A WORK-RELATED INJURY? YES ☐ NO ☐

_____ _____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN (If patient is under 18) **DATE**

PATIENT NAME: _____ DATE:_____

MEDICAL INFORMATION

Past Medical History

Have you ever had any of the following?

☐ Measles	□ Asthma	□ Fevers over 103°	□ Psychological Problems
☐ Mumps	□ Balance Problems	□ Heart Disease	□ Sexually Transmitted Disease
☐ Chickenpox	□ Bladder Problems	□ High/Low Blood Pressure	□ Skin Problems
☐ Whooping Cough	□ Blood Clots	□ Hearing Loss	□ Stroke
☐ Scarlet Fever	□ Bowel Problems	□ Hepatitis	□ Swelling of Feet/Ankles
☐ Diphtheria	□ Cancer	□ Kidney Disease	□ Tuberculosis
☐ Smallpox	□ Diabetes	□ Liver Disease	□ Thyroid Disease
☐ Pneumonia	□ Digestion Problems	□ Migraine Headaches	□ Ulcer
☐ Rheumatic Fever	□ Dizziness	□ Numbness/Tingling	□ Varicose Veins
☐ AIDS or HIV+	□ Ear/Nose Throat Problems	□ Pacemaker	□ Vision Problems
☐ Anemia	□ Epilepsy	□ Polio	□ Other _____
☐ Arthritis	□ Fainting	□ Prolonged Bleeding	_____

HEIGHT:_____ WEIGHT: _____

Previous Hospitalizations, Surgeries, or Serious Illness (and When?)

_____

_____

What medications and/or supplements are you taking now and what dose?

_____

_____

Vaccination History:

_____

Are you pregnant? □ Yes □ No **Are you taking Birth Control Pills? □ Yes □ No**

Are you under the care of a physician? □ Yes □ No **If yes, for what reason (s)? _____**

Social History

Do you live alone? □ Yes □ No **For how long? _____**

Do you have children? □ Yes □ No **If yes, how many? _____**

Do you exercise? □ Yes □ No **If yes, how often? _____ What kind of exercise? _____**

Are you on a special diet? □ Yes □ No **If yes, what kind? _____**

Do you smoke? □ Yes □ No **If yes, how many packs per day? # _____ for # _____ years.**

If no, when did you quit? _____ **How many packs had you smoked? # _____ per day for # _____years.**

Do you drink alcohol? □ Yes □ No **How much: Daily _____ Weekly _____ Monthly_____ Yearly_____**

Do you have a history of substance abuse? □ Yes □ No **If yes, what substance(s)? _____**

PATIENT NAME: _____ DATE:_____

MEDICAL INFORMATION

Family History

Has anyone in your family ever been diagnosed with the following? Name the relationship next to the condition in the space provided.

☐ **Heart Disease _____** □ **Cancer _____** □ **Diabetes _____**

☐ **Circulatory Disease _____** □ **Hypertension _____** □ **Arthritis _____**

☐ **Neurological Problems _____** □**Skin Disease _____** □ **Foot Problems _____**

Additional space, if necessary

_____

_____

Allergies

Do you have a history of skin reaction or other adverse reaction to:

□ **Anesthetics _____** □ **Pain Medication _____** □ **Environmental Substances _____**

□ **Antibiotics _____** □ **Foods _____** □ **Penicillin _____** □ **Tape _____**

□ **Aspirin _____** □ **Iodine _____** □ **Seasonal Allergies _____** □ **IV Dye _____**

□ **Codeine_____** □ **Sulfa_____** □ **Silver_____** □ **Tetanus _____**

□ **Other _____**

Specify above and any others:

_____

NOTES: _____

_____

_____

_____

_____

_____

_____

_____

To the best of my knowledge, the above information submitted is correct. I understand that giving incorrect information can be dangerous to my health. It is my responsibility to inform the doctors' office of any changes in my medical status. I, hereby, give my permission to Dr. Vekkos to diagnose and administer treatment of my foot condition.

_____ _____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN **DATE** **REVIEWED BY**

FOOT AND ANKLE WELLNESS CENTER
DR. LEONARD E. VEKKOS
PATIENT AGREEMENTS AND AUTHORIZATIONS

CONSENT FOR TREATMENT:
I hereby consent to the treatment provided by Foot and Ankle Wellness Center and its employees or designees. I authorize the physical health care services deemed necessary or advisable by my caregivers to address my needs.

PRIVACY POLICY:
I acknowledge having received the Foot and Ankle Wellness Center's, "Notice of Privacy Policies". My rights, including the right to see and copy my record, to limit disclosure of my health information, and to request an amendment to my record, are explained in the Policy. I understand that I may revoke in writing my consent for release of my health care information, except to the extent that Foot and Ankle Wellness Center has already made disclosures with my prior consent.

HMO POLICIES:
I understand that it is my responsibility to obtain referrals from my primary care physician. If I do not supply Foot and Ankle Wellness Center with a referral for any appointment where one is required, I understand that I will be responsible for payment in full at the time of service.

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION:
I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of Foot and Ankle Wellness Center. I authorize Foot and Ankle Wellness Center to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that Foot and Ankle Wellness Center may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent.

PRIOR AUTHORIZATIONS AND BENEFIT INFORMATION:
As a courtesy to our patients, the Foot and Ankle Wellness Center will check benefits prior to procedures and office visits. The information obtained from the insurance company is not guaranteed and may not be accurate. It is my responsibility as the patient to contact my insurance company prior to any treatment to confirm prior authorization is required.

_____ _____

PRINTED NAME OF PATIENT **PRINTED NAME OF LEGAL GUARDIAN**

_____ _____

SIGNAURE OF PATIENT OR LEGAL GUARDIAN IF PATIENT IS UNDER 18 **DATE**

FOOT AND ANKLE WELLNESS CENTER
DR. LEONARD E. VEKKOS
FINANCIAL POLICY & PATIENT AGREEMENTS AND AUTHORIZATIONS

REQUIRED AT CHECK IN: 1. Current insurance card
2. Photo ID and Credit Card
3. Verify personal contact information
4. Payment of outstanding balance and Co-pay

PAYMENTS FOR SERVICES:
I understand that payment is due at time of service. I understand that all co-pays, deductibles and co-insurance are my responsibility and can be collected at time of service.

Foot and Ankle Wellness Center requires a valid credit card be kept on file to cover past due balances. Please see the next page for details.

ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT GUARANTEE/COLLECTION FEE.
I authorize payment to be made directly to Foot and Ankle Wellness Center for insurance benefits payable to me. I understand that I am financially responsible to Foot and Ankle Wellness Center for any covered or non-covered services, as defined by my insurer. I understand that if my account balance becomes overdue, it will be referred to the collection agency, Keynote Consulting. I will be responsible for the costs of collection including balance owed, 30% of balance owed for collection fee, court costs and filing fees, and attorney fees if applicable. **AFTER 90 DAYS MY UNPAID BALANCE WILL BE SENT TO COLLECTIONS. IT WILL BE REPORTED TO THE CREDIT BUREAUS.**

PAYMENT ARRANGEMENTS are available for patient-due balances over $500. Payment agreements are made on a case by case basis. It is my responsibility to contact Foot and Ankle Wellness Center's billing department to make such arrangements within 30 days of my first statement.

RETURNED CHECKS: I understand I will be charged **$30** for any returned check from the bank for "non-sufficient funds". All future payments must be made by credit card or cash.

FOOT AND ANKLE WELLNESS CENTER REQUIRES 24 HOUR ADVANCED NOTICE FOR APPOINTMENT CANCELLATION:
NO CALL / NO SHOW FEE, $25.00 SECOND NO CALL / NO SHOW FEE, $50.00

SELF-PAY: If I am uninsured, a 30% discount off standard fees will apply. Payment is due at time of service.

MEDICAL RECORDS REQUESTS: I understand there will be, at minimum, a **$10** handling and preparation fee for requests for medical records from any party other than my health insurance company and that this fee will be paid prior to the records being released. An additional fee of **$5** will be charged for copies of x-rays in either disc or photo format. A medical record release form is required to be signed before records can be released.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communications. Questions about financial arrangement should be asked prior to services provided. By signing below, you acknowledge that you have read and agree to this Financial Policy.

_____ _____
PRINTED NAME OF PATIENT **PRINTED NAME OF LEGAL GUARDIAN**

_____ _____
SIGNAURE OF PATIENT OR LEGAL GUARDIAN IF PATIENT IS UNDER 18 **DATE**

Foot and Ankle Wellness Center Credit Card on File Policy (2014)

Your signature at the end of this document will indicate that you have read, understand and agree to the policies outlined below.

As of January 2014, FAWC requires a valid credit card be kept on file.
This policy is designed to:

- Help you avoid all billing related fees
- Streamline the billing process in our office and eliminate the expenses related to handling overdue accounts
- Focus our time and energy on your family's medical care

The card information is stored electronically in an encrypted form and cannot be viewed by our office staff. Your signature will authorize the card to be used only when your balance becomes past due (60 days from first statement), you have a scheduled payment plan, or at the cardholder's request.

How the policy works:

1. At the time of registration or check-in, your credit card information will be electronically stored in encrypted form in our computer. Only the last four digits are visible to our staff.
2. As before, we will bill your insurance carrier for all charges related to the visit.
3. When we receive an explanation of benefits (EOB) from your insurance we will send you a statement on the 1st of the following month. If we have not received payment by the 30th of the following month, we will charge the credit card on file for the balance due on statement unless you have set up a payment plan.
4. You are responsible to update our office if your address changes. If your mail is returned and we do not receive payment within the allotted time, your credit card will be charged the full amount of the statement.
5. If Foot and Ankle Wellness Center attempts to use your card and it is declined or has expired, our billing department will contact you by telephone, and you will be responsible for updating our records.
6. If you choose not to provide us with your credit card information, you will be required to pay the ESTIMATED charges based on your current insurance coverage at the TIME OF SERVICE. Any overpayment will be refunded after your claim adjusted by insurance.

Please remember that this policy does not restrict your right to appeal any charge made to your credit card. Should you feel that we have charged your card in error, you may contact our billing office. If a mistake has been made we will reverse the charges.

I have reviewed a copy of Foot and Ankle Wellness Center's billing policy and agree to provide my credit card information to Foot and Ankle Wellness Center for the sole purpose of payment for medical care.

PATIENT NAME: _____

CARDHOLDER NAME: _____

CARDHOLDER ADDRESS: _____

TYPE OF CARD: VISA____ MC____ AMEX____ DISCOVER____ CID#_____

CREDIT CARD#: _____ EXP. DATE: _____

CARDHOLDER SIGNATURE: _____ DATE: _____