Welcome to Jackson Family Foot & Ankle Care

MODERN PODIATRY

Patient Information

Patient Name: _____ **D.O.B:** _____ **SSN:** _____

Home Address: _____ **Apartment:** _____

City: _____ **State:** _____ **Zip Code**: _____

Home Phone: _____**Cell Phone:** _____

Email Address: _____

Would you like access to your records online through our secure patient portal? ☐ Yes ☐ No

Sex: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Preferred Language: _____

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unreported/Refused to Report

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ More than one race

☐ Native Hawaiian ☐ Pacific Islander ☐ White ☐ Unreported/Refused to Report

Primary Physician: _____Phone: _____

Specialty Doctors:_____

Pharmacy: _____ Phone: _____

Emergency Contact _____ Emergency Phone _____

Disclosure to Designated Family/Friends Caregivers

I allow Jackson Family Foot & Ankle Care to disclose medical information as needed to the following designed individual(s) involved with my health care. I understand that I am not required to list anyone. I also understand that I may change my list in writing at any time.

Print Name: _____ Relationship: _____Phone #: _____

Print Name: _____ Relationship: _____Phone #: _____

Insurance Information

Insurance Carrier _____ Group # _____ ID #_____

Person Responsible for Account _____

Relationship to Patient _____ D.O.B _____ SSN _____

Address (if different from patient) _____

Secondary Insurance _____ Group _____ ID # _____

Person Responsible for Account _____

Relationship to Patient _____ D.O.B _____ SSN _____

Is this a compensation or work relate case? ☐ Y ☐ N Date of Injury _____

New Patient Review of Symptoms

Name: _____ **D.O.B:** _____

Shoe Size: _____ **Height:** _____ **Weight:** _____

What type of shoes do you wear most often? _____

- What is your chief complaint you are here to address today? _____

_____

_____

- Description of Pain (dull, sharp, aching, etc.): _____
- Aggravating Factors (when is the pain at its worst?) _____
- How long has this bothered you? _____Days _____Weeks _____Months _____Years
- Relieving Factors: ☐ Rest ☐ Ice ☐ Heat ☐ Medications ☐ Home Remedies ☐ Stretching ☐ Other:_____
- Does your foot pain limit your activities? ☐ Yes ☐ No Do you have difficultly/pain walking? ☐ Yes ☐ No
- Have you had any previous treatment for this problem? ☐ Yes ☐ No

  If yes, please explain: _____
- Have you had diagnostic imaging for this problem? ☐ Yes ☐ No

  If yes, when and where were they done? _____
- Please indicate which foot problems you now have or have had in the past:

☐ Ankle Pain
☐ Ankle Instability (Easy Twisting Injuries)
☐ Ankle Swelling or Stiffness
☐ Achilles Tendon Pain
☐ Pale or Blue Discoloration of the Feet
☐ Swelling in Feet or Ankles
☐ Ingrown Toenails
☐ Athlete's Foot
☐ Corns/Calluses
☐ Plantar Wart
☐ Heel or Arch Pain
☐ Cramps in Feet or Legs
☐ Leg Pain
☐ Tired Feet
☐ Bunions
☐ Flat Feet
☐ Numbness in Feet/Toes or Legs
☐ "Toe-in"or"Toe-out" Gait (Walking)
☐ Pain or Fatigue of Feet or Legs During Activity or Exercise
☐ Non/Poor Healing Sore, Ulcer or Gangrene on the Leg or Foot

- Have your ever been to a podiatrist before? ☐ Yes ☐ No

  Last Visit? _____

Medical History

Name: _____ **D.O.B:** _____

Please indicate with a (✓) any of the medical conditions below that pertain to you

- ☐ Abdominal Aortic Aneurysm
- ☐ AIDS/HIV
- ☐ Allergies (Seasonal)
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Heart Valves/Joints
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Back Problems
- ☐ Benign Prostatic Hypertrophy
- ☐ Blood Disorder
- ☐ Blood Clots/DVT/PE
- ☐ Cancer
- ☐ Cardiomyopathy
- ☐ Chemical Dependency
- ☐ Circulation Problems
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ CVA (Stroke)
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ DNR
- ☐ Edema
- ☐ Epilepsy
- ☐ Fainting
- ☐ Fracture
- ☐ GERD
- ☐ Glaucoma
- ☐ Gout
- ☐ Headaches
- ☐ Hearing/Ear Problems
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Keloids/Thick Scars
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lyme's Disease
- ☐ Macular Degeneration
- ☐ Mitral Valve Prolapse
- ☐ Neuropathy
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Palpitations
- ☐ Phlebitis
- ☐ Pneumonia
- ☐ Polio
- ☐ Psychiatric Care
- ☐ Pulmonary Nodule
- ☐ Radiation Treatment
- ☐ Rash
- ☐ Rheumatic Arthritis
- ☐ Rheumatic Fever
- ☐ Sciatica
- ☐ Sinus Problems
- ☐ Skin Disorder
- ☐ Sleep Apnea
- ☐ Stomach Ulcers
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Vascular Disease
- ☐ Varicose Veins
- ☐ Venereal Disease
- ☐ Varicose Veins
- ☐ Weight Loss
- ☐ Other: _____

_____

_____

_____

Surgical History

- ☐ Amputation of Foot or Toes
- ☐ Ankle Surgery
- ☐ Bariatric Surgery
- ☐ Bunion Surgery
- ☐ Colon Surgery
- ☐ Foot Surgery
- ☐ Fracture Repair
- ☐ Hammertoe Surgery
- ☐ Hip Replacement
- ☐ Knee Replacement
- ☐ Open Heart Surgery
- ☐ Organ Transplant
- ☐ Pacemaker/Defibrillator
- ☐ Vein Surgery

Please list all other surgeries: _____

Allergies

Are you allergic or sensitive to any of the following:

☐ No Known Drug Allergies

- ☐ Penicillin
- ☐ Sulfa
- ☐ Tape
- ☐ Latex
- ☐ Betadine (iodine)
- ☐ Aspirin
- ☐ Tylenol
- ☐ Ibuprofen
- ☐ Vicodin
- ☐ Codeine
- ☐ Local or General Anesthesia
- ☐ Other: _____

Medication List

Please list current medications prescribed by a doctor, including over the counter medications, vitamins, and supplements: _____

_____

_____

Social History

Name: _____ **D.O.B:** _____

Please indicate with a (✓) any of the responses below that pertain to you

- Tobacco Use:
  - Cigarettes: ☐ Never Smoked
    ☐ Current Smoker _____Packs per day _____Number of Years
    ☐ Former Smoker _____Number of Years _____Quit Date
  - Other Tobacco: ☐ Vape ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew
  - Are you interested in quitting? ☐ Not Ready to Quit
    ☐ Thinking about Quitting
    ☐ Ready to Quit
- Alcohol: ☐ None ☐ Rarely ☐ Moderate ☐ Quit
- Drug Use: ☐ Yes ☐ No
- Exercise:
  - Do you exercise daily regularly: ☐ Yes, List Activities:_____ ☐ No

Family History

Please indicate with a (✓) for any responses below that pertain to your family members

Medical Condition	Father	Mother	Siblings	Children
Living				
Deceased				
AAA-Abdominal Aortic Aneurysm				
Cancer				
CHF – Congestive Heart Failure				
COPD				
Diabetes				
DVT				
Gout				
Heart Disease				
Hypertension				
Thyroid Disease				
Unknown				

Authorization to Access Electronic Prescription Records

I authorize Jackson Family Foot & Ankle Care and Dr. Christopher Blakeslee to view my external prescription history via electronic prescribing services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies and pharmacy benefit managers may be viewable by my provider and staff here. It may include prescriptions back in time for several years and may include prescriptions to treat HIV, substance abuse and psychiatric conditions, if applicable. I understand that my prescription history will become part of my Jackson Family Foot & Ankle Care medical record.

_____I agree to allow access to my electronic prescription records.

Health Information Exchange (HIE)

Jackson Family Foot & Ankle Care also participates in electronic health information exchanges (HIEs) with hospitals and various other health care providers. I authorize Jackson Family Foot & Ankle Care and the HIEs with which it participates to share my health information, through the HIE networks, for purposes permitted by law, including my treatment and coordination of my care, with all health care providers that are authorized under the HIEs' policies and applicable law to access my information. I understand and agree that the information about me that may be shared and accessed through the HIEs may include information about HIV/AIDS status, sexually transmitted diseases, family planning, mental health treatment, genetic test results, use of alcohol and other substances and other sensitive categories of my health information. I understand that I have the right to "opt-out" of having my information shared through HIEs.

_____I agree to allow access to HIE (Health Information Exchange).

Consent to Treat

I, the underlying, voluntarily consent to and authorize Dr. Christopher Blakeslee and the employees of Jackson Family Foot & Ankle Care to provide such podiatric care and examinations, on a continuing basis, and to administer such routine diagnostic, radiological and/or therapeutic procedures, test and treatments as are considered necessary or advisable, in my diagnosis, care and treatment, in the judgement of Dr. Christopher Blakeslee, including, but not limited to, collecting and testing specimens, and administration of pharmaceutical products. I acknowledge that no guarantees have been made to me about the results of any examination or treatment.

_____I agree to treatment as described above.

Acknowledge and Agreement

Please initial the following stating you have read and agreed;

_____I acknowledge receipt of the Notice of Privacy Practices.

_____I have read this form, my questions have been answered, and I understand and agree to its content.

Print Patient/Representative's Name: _____ **D.O.B:** _____

Patient/Representative's Signature: _____ **Date:** _____

If signed by Authorized Representative, print name of Signatory Patient: _____

Relationship to Patient/Authority to Sign for: _____

Financial Policy for Jackson Family Foot and Ankle Care

Thank you for choosing our office for your medical care. We are committed to serving you with skill and quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

INSURANCE: We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

MEDICARE: We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. However, that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any copayments, which are usually 20% for the allowed amount for an item or service

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance (if any) after payment and /or explanation of benefits (EOB) is received from your primary insurance company.

COPAYMENTS AND DEDUCTIBLES: All copayments and deductibles must be paid at the time of services. This arrangement is part of your contract with your insurance company. Failure on our part to collect copayments or deductibles from patients can be considered fraud. Please help us in upholding the law by paying your copayment at each visit.

SELF PAY: Payment in full is due at the time of service if you do not have health insurance.

NON-COVERED SERVICES: Please be aware that some of the services that you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payment of these services.

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan which mandates us that when you visit a specialist such as ours, you must have a referral from your primary care physician prior to seeking specialty care. Therefore, you are finically responsible for the services received, unless your referral is presented at the time of this visit. If you do not have a referral from your primary care physician at the time of a visit, you will be financially responsible for all services received due in full upon completion of the visit. Full credit will be given if a referral is presented to our office within 48 hours of this visit. You will also be given the option to reschedule your appointment

CLAIM SUBMISSION: We will submit you claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

PATIENT BILLING: You will be sent a statement for any outstanding balance owed after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. **If a second or third statement is required, a $10 rebilling fee will be added to your account for each subsequent statement. You will be sent up to three notices of your financial responsibility** (coinsurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. **If payment is not received after the third and last notice, your account will be forwarded to collections (with a $50 fee) or small claims court (where additional fees will apply)**. Please let the billing office know if you have any difficulties resolving your bill. Payment arrangements can be made on a case by case basis. We accept the following payment methods: Cash, Check or Visa/MasterCard/AMEX. An additional $50.00 will be added to your statement if the check is returned for insufficient funds. In the event that your insurance company should happen to send payment to you, the patient, we expect that you would forward it you our office to be applied to your balance.

MISSED/CANCELED APPOINTMENTS: If 24-hour notice is not giving for any cancellation or missed appointment, I will be subject to a $25 fee. A $75 cancellation fee will be charged for any missed home visits. See separate house call policies and guidelines.

PRIVACY STATEMENT: Any information disclosed in your records will remain confidential and will not be used for any other reason except in providing quality care and treatment as well as to submit your claim to your insurance company and contact you as needed.

Assignment of Benefits

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to **Jackson Family Foot and Ankle Care** all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, copayments and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested by physicians to provide continuity of care. I authorize the use of this signature on all insurance submissions.

I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance and acknowledge I was provided with a copy of the Notice of Privacy Practices and understand and accept its terms. **I have read the above policy regarding my *financial responsibility* to Jackson Family Foot and Ankle Care for medical services provided. I agree to pay Jackson Family Foot and Ankle Care any balance unpaid by my insurance carrier for myself or the below named person.**

PRINT Patient Name:_____ Signature: _____

FINANCIALLY RESPONSIBLE PARTY

PRINT Name:_____ Signature:_____

Relationship to Patient:_____ Date: _____