



Welcome to Central Florida Foot and Ankle Center, LLC

PATIENT INFORMATION	INSURANCE INFORMATION
Date _____ Birth Date _____ Sex <input type="checkbox"/> M <input type="checkbox"/> F Patient Name _____ Address _____ City _____ State _____ Zip _____ Out of State Address _____ City _____ State _____ Zip _____ SS# _____ DL# _____ E-Mail _____ <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <p style="text-align: center;">PHONE NUMBERS</p> Home Phone (____) _____ Cell Phone (____) _____ <p>In case of emergency, contact</p> Name _____ Relationship _____ Phone (____) _____ <p>How did you hear about us? _____ Google, Yahoo, Online, Patient, RefDoctor, YellowPages, Family, Friend</p> Have you ever been to a Podiatrist before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list. Name _____ Last Visit _____	Name of Insured _____ Name of PRIMARY Insurance _____ Policy# _____ Is patient covered by additional insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Insured _____ Name of SECONDARY Insurance _____ Policy# _____ <p>INSURANCE ASSIGNMENT AND RELEASE</p> I request that payment of authorized benefits will be made on my behalf to Central Florida Foot and Ankle Center, LLC for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown in assigned cases, the physicians or suppliers agree to accept the charge determination of the insurance carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, copay and/or non-covered on unpaid services. Coinsurance, copay, and the deductible are based upon the charge determination of the carrier. _____ / ____ / ____ Signature of Patient, Guardian or Personal Representative Date Office use only: Verified by: _____ Date: _____ DL: _____ Checked by: _____ Date: _____ INS: _____

PODIATRIC HISTORY		
What is the chief complaint for which you came to have treated? _____ <div style="background-color: #e0e0e0; padding: 5px;"> <p>Is this injury/problem related to:</p> <p>Work <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Car Accident <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Personal Injury Case? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is there an ongoing lawsuit regarding this injury? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> </div>	Occupation/Job _____ Cigarette/Tobacco use _____ Years Smoked _____ Shoe size:____ Weight:____ Height: ____ Are you in the past or currently on any type of street drug <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what type of Drug? _____ Athletic activities in which you participate (please list and indicate frequency) _____ How long have you had the problem? ____ Describe your pain: _____	Please indicate which foot problems you have now or have had in the past. Ankle Pain <input type="checkbox"/> Yes <input type="checkbox"/> No Bunions <input type="checkbox"/> Yes <input type="checkbox"/> No Corns and Calluses <input type="checkbox"/> Yes <input type="checkbox"/> No Numbness in Feet/Legs <input type="checkbox"/> Yes <input type="checkbox"/> No Flat Feet <input type="checkbox"/> Yes <input type="checkbox"/> No Foot or Leg Cramps <input type="checkbox"/> Yes <input type="checkbox"/> No Heel Pain <input type="checkbox"/> Yes <input type="checkbox"/> No Ingrown Toenails <input type="checkbox"/> Yes <input type="checkbox"/> No Rate your pain level (1-10) _____

Please **CIRCLE** to indicate if you have had any of the following:

Acid Reflux / GERD Amputation of Body Part or Limb AIDS/HIV Arthritis Artificial Heart Valves Artificial Joints Cancer Type: _____ Chemical Dependency to what? _____	Circulatory Problems COPD Diabetes Yrs _____ type _____ Ear Problems Epilepsy Gout Hepatitis or Jaundice type _____ when _____	High Blood Pressure High Cholesterol Kidney Problems Liver Disease Low Blood Pressure Neuropathy Pacemaker Psychiatric Care when _____	RSD/CRPS Tuberculosis Ulcers Varicose Veins History of DVT/Blood Clot Other: _____ _____ NONE APPLY (circle if applicable)
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Patient Name: _____

Are you currently PREGNANT or is there a chance you could be pregnant? _____ Last Menstrual Date: _____

Family Physician _____ Date of last visit _____

List of Surgeries you have had: _____

Allergies (write NONE if no known drug allergies): _____

MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins (write NONE if not on any medications):

Pharmacy Name(s) _____ Pharmacy Phone(s) (_____) _____

Do you take oral contraceptives? No Yes Do you take any blood thinners? No Yes what _____

TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

Signature of Patient, Parent, Guardian or Personal Representative Date

Please print name of Patient, Parent, Guardian or Personal Representative Date

**Acknowledgment of Notice of Privacy Practices,
Policies and Procedures
and Permission Form**

I have received /had the opportunity to read and understand this practice's Notice of Privacy Practices written in plain language. The notice was updated on 9/23/2013 and provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information, resident at, or controlled by, this practice. If changes to the policy occur, this practice will provide me with a revised Notice of Privacy Practices upon written request.

Signature of patient or responsible party Date

Acknowledgment of Policies and Procedures

Policies and procedures for CFFAC can be found online at www.flfootandankle.com. By signing below, I testify that I have read, been given the opportunity to read or can request a copy of the policies and procedures at the time of my appointment for my own records. I understand these policies and procedures and will adhere to them.

Also, I authorize the release of any medical information necessary to my insurance company, hospitals or physicians involved in my care. I also authorize payment of medical benefits to Central Florida Foot and Ankle Center and any/all doctors of Central Florida Foot and Ankle Center.

Signature of patient or responsible party Date

Patient Name: _____

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

The Patient hereby consents to the use or disclosure of his/her individually identifiable health information ("protected health information") by Central Florida Foot and Ankle Center, LLC. in order to carry out treatment, payment, or health care operations. The Patient should review the Practice's Notice of Privacy Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information, and the Patient has the right to review such Notice prior to signing this consent form.

Practice reserves for itself the right to change the terms of its Notice of Privacy Practices for Protected Health Information at any time. If the Practice does change the terms of its Notice of Privacy Practices, Patient may obtain a copy of the revised Notice.

Patient retains the right to request that the Practice further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Practice is not required to agree to such requested restrictions; however, if the Practice does agree to Patient's requested restriction(s), such restrictions are then binding on the Practice.

Patient acknowledges and agrees that the Practice may disclose Patient's protected health information and patient medical record information to the following individuals who are the Patient's family members, legal representatives, guardians, health care surrogates, or have power of attorney on behalf of the Patient:

******* Note: The names of the individuals must be listed in order for information to be release. Do not leave blank *******

- | | |
|--|---|
| <input type="checkbox"/> PCP _____ | <input type="checkbox"/> REFERRING DOCTOR _____ |
| <input type="checkbox"/> INSURANCE _____ | <input type="checkbox"/> FAMILY MEMBER _____ |
| <input type="checkbox"/> OTHER _____ | <input type="checkbox"/> ALL (NO RESTRICTIONS) |

The Patient **agrees that the Practice may disclose** the following types of information contained in the Patient's medical records (please initial the appropriate categories listed below):

- _____ HIV/AIDS Information
- _____ Mental Health Information
- _____ Substance Abuse Information
- _____ Sexually Transmitted Disease Information
- _____ If Patient is under the age of eighteen (18), Pregnancy Information
- _____ All current and past medical conditions/treatment
- _____ These conditions do not apply

Patient agrees and consents to the Practice releasing information to Patient in the following alternative manners (please initial the appropriate spaces below):

- _____ Via Regular Mail with any envelopes being marked personal and confidential and addressed to Patient.
- _____ Via telephone, if Patient contacts the Practice and provides the appropriate information (including the Patient's name, social security number and unique personal identifier).

At all times, Patient retains the right to revoke this Consent. Such revocation must be submitted to the Facility in writing. The revocation shall be effective except to the extent that the Practice has already taken action in reliance on the Consent.

The Practice may refuse to treat Patient if he/she (or an authorized representative) does not sign this Consent Form (except to the extent that the Practice is required by law to treat individuals). If Patient (or authorized representative) signs this Consent Form and then revokes Consent, the Practice has the right to refuse to provide further treatment to Patient as of the time of revocation (except to the extent that the Practice is required by law to treat individuals).

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS SEALED DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

Date: _____ Time _____ AM/PM

Signature of Patient (or Authorized Representative*)

Please print name

