Welcome to Central Florida Foot and Ankle Center, LLC

PATIENT INFORMATION

Date_____
Birth Date_____ Sex ☐M ☐F
Patient Name_____
Address_____ _____
City_____ State_____ Zip____ _____
Out of State Address_____
City_____ State_____ Zip__ _____

SS#_____DL#_____ _____
E-Mail_____
☐ Married ☐Widowed ☐ Single ☐Separated ☐ Divorced

PHONE NUMBERS

Home Phone (____)_____
Cell Phone (____)_____

In case of emergency, contact
Name_____ _____
Relationship_____ _____
Phone (_____)_____

How did you hear about us? _____
Google, Yahoo, Online, Patient, RefDoctor, YellowPages, Family, Friend

Have you ever been to a Podiatrist before?
☐Yes ☐ No If yes, please list.
Name_____
Last Visit_____

PODIATRIC HISTORY

Reason for your appointment today:
_____

Is this injury/problem related to:
Work ☐ **Yes** ☐ **No**
Car Accident ☐ **Yes** ☐ **No**
Personal Injury Case? ☐ **Yes** ☐ **No**

Is there an ongoing lawsuit regarding this injury? ☐ **Yes** ☐ **No**

Occupation/Job_____
Cigarette/Tobacco use_____
Years Smoked_____
Shoe size:____ Weight:____ Height: ___
Are you in the past or currently on any type of street drug ☐Yes ☐ 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: _____
Rate your pain level (1-10) _____
Family Physician: _____ Last Visit: _____

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)

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):
_____

Patient Name: _____

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 *********

☐ PCP _____ ☐ REFERRING DOCTOR _____

☐ INSURANCE _____ ☐ FAMILY MEMBER _____

☐ OTHER _____ ☐ 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

Central Florida Foot and Ankle Center
Credit Card Authorization Form

Patient Name: _____ **DOB**: _____

Guardian's Name (if applicable): _____

Email: _____

Phone number: _____ **Alt #**: _____

The purpose of this form is to authorize Central Florida Foot and Ankle Center to retain a valid credit card number on file for you our patient**.** ***If you are paying for copays, deductibles, coinsurance, balances, non-covered services, etc. by card today, the credit card information will be automatically saved to the bank's secure database at the time of processing.***

Your supplied credit card will be charged **ONLY** under the following circumstances:

1.) If you, as the patient receives services within our office that are non-covered, denied, applied to deductible, or for any reason not paid by your insurance carrier, CFFAC reserves the right to charge the credit card on file for charges that you are responsible for. A message will be sent to the email that you have provided above and you will have 5 business days to respond. If no email address is present or the email is rejected, then you will receive a phone call at the number on file. If no response to email/phone call after 5 business days, the credit card on file will be charged the full balance amount. A receipt will be mailed at your request. If you're balance is $100 OR LESS, we will reach out to you by phone one time and you will have 24 hours to get back to us. (If you are called on a Friday, we must hear from you by the end of the day on Monday). If we do not hear back from you, your card will be charged the full balance. We highly encourage you to make sure your information on file is accurate at all times. **(Patient Initials _____)**

2.) If you, as the patient, miss a scheduled appointment without 24 hour notice to cancel or reschedule, CFFAC reserves the right to charge the credit card listed below, $35.00 for our standard no-show fee. This notice serves as your consent to be charged for all no-shows. A receipt will be mailed upon your request. *(As is customary, an automated system for CFFAC will call the phone number on file to remind you of your scheduled appointment. this reminder is usually done 24 hours prior to your scheduled appointment. It is the patient's responsibility to ensure that we have a correct, current telephone number on file)*

3.) If you, as the patient, request paper records and do not pick the records up after preparation, CFFAC reserves the right to charge the credit card on file for the fees involved. *(Medical Record Policy will be followed: consent must be signed, pt will be notified of the cost prior to preparation, CFFAC will release within 5 business days or receipt of request, pt will be notified once ready)*

Other than the conditions mentioned above, under **NO** circumstance will CFFAC charge your credit card for anything not discussed with you personally. In conjunction with HIPAA regulations, all credit card information will be confidentially kept within your medical chart in our office. Only authorized staff will be able to access this information.

Acknowledged, Agreed, and Accepted:
Having read this form and talked with the physician, and/or staff, my signature below acknowledges that I voluntarily give my authorization and consent to providing the requested information for my credit card to be charged accordingly for the conditions listed above.

****** Please note: If you are paying by CASH, Flex Spending Card or HSA Visa/Mcard today for your copay, deductible, coinsurance, non-covered services, supplies, etc., you will still be required to place a credit card on file that is saved to the bank's secure database or complete info below. Please be prepared to provide this information to the front desk at check-in prior to being seen******

Circle One: **VISA** **MCARD** **DISCOVER**

Name on Card (name must match signature on file): _____

Card Number: _____ **Expiration:** _____ **Zip:** _____

*x*_____ _____
Patient Signature *Date*

(eff 2/2018)