Kentucky / Indiana
Foot and Ankle Specialists

Care That's Always a Step Ahead.

PATIENT REGISTRATION FORMS

Last Name:_____ First Name: _____ Middle Initial: _____ DOB:____ /____/_____

Street Address: _____ City: _____ State:____ Zip: _____

Cell Phone: ____- ____- _____ Secondary Phone: ____- ____- _____ SSN: ____ - ____ - _____ Sex: M / F

Email: _____ (for patient portal purposes only)

Marital Status (please check): ☐S ☐M ☐W ☐D Other Language: _____

Ethnicity (please check) ☐ Hispanic or Latino ☐ Non Hispanic or Latino ☐ Other

Race (please check) ☐ Alaskan Native / American Indian ☐ Asian ☐ Black / African American

☐ Native Hawaiian / Other Pacific Islander ☐ White ☐ Declined to Answer

Employer: _____ Work Phone: _____

Primary Care Physician: _____ Practice Name: _____ Phone: _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

GUARANTOR INFORMATION: COMPLETE THIS SECTION IF PATIENT IS A MINOR

Patient's Relationship to Guarantor: _____ Name: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Employer: _____ Work Phone: _____

SSN: _____ - _____ - _____ DOB: _____ / _____ / _____ Sex: M / F

Are you POWER OF ATTORNEY or LEGAL GUARDIAN of the patient? (circle one): Yes / No

****If yes, you MUST provide our office with the appropriate paperwork before treatment will be performed.**

INSURANCE INFORMATION: We must have copies of ALL insurance cards if filing with personal insurance.

Please Circle One: Personal Insurance? Work Comp? Self-Pay? Auto Ins.?

Date of Injury / Onset of Symptoms: _____ /_____/_____

Primary Insurance: _____ ID / Policy #: _____

Subscriber Name: _____ DOB:____/____/____ Patient Relation to Insured Party: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ SSN: ____- ____ - _____ Sex: M / F

Subscriber Employer Name / Phone: _____

Adjuster's Name and Phone: _____ Address: _____

Secondary Insurance: _____ ID / Policy #: _____

Subscriber Name: _____ DOB:____/____/____ Patient Relation to Insured Party: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ SSN: ____- ____ - _____ Sex: M / F

Subscriber Employer Name / Phone: _____

Patient Name: _____ Date: _____

Height: _____ feet _____ inches Weight: _____ lbs. Shoe Size _____

Please tell us your chief foot / ankle complaint today: _____

CONSENT TO OBTAIN ELECTRONIC MEDICATION HISTORY, TELEPHONE CALLS AND EMAIL USAGE

I understand that my medication history may be obtained utilizing electronic information exchange and that this protected health information may provide valuable information for my healthcare provider. I hereby authorize KY/IN Foot & Ankle Specialists to access my medical history without limitations or exclusions as is required and/or reasonably advisable to disclose, process, retrieve, transmit and view, for the purpose of the transmission of an electronic prescription issued by a provider authorized by law to prescribe, as necessary for my care and treatment.

If at any time I provide a telephone number at which I may be contacted, I consent to receive calls or text messages, including, but not restricted to communications regarding billing and payment for items and services, unless I notify the provider to the contrary in writing. In this section, calls and text messages include but are not restricted to prerecorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication from the hospitals, contractors, servicers, clinical providers, attorneys or its agents, including collection agencies.

If at any time I provide my email address at which I may be contacted, unless I notify the provider to the contrary in writing, I consent to receiving communications regarding billing and payments for items and services at the email address from the hospitals, contractors, servicers, clinical providers, attorneys or its agents, including collection agencies.

_____ _____

Pharmacy Name & Phone #: **Pharmacy Location:**

X _____

Signature

List all your **CURRENT MEDICATIONS**: _____

_____

_____

_____

☐ Check if none

Are you a patient of a Pain Management program? ☐ Yes ☐ No If yes, Physician's Name: _____ Phone: _____

• If you are under the care of a pain management physician, our office requires all narcotics to be prescribed through that physician.

• Failure to provide accurate information will result in discharge from our practice.

Are you allergic to any medications, x-rays, or other substances? Yes / No (If yes, please mark all that apply):

☐ Novocaine	☐ Demerol	☐ Tape
☐ Darvon	☐ Dye	☐ Penicillin
☐ Aspirin	☐ Latex	☐ Iodine
☐ Sulfa	☐ Mercurials	☐ Other: _____
☐ Codeine	☐ Merthiolate	_____

GENERAL SOCIAL HISTORY

Smoking: ☐ Never Smoked ☐ Current Every Day Smoker ☐ Former Smoker

If you are a smoker or a former smoker: Number of years? _____ Number of packs per day? _____

Alcohol: I drink ☐ Never ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely

Recreational Drug Use: ☐ Yes ☐ No ☐ Former User Type of substance used: _____

Are you currently disabled? ☐ Yes ☐ No

Do you have a living will? ☐ Yes ☐ No Do you have a durable power of attorney? ☐ Yes ☐ No

If yes, who? _____ Phone: (____) _____

Occupation: (Please describe briefly what your job requires.) _____

_____

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FAMILY HISTORY

Has any member of your family ever had the following conditions? *(Check Yes or No)*

Bleeding Diseases ☐ Yes ☐ No Relation: _____
Cancer ☐ Yes ☐ No Relation: _____
Diabetes ☐ Yes ☐ No Relation: _____
Drugs / alcohol addiction ☐ Yes ☐ No Relation: _____
Heart Disease ☐ Yes ☐ No Relation: _____
Hypertension ☐ Yes ☐ No Relation: _____
Mental Disease (anxiety, depression, etc.) ☐ Yes ☐ No Relation: _____
Strokes ☐ Yes ☐ No Relation: _____
Other: _____

PATIENT MEDICAL HISTORY

Are you (**patient**) currently or have you previously received treatment for the following?

CONDITION	YES	NO	CONDITION	YES	NO	CONDITION	YES	NO	CONDITION	YES	NO
1. Anemia			11. Diabetes			21. Hypothyroidism			30. Rheumatoid Arthritis		
2. Anxiety			12. Epilepsy or seizures			22. Kidney or Bladder Problems			31. Skin Conditions / Psoriasis		
3. Arthritis			13. Fibromyalgia								
4. Asthma			14. GERD			23. Liver Problems			32. Sleep Apnea		
5. Bleeding disorder			15. Gout			24. Lung Problems			33. Stomach Problems		
6. Blood Clots / DVT			16. Heart Disease			25. Lymphedema			34. Stroke		
7. Cancer			17. Hepatitis			26. MRSA			35. Ulcers		
8. Chemical Dependency			18. High Blood Pressure			27. Neuropathy			36. Vancomycin-Resistant Enterococci		
9. Cholesterol (high)			19. HIV / AIDS			28. Osteoporosis					
10. Chronic Pain			20. Hyperthyroidism			29. PVD			37. Other		

SURGERIES / HOSPITALIZATIONS

Have you ever had surgery or been hospitalized? ☐ Yes ☐ No If yes, please fill in the below:

OPERATION or REASON FOR ADMISSION	DATE	ANY PROBLEMS?

Have you or anyone in your family had problems or reactions to anesthesia? _____

REVIEW OF SYSTEMS

1. CONSTITUTIONAL	☐ NONE ☐ Fatigue ☐ Weight Gain ☐ Weight Loss ☐ Fever ☐ Weakness ☐ Decline in Health ☐ Other
2. EYES	☐ NONE ☐ Blurry Vision ☐ Double Vision ☐ Eyeglasses/Contacts ☐ Pain with Light ☐ Unusual Sensations ☐ Cataracts ☐ Glaucoma ☐ Recent Injury ☐ Vision Loss ☐ Excessive Tearing ☐ Discharge ☐ Eye Pain ☐ Infections ☐ Redness ☐ Other
3. CARDIOVASCULAR	☐ NONE ☐ Painful Breathing ☐ Palpitations ☐ Chest Pain ☐ Swelling of legs ☐ Difficulty Breathing ☐ Heart Murmur ☐ Other
4. ENT	☐ NONE ☐ Sore Throat ☐ Mouth Sores ☐ Sinusitis ☐ Hearing Loss ☐ Other
5. ENDOCRINE	☐ NONE ☐ Heat/Cold Intolerance ☐ Hypothyroid ☐ Hyperthyroid ☐ Hair Loss ☐ Hot Flashes ☐ Other
6. GASTROINTESTINAL	☐ NONE ☐ Diarrhea ☐ Constipation ☐ Bloody Stool ☐ Pain ☐ Indigestion ☐ Nausea/Vomiting ☐ Stomach Ulcers ☐ Jaundice ☐ Other
7. HEAD	☐ NONE ☐ Headache ☐ Sweats ☐ Fainting ☐ Pain ☐ Dizziness ☐ Other
8. HEMATOLOGIC	☐ NONE ☐ Bruises ☐ Enlarged Lymph Nodes ☐ Bleeding ☐ Anemia ☐ Gout ☐ Other
9. MUSCULOSKELETAL	☐ NONE ☐ Muscle Weakness ☐ Muscle/Joint Pain ☐ Arthritis ☐ Gout ☐ Muscle Cramps ☐ Back Problems ☐ Joint Pain ☐ Muscle Stiffness ☐ Other
10. NEUROLOGIC	☐ NONE ☐ Severe Memory Problems ☐ Seizures ☐ Numbness ☐ Trouble Walking ☐ Tingling ☐ Burning ☐ Tremors ☐ Strokes ☐ Unsteady Gait ☐ Other
11. PSYCHIATRIC	☐ NONE ☐ Depression ☐ Crying ☐ Severe Anxiety ☐ Behavioral Change ☐ Disturbing Thoughts ☐ Mood Changes ☐ Hallucinations ☐ Nervousness ☐ Other
12. RESPIRATORY	☐ NONE ☐ Wheezing ☐ Coughing ☐ Shortness of Breath ☐ Spitting Up Blood ☐ Other
13. SKIN	☐ NONE ☐ Rash ☐ Dry Skin ☐ Sores ☐ Moles ☐ Itching ☐ Skin Color Change ☐ Eczema ☐ Hives ☐ Other
14. ALLERGIC	☐ Coughing ☐ Itchy Eyes ☐ Runny Nose ☐ Watery Eyes ☐ Coughing with Exercise ☐ Itchy Nose ☐ Sneezing ☐ Wheezing ☐ Other

FINANCIAL POLICY

We are glad you have chosen us to provide you with your health care. We are a professional service organization that is dedicated to the practice of medicine, specializing in podiatry. The mission of our practice is to provide high quality medical care at a fair and reasonable cost to those in the area. We charge what are usual and customary fees for our area.

Your insurance policy is a contract between you and your insurance company. Please understand our office cannot accept responsibility for collecting your insurance claim or negotiating a settlement on a disputed claim. Whatever the outcome of your insurance claim, you are responsible for payment of your account. Past due accounts are an extra cost in operating an office. Our costs, and therefore your cost, are substantially increased when bills are not paid promptly.

The following is a statement of our Financial Policy, which we require that you read and sign prior to treatment.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE.
WE ACCEPT CASH, PERSONAL CHECKS, AND CREDIT CARDS.

An exception to the above is the select insurance companies we bill directly or health maintenance organizations in preferred provider organizations we participate in. If we are a participating provider for your insurance company we will submit your claim directly to your managed care insurer. Co-payments, if any, will be collected at the time of your visit. Please be aware there is a possibility that some and perhaps all services provided may be a non-covered service that insurance did not consider reasonable and necessary under your medical insurance. If you received a service your insurance does not cover or if you have a deductible you have not met, we will request payment in full from you at the time you receive the service. Some insurance companies require a pre-certification with the insurance company prior to our doctors treating you. Please check your policy for this requirement.

Extended Payment Plan

We also understand that financial problems arise from time to time. Please let us know if you need to arrange a payment plan that allows you to pay off your balance in monthly installments. Our Patient Accounts Representative can assist you with these arrangements.

Thank you for reading and understanding our Financial Policy. Please let me know if you have any questions or concerns.

I have read, understand, and agree to this Financial Policy.

Signature of Responsible Party	**Date**

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MEDICARE: I request that payment of authorized Medicare benefits be made either to me or on my behalf to the above physicians for any services furnished by them. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine the benefits or the benefits payable for related services. I hereby authorize Medicare to furnish to the above named physicians any information regarding my Medicare claims under Title XVIII of the Social Security Act.

COMMERCIAL INSURANCE: I hereby authorize the release of information necessary to file a claim with my insurance company and assignment of benefits otherwise payable to me, to the doctor or group indicated on the claim that performs this service. I understand that I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

_____ _____

Signature of Patient **Date**

HIPAA RELEASE FORM

Date Completed: _____

Release of Information

☐ I authorize the release of information including my diagnosis, records, examinations rendered to me, and claims information. This information may be released to the following people:

- ☐ Spouse / Partner Name: _____
- ☐ Parent / Guardian(s) Name(s): _____
- ☐ Child(ren) Name(s): _____
- ☐ Physician(s) Name(s): _____
- ☐ Other: _____

☐ DO NOT RELEASE TO ANYONE

This release will remain in effect until terminated by me in writing.

MESSAGES / CALL PREFERENCE

Please call: ☐ My home ☐ My work ☐ My cell ☐ Other: _____

If unable to reach me: ☐ You may leave a detailed message.

ACKNOWLEDGMENT OF RECEIPT - NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

_____ _____

Patient Name (please print) **Patient Date of Birth**

_____ _____

Signature of Patient / Parent / Responsible Party **Date**

_____ _____

Print Name of Parent / Responsible Party (if applicable) Relationship to Patient

☐ Patient refused to sign this acknowledgment.

Employee: _____ Witness: _____

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CANCELLATION / NO SHOW POLICY

We understand that situations may arise in which you must cancel your appointment. It is therefore requested that if you must cancel or reschedule your appointment, you provide more than 24 hours notice. This will allow another patient who is waiting for an appointment to be scheduled in that appointment slot

Office appointments which are cancelled with less than 24 hours notification may be subject to a $35.00 cancellation fee.

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

Patients who do not show up for their appointment without a call to cancel will be considered as NO SHOW. Patients who No-Show three (3) times within a 12 month period will be discharged from the practice and denied any future appointments.

We understand that "special" unavoidable circumstances may cause you to cancel within 24 hours and fees in this instance may be waived but only with the Administrator's approval.

Please sign that you have read, understand and agree to this Cancellation and No Show Policy.

_____ _____

Patient Name (Please Print) **Date of Birth**

_____ _____

Signature of Patient or Patient Representative **Date**

POS Reorder # 1608633