PA Foot & Ankle associates

Specializing in Medicine and Surgery of the Foot & Ankle

Thank you for choosing PA Foot & Ankle Associates!

Patient Information			
First Name	Last Name	MI	DOB
Address	City	State	Zip Code
Social Security Number:	Gender:	Marital Status:	Preferred Language:
Home Phone:	Email:		
Cell Phone:	Employer Name:		
Work Phone:	Occupation:		

Primary Care Physician Information		
Name:	Phone Number:	Date Last Seen:
Endocrinologist Information		
Name:	Phone Number:	Date Last Seen:

Emergency Contact Information			
First Name:	Last Name:	Phone Number:	Relationship:

Insurance	
Name of Primary Insurance:	Name of Secondary Insurance:
Subscriber Name:	Subscriber Name:
Policy #	Policy #
Group #	Group #
Patient's relationship to subscriber: ❑ Self ❑ Child ❑ Spouse ❑ Other	Patient's relationship to subscriber: ❑ Self ❑ Child ❑ Spouse ❑ Other

I authorize PA foot & Ankle Associates to perform examination or treatment needed to diagnose and/ or treat my foot/ankle condition. I also authorize the taking of and usage of clinical photographs. It is understood that these photos may be used to further medical education and that my identity will be revealed. I further understand that these X-rays are the property of PA Foot & Ankle Associates.

_____ _____

Signature of Patient /Responsible Party Date

_____ _____

Name of Patient/Responsible Party (please print) Relationship to Patient

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Patient Name:_____ Date of Birth:_____

PODIATRIC HISTORY

What is your present foot or ankle problem?

_____

_____

Where is the problem located? ☐Toe ☐Ball of foot ☐Midfoot/Arch ☐Heel ☐Ankle ☐Leg

What is the level of pain? ☐Mild ☐Moderate ☐Severe

What type of pain are you experiencing? ☐Aching ☐Throbbing ☐Burning ☐Shooting ☐Stabbing ☐Sharp

☐Numbness ☐Stiffness ☐Cramping ☐Other:_____

What is the duration of the symptoms? ☐ Days ☐Weeks ☐Months ☐Years

Does anything improve the symptoms? _____

Does anything worsen the symptoms?

_____

Are symptoms worse at a time of the day? _____

What is the frequency of pain? ☐Intermittent ☐Constant ☐After Rest ☐Other:

Did the symptoms occur as a result of an injury? ☐ Yes ☐No

What treatment(s) have been rendered by yourself or a physician? (Shoe inserts, medication, injections, etc.?)_____

Does your occupation require prolonged walking or standing? ☐Yes ☐No

What best describes your activity level? ☐Inactive ☐ Moderate ☐Active ☐Very Active

Did you have any foot or ankle problems as a child? ☐Yes ☐ No

Have you experienced any of the following conditions?

Ankle Pain	☐Yes ☐No	Athlete's Foot	☐Yes ☐No
Bunions	☐Yes ☐No	Corns and Calluses	☐Yes ☐No
Cramps Foot/Leg(s)	☐Yes ☐No	Flat Feet	☐Yes ☐No
Numbness Foot/Leg(s)	☐Yes ☐No	Heel Pain	☐Yes ☐No
Ingrown Toenails	☐Yes ☐No	Plantar Warts	☐Yes ☐No
Infectious Feet	☐Yes ☐No	Ulcerations	☐Yes ☐No
Amputations	☐Yes ☐No	Swelling Ankle/Feet	☐Yes ☐No

Other: _____

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Patient Name:_____ Date of Birth:_____

Medical History: Please check if you have ever experienced any of the following conditions-	
Cardiovascular-	**Respiratory-**
☐Heart Attack	☐Asthma
☐Heart Murmur	☐Emphysema
☐Pacemaker	☐Chronic Cough
☐Bypass Surgery	**Endocrine-**
☐High Blood Pressure	☐Diabetes
☐Chest Pain	☐Hypothyroid
☐Heart Failure	☐Hyperthyroid
☐Artificial Valve	☐Low Blood Sugar
☐Swelling in Ankles	**Digestive-**
Nervous-	☐Hepatitis
☐Stroke	☐Jaundice
☐Epilepsy	☐Reflux
☐Headaches	☐Ulcers
☐Numbness/tingling	**Urinary-**
☐Fainting/Dizziness	☐Kidney Disease
☐Paralysis	☐Dialysis
Musculoskeletal-	☐ Kidney Stones
☐ Arthritis	☐ Burning
☐ Artificial Joint	**Skin-**
☐ Gout	☐ Rash/Hives
☐ Joint Infraction	☐ Open Wound/Blisters
☐ Weakness	☐ Dry/Scaly
☐ Spasms	☐ Change in Color
☐ Back Pain	**Blood-**
Psychiatric-	☐ Difficult Clotting
☐ Depression	☐ Bruise Easily
☐ Anxiety	☐ Anemia
☐ Bipolar	**Other-**
☐ Schizophrenia	☐ Cancer
HEENT-	☐ HIV
☐ Hearing Impairment	☐ Smoke/ How much?
☐ Visual Impairment	☐ Alcohol/ How much?
☐ Throat Conditions	
☐ Ringing in the ear(s)	
☐ Balance Disturbance	
☐ Sinus/Allergies	

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Patient Name:_____ Date of Birth:_____

FAMILY HISTORY: (Blood relatives only, not family members related by marriage) Indicate the disease in the disease column and place a check mark in the family member's column who had the disease.					
Disease	**Mother**	**Father**	**Grandmother**	**Grandfather**	**Other**
Asthma/Respiratory Disease					
Cancer					
Diabetes					
Gout					
Heart Disease					
Severe Arthritis					
Strokes					
Other					

Prior Surgeries: List all surgeries & dates ☐**NO Previous Surgeries**

Allergies: List all know allergies (medications, food, animals, etc.)

Medications: List all medications and dosage (Including prescriptions, over the counter medications, vitamins and herbal medicines)	
Medication Name	*Dosage*

Pharmacy Information:	
Name:	Address:
Phone:	

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Communication Consent Form

Patient Name: _____ Date of Birth: _____

I agree to allow PA Foot & Ankle associates to contact me using the following methods regarding my personal health information, evaluation and treatment. I authorize/do not authorize PA Foot & Ankle associates to leave messages for me when I am unavailable as indicated below.

INITIAL TO CONFIRM APPROVAL OF METHOD	METHOD	NUMBER/ADDRESS	MESSAGES (YES OR NO)
	Home Phone	( ) -	☐Yes ☐ No
	Cell Phone	( ) -	☐Yes ☐ No
	Text Messaging	( ) -	☐Yes ☐ No
	Work Phone	( ) -	☐Yes ☐ No
	Email		☐Yes ☐ No

I authorize PA Foot & Ankle associates and medical staff to discuss my personal health information with the individuals listed below. I understand that by leaving spaces blank, I am indicating my choice that I do not want my information shared with or released to anyone else not otherwise authorized under the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH).

Name	Relationship to Patient	Contact Information

By my signature below, I hereby acknowledge that I have read and understand the information provided on this Consent Form. I understand the risk associated with different methods of communication, especially email, and consent to the communications outlined in this Consent Form.

_____ _____

Signature of Patient /Responsible Party Date

_____ _____

Name of Patient/Responsible Party (please print) Relationship to Patient

Release of Billing Information

_____(initial)I hereby authorize PA foot & Ankle Associates to; (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from PA Foot & Ankle Associates on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement.

Assignment of Benefits

_____(initial)I hereby assign all medical benefits to include major medical benefits to which I am entitled. I hereby authorize and direct insurance carrier(s), include Medicare, Medicaid, private insurance and any other health/medical plan, to issue payment check(s) directly to PA Foot & Ankle associates for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Acknowledgement of Receipt of Notice of Privacy Practices

_____(initial)I acknowledge that I have received a copy of PA Foot & Ankle Associates Notice of Privacy Practices. This notice describes how PA Foot & Ankle Associates may use and disclose my protected health information, certain restrictions on the use and disclosure of my health information, and the rights I may have regarding my protected health information.

I, or my legal representative, certify that I have read this document, that it has been fully explained to me and that I understand its contents, and hereby agree to all terms and conditions set forth above and acknowledge the receipt of a copy if requested.

_____ _____

Signature of Patient /Responsible Party Date

_____ _____

Name of Patient/Responsible Party (please print) Relationship to Patient

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Financial Policy

Thank you for choosing PA Foot & Ankle Associates. We realize you have a choice in selecting healthcare and we are honored you have chosen us. Our staff is committed to providing our patients with the highest quality of care possible. In doing so, we would like to provide you with information regarding our office policies. Please feel free to contact or office anytime Monday – Friday during routine business hours if you have questions, concerns, or suggestions.

- *Verification of Benefits*- We will attempt to verify coverage and benefits prior to your visit. If we are unable to obtain a verification of coverage, you may be asked to pay in full or reschedule your visit for a time the verification can be obtained. This verification will be used to estimate your financial responsibility; however, this verification is not a guarantee by your health plan to pay for services received. **You are responsible for obtaining an insurance referral from your primary care provider**.
- *Payment of Patient Responsibility*- Payment of your estimated patient responsibility is expected at the time services are rendered. This payment will include known deductibles, copays, and coinsurance amounts applicable for each visit and or procedure. While we may estimate your financial responsibility, it is your insurance company that makes the final determination regarding eligibility and benefits. For your convenience we accept cash, checks, most major credit cards and debit cards.
- *NSF Checks/Denied Credit Card Payments*- You will be charged a $25.00 fee should a payment be returned for insufficient funds. This fee applies to payments made at our front desk, mailed into the Business Office, electronically via the internet, or payments by phone.
- *Past Due Amounts*- In the event your account becomes past due, and all efforts to collect payment have failed, your account may be referred to a collection agency.
- *Forms/Medical Letters*- We are happy to assist you by completing forms and generating medial letters for you upon your request. The fee for this service varies depending on the form or letter, but most do not exceed $30.00 per form. Payment is collected when you pick up the documents. Please allow 14 business days.
- *Medical Records*- Requests for your medical records and X-rays must be in writing via a special release form. Original X-rays are the property of PA foot & Ankle Associates. Records transferred for continued care directly to another doctor have no charge. Hard copies requested for the patients use will be charged based on the Department of Health's guidelines.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility.

_____ _____

Signature of Patient /Responsible Party Date

_____ _____

Name of Patient/Responsible Party (please print) Relationship to Patient