PODIATRIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SSN# _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

Sex: ❑ M ❑ F Age _____ Birthdate _____

❑ Married ❑ Widowed ❑ Single ❑ Minor

❑ Separated ❑ Divorced ❑ Partnered for _____ years

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (____) _____

Spouse's Name _____

Birthdate _____ SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber Name _____

Birthdate _____ SS # _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I have insurance coverage and assign directly to Foot Health Centers, P.A. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

Foot Health Centers, P.A. may use my health care information and may disclose such information to the above-named insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable Medigap benefits be made to Foot Health Centers, P.A. for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____
Signature of Beneficiary, Guardian or Personal Representative

_____
Please print name of Beneficiary, Guardian or Personal Representative

_____ _____
Date Relationship to Beneficiary

3 PHONE NUMBERS

Home _____ Work _____ Cell _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone _____

Work Phone _____

4 PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (include foot, ankle, knee, thigh, and hip complaints.)

_____

_____

_____

Have you ever been to a Podiatrist before? ❑ Yes ❑ No

If yes, please list.

Name _____

Last visit _____

Is there any personal or family history of diabetes? ❑ Yes ❑ No

Cigarette/Tobacco use _____

100 Cigarettes Lifetime? _____

Years smoked _____

❑Smokeless Tobacco

❑Secondary Smoke

Athletic activities in which you participate (please list and indicate frequency)

_____

Occupation _____

Height _____ Weight _____

Please indicate which foot problems you now have or have had in the past.

Ankle Pain	❑ Yes	❑ No
Athlete's Foot	❑ Yes	❑ No
Bunions	❑ Yes	❑ No
Corns and Calluses	❑ Yes	❑ No
Cramps or Numbness in Feet or Legs	❑ Yes	❑ No
Flat Feet	❑ Yes	❑ No
Foot or Leg Cramps	❑ Yes	❑ No
Heel Pain	❑ Yes	❑ No
Ingrown Toenails	❑ Yes	❑ No
Plantar's Warts	❑ Yes	❑ No
Swelling Ankles or Feet	❑ Yes	❑ No
Tired Feet	❑ Yes	❑ No

— OVER —

5 MEDICAL HISTORY

Place a mark or "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	❑ Yes	❑ No	Diabetes	❑ Yes	❑ No	Psychiatric Care	❑ Yes	❑ No
Allergies to Anesthetics	❑ Yes	❑ No	Ear Problems	❑ Yes	❑ No	Radiation Treatment	❑ Yes	❑ No
Allergies to Medicine or Drugs	❑ Yes	❑ No	Epilepsy	❑ Yes	❑ No	Rash	❑ Yes	❑ No
Anemia	❑ Yes	❑ No	Eye Problems	❑ Yes	❑ No	Respiratory Disease	❑ Yes	❑ No
Angina	❑ Yes	❑ No	Fainting	❑ Yes	❑ No	Rheumatic Fever	❑ Yes	❑ No
Arthritis	❑ Yes	❑ No	Foot or Leg Cramps	❑ Yes	❑ No	Shortness of Breath	❑ Yes	❑ No
Artificial Heart Valves or Joints	❑ Yes	❑ No	Gout	❑ Yes	❑ No	Sinus Problems	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Headaches	❑ Yes	❑ No	Special Diet	❑ Yes	❑ No
Back Problems	❑ Yes	❑ No	Heart Disease	❑ Yes	❑ No	Stroke	❑ Yes	❑ No
Bleeding Disorders	❑ Yes	❑ No	Hemophilia	❑ Yes	❑ No	Swelling in Ankles, Feet	❑ Yes	❑ No
Cancer	❑ Yes	❑ No	Hepatitis or Jaundice	❑ Yes	❑ No	Swollen Neck Glands	❑ Yes	❑ No
Chemical Dependency	❑ Yes	❑ No	High Blood Pressure	❑ Yes	❑ No	Tired Feet	❑ Yes	❑ No
Chest Pain	❑ Yes	❑ No	Kidney Problems	❑ Yes	❑ No	Tuberculosis	❑ Yes	❑ No
Chronic Diarrhea	❑ Yes	❑ No	Liver Disease	❑ Yes	❑ No	Ulcers	❑ Yes	❑ No
Circulatory Problems	❑ Yes	❑ No	Low Blood Pressure	❑ Yes	❑ No	Varicose Veins	❑ Yes	❑ No
			Neuropathy	❑ Yes	❑ No	Venereal Disease	❑ Yes	❑ No
			Phlebitis	❑ Yes	❑ No	Weight Loss, unexplained	❑ Yes	❑ No

Surgeries you have had _____

_____

_____

Hospitalization other than for the surgeries listed _____

_____

_____

Family Physician _____ Last visit date _____

Are you now, or have you been, under any other doctor's care for any reason over the past two years? ❑ Yes ❑ No

If yes, please explain _____

_____

_____

6 MEDICATIONS

Include prescriptions, over the counter medications and vitamins _____

_____

_____

Pharmacy Name(s) _____

Pharmacy Phone(s) _____

Do you take oral contraceptives? ❑ Yes ❑ No

7 ALLERGIES

- ❑ Adhesive Tape
- ❑ Anticoagulant Therapy
- ❑ Aspirin
- ❑ Codeine
- ❑ Demerol
- ❑ Iodine
- ❑ Local Anesthetics
- ❑ Novacaine
- ❑ Penicillin
- ❑ Seafoods
- ❑ Sulfa

Other _____

TREATMENT CONSENT

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

_____ _____

Signature or Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

Fall Risk Questionnaire

Patients 65 or older

Name: _____ **Date:** _____

1. Have you fallen in the past 12 months? ☐ Yes ☐ No

   1a. If yes, how many times have you fallen? _____

   1b. How did you fall? _____

   _____

   _____

   1c. Did you injure yourself and, if so, what was the injury?

   _____

   _____

   _____

2. Can you stand up from a chair without using your arms? ☐ Yes ☐ No

3. Do you always feel steady when you walk or stand? ☐ Yes ☐ No

4. Can you balance on one leg? ☐ Yes ☐ No

5. Can you walk without a cane or other assistive device? ☐ Yes ☐ No

6. Do your shoes fit properly? ☐ Yes ☐ No

7. Can you see well without glasses or bifocals? ☐ Yes ☐ No

8. Can you hear well in a noisy room? ☐ Yes ☐ No

9. Do you feel you are as active as you would like to be? ☐ Yes ☐ No

10. Do you have a nightlight or lamp in your bedroom? ☐ Yes ☐ No

11. Have you removed all of the throw rugs in your home? ☐ Yes ☐ No

ADVANCED CARE DIRECTIVE

Name: _____ Date_____

Do you have an advanced care directive? ☐ Yes ☐ No ☐ Declined

If yes, please answer the following questions:

1. What is your DNR (Do Not Resuscitate) status? ☐ Full code ☐ Partial code

2. Do you wish to have mechanical ventilation? ☐ Yes ☐ No

3. Do you wish to have a feeding tube? ☐ Yes ☐ No

4. Do you wish to have antibiotics? ☐ Yes ☐ No

5. Are you an organ donor? ☐ Yes ☐ No

Emergency Contact

Name: _____

Relationship to patient: _____

Phone # ( ) _____-_____

WELCOME TO OUR PATIENT PORTAL

Please provide your email address below to allow digital access to your records through our secure server.

_____

You will receive an email to confirm the correct email. Please select confirm and your access will be completed.

Phone number we can contact you for appointment reminders?

Phone # ( ) _____-_____

May we leave a message on your voicemail? ☐ Yes ☐ No

Is your Emergency Contact someone we may discuss your medical care with?:

☐ Yes ☐ No

If No, please provide the appropriate information below.

Name: _____

Relationship: _____

Phone # ( ) _____-_____

Foot Health CENTERS, P.A.

PATIENT FINANCIAL POLICY

Thank you for choosing Foot Health Centers. We consider it a privilege to have you as a patient.

With your care in mind, we want to advise and inform you of our financial policy in order to avoid possible misunderstandings or difficulties at a later date. By far, the majority of our patients pay their accounts in a timely fashion or if, they have insurance, pay the portion that they are responsible for promptly. In order to ensure the level of care you require and deserve, we have developed a new policy to ensure quality care to you at a reasonable cost.

1. If you have no verifiable insurance coverage, payment in full is expected at time of service unless prior arrangements have been made and approved.

2. Your Insurance Co-Payment, if any, is due in full at time of service.

3. Unpaid accounts reaching 60 days after it becomes patient responsibility may be referred to a collection agency for further action. An additional fee of 20% may be added to these accounts.

Insurance: Insurance is a contract between you and your insurance company. We are not a party to this contract. We will bill your insurance carrier, however your insurance company makes the final determination of your eligibility and the amount they will pay. You agree to pay any portion of the charges not paid for by insurance after contractual adjustments, if any. If your insurance requires a referral you are responsible for obtaining it. The balance of your account is ultimately your responsibility whether your insurance company pays or not.

Authorization to Contact: You authorize Foot Health Centers, or any agent or servicer of your patient account to use any information you have provided, including contact information, e-mail addresses, cell phone numbers, and landline numbers, to contact you for purposes related to your account, including debt collection.

Once you have signed this agreement, you agree to all of the terms and conditions contained herein and this agreement will be in force and effect.

_____

Signature Date

_____

Print SS#

Foot Health CENTERS, P.A.

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act – 45 C.F.R. Parts 160 and 164)

1. I authorize Foot Health Centers, P.A. to use and disclose the protected health information described below to

   Name _____ Relationship_____

   Name _____ Relationship _____

   ☐ I do not want any of my information released.

2. Authorization for release of PHI covering the period of health care (check one)
   - ☐ From (date) _____ to (date) _____or
   - ☐ All past, present and future periods

3. I hereby authorize the release of PHI as follows (check one)
   - ☐ My complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse). OR
   - ☐ My complete health record with the exception of the following (check as appropriate)
     - ☐ Mental Health records
     - ☐ Communicable diseases (including HIV and AIDS)
     - ☐ Alcohol/drug abuse treatment
     - ☐ Other (please specify)_____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____(date or event), at which time this authorization expires or nine (9) months after my death.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest the claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and my no longer be protected by federal or state law.

Signature of patient or representative _____Date_____

Printed name of patient or representative _____Date_____

Foot Health CENTERS, P.A.

Informed Consent for Telemedicine Services

PATIENT NAME: _____

LOCATION OF OFFICE: _____

DATE OF BIRTH: _____ MEDICAL RECORD #: _____

PHYSICIAN NAME: _____ LOCATION: _____

CONSULTANT NAME: _____ LOCATION: _____

DATE CONSENT DISCUSSED: _____

Introduction

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

• Improved access to medical care by enabling a patient to remain in his/her podiatrist's office (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites.

• More efficient medical evaluation and management.

• Obtaining expertise of a distant specialist.

Possible Risks:

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

• In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);

• Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;

• In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;

• In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors;

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.

2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.

3. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.

4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My podiatrist has explained the alternatives to my satisfaction.

5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.

6. I understand that it is my duty to inform my podiatrist of electronic interactions regarding my care that I may have with other healthcare providers.

7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

Patient Consent to the Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my podiatric physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize _____ (Dr. _____) to use telemedicine in the course of my diagnosis and treatment.

Signature of Patient (or person authorized to sign for patient):_____

Date:

If authorized signer, relationship to patient: _____

Witness:

Date:

I have been offered a copy of this consent form (patient's initials) _____