Foot and Ankle Specialist of Ohio

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Podiatric & Sports Medicine/Reconstructive Foot & Ankle Surgery
www.fasohio.com

Today's Date: _____

Please complete the following information and the next couple pages. All information is strictly confidential. (Please print clearly)

General Information

Patient's name: _____
(Last) (First) (Middle Name)

Address: _____ _____ _____ _____
(Street/Apt) (City) (State) (Zip)

Home Ph. ( ) _____ Cell Ph. ( ) _____ Work Ph. ( ) _____

SSN: _____ Date of Birth: _____ Age: _____ yrs. Male____ Female____

Email: _____ Employer: _____

Responsible Party if Minor: _____ Phone no: _____

Address (If Different from above) _____

Emergency Contact: _____ Relationship: _____ Phone no: _____

Primary Doctor: _____ Referred by: _____

Marital Status: (Single _____) (Married _____) (Divorced _____) (Widowed _____) (Other _____)
Race: (African American ____) (White _____) (Asian _____) (Hispanic_____) (American Indian _____) (Other _____)
Ethnicity: (Hispanic or Latino _____) (Not Hispanic or Latino _____) (Patient Declined to Answer _____)

Pharmacy: (Name & Address) _____

Insurance Information

Primary Insurance Company: _____

ID #:_____ Group #: _____

Insured Name (Exactly as it reads on the card) _____ DOB:_____

Secondary Insurance Company: _____

ID #: _____ Group #: _____

Insured Name (Exactly as it reads on the card): _____ DOB: _____

Foot & Ankle Specialists of Ohio Financial Policy

Please read carefully and ask if you have questions. A copy of this form will be provided upon request

In order to provide you with the most affordable cost, our office requires payment at the time of service.

IF YOU HAVE INSURANCE: We will file insurance claims, but you are responsible for any balances. If after 30 days, your insurance has not paid in full, the entire balance becomes your responsibility.

Due to many changes in insurance policies, different policies within the same company and the volume of insurances, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible.

Therefore, we urge you, as the patient, to please check with your insurance company prior to appointments. It is your responsibility to know your individual coverage. Failing to comply with this suggestion could result in you, the patient, being responsible for all costs incurred.

Please remember, your insurance policy is between you and your insurance company and not with the insurance company and your doctor.

SELF PAY: If you are without insurance, we will require payment at the time of service. If full payment cannot be made, our staff will be happy to discuss payment plan options with you.

OUR COLLECTION POLICY: If after 30 days from the date of service, any balance remains on your account, we will assess a 1% finance charge per month.

If after 120 days from the date of service, any balance remains on your account, we will turn the account over to an outside collection/credit agency and a $100 collection fee will be assessed. For this reason, it is important that you discuss any financial problems with us immediately.

RETURNED CHECKS: A $35.00 service charge will be applied to your account for all returned checks.

MISSED APPOINTMENT: We understand that on rare occasions, issues may arise causing you to miss your appointment without the ability to notify our office prior to your appointment. Should you experience any unforeseen circumstance that causes you to miss your appointment, please call our office to have it rescheduled.

Our highly skilled Physicians are committed to your wellbeing and have reserved time just for you. Patients that miss more than two appointments, without notifying our office prior to the scheduled appointment, are subject to a $25.00 missed appointment fee. This fee will need to be paid before any further appointments can be scheduled.

OTHER FEES NOT COVERED BY INSURANCE:

- Disability Forms - We will be happy to provide you with a form that will state your condition and dates that you will be unable to work. However, due to the complexity of disability and FMLA forms, there will be a $15.00 charge for processing these forms.
- Copies of Medical Records - As a patient, you have the right to a copy of your medical record. A written consent must be signed and dated before any records can be released. There will be a pre-pay fee of .50 cents per page required for these records.

My signature below indicates that I have read and understand the terms of this financial policy

_____ _____

Signature Date

Foot & Ankle Specialists of Ohio Consent and Understanding
Please read carefully and ask if you have questions. A copy of this form will be provided upon request

CONSENT RELATED TO PRIVACY NOTICE:
I have had a chance to review the Practice Privacy Notice as part of this registration process. I understand that the terms of the PRivacy NOtice may change and I may obtain these revised notices by contracting the practice by phone or in writing. I understand that I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions, If it does agree to my restrictions on PHI use, it is bound by that agreement.

CONSENT FOR CARE:
I, with my signature, authorize (Foot & Ankle Specialists of Ohio) and any employee working under the direction of the physician to provide medical care for me, or to this patient for which I am legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but not limited to) preventive, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the state or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professional for care and treatment.

CONSENT FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS
I authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I consent to assign all payments for services directly to this practice. I further consent to the use of my protected health information for any practice operational needs as identified in the Practice Privacy Notice. I authorize this practice to freely discuss my protected health information, including insurance and/or billing questions, chart information, test results, or appointment issues ONLY with the following individual(s):

_____ _____
Name Name

AUTHORIZATION TO PARTICIPATE IN HEALTH INFORMATION EXCHANGES (HIE)
Foot & Ankle Specialists of Ohio participates in one or more HIEs. Your healthcare providers can use this electronic network to securely provide access to your health records for a better picture of your health needs. We, and other healthcare providers, may allow access to your health information through the Health Information Exchange for treatment, payment or other healthcare operations. This is a voluntary agreement. You may opt-out at any time by notifying in writing Foot & Ankle Specialists of Ohio Management Dept. at 7482 Center St. Suite 100, Mentor, Ohio 44060.

ADVANCED CARE PLAN:

I have an Advance Directive - Living Will	☐ Yes ☐ No
I have a Durable Power of Attorney for Health Care	☐ Yes ☐ No
I am an Organ Donor	☐ Yes ☐ No

Thank you for your understanding and cooperation with this policy. It is our privilege to provide your medical are. I have read and understand the Consents stated above and agree to accept full responsibility as described above.

_____ _____
Patient/Responsible Party Date

CONSENT FOR TELEPHONE, EMAIL, AND/OR TEXT MESSAGE COMMUNICATIONS

I hereby authorize Foot & Ankle Specialists of Ohio to communicate the following protected health information contained in my medical record with me via the following forms of communication (check where applicable):

☐ Home Phone (_____) _____ - _____

- ☐ I consent to receiving information at this number via voicemail.
- ☐ I consent to receiving information at this number via text message.

☐ Work Phone (_____) _____ - _____

- ☐ I consent to receiving information at this number via voicemail.
- ☐ I consent to receiving information at this number via text message.

☐ Cell Phone (_____) _____ - _____

- ☐ I consent to receiving information at this number via voicemail.
- ☐ I consent to receiving information at this number via text message.

☐ E-mail _____

I understand that voicemail, email, and text messages are not a confidential method of communication. I further understand that there is a risk that voicemail, email, and text communications between myself and Foot & Ankle Specialists of Ohio regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended parties. I understand that Foot & Ankle Specialists of Ohio is not responsible for email or text messages that are lost due to technical failure during composition, transmission, and/or storage. I also understand that in an urgent or emergent situation I should call my provider or go to the Emergency Room and not rely on e-mail or text messaging.

This authorization shall be in force and effect for twelve (12) months from the date of signature. 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.

I understand that treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may no longer be protected by federal or state law.

THESE CONSENTS AND AUTHORIZATIONS ARE VALID FOR TWELVE (12) MONTHS FROM THE DATE OF SIGNATURE BUT MAY BE REVOKED BY NOTIFYING FOOT & ANKLE SPECIALISTS OF OHIO IN WRITING AT ANY TIME. I UNDERSTAND THE NATURE OF THIS CONSENT AND IT IS REVOCABLE AT ANY TIME.

Patient/Legal Guardian Signature: _____ Date: _____

Relationship: _____

Patient Name: _____ Date: _____

Medical Information

Height: _____Weight: _____ Shoe Size: _____ Previous Podiatrist: _____

Are you diabetic? _____ If yes, what type? Type I or Type II Date of Last Physical: _____

Who is managing your diabetes? Doctor Name: _____ Date Last Seen: _____

Please list other medical problems you have: _____

_____

What is your main foot/ ankle problem today: _____

_____

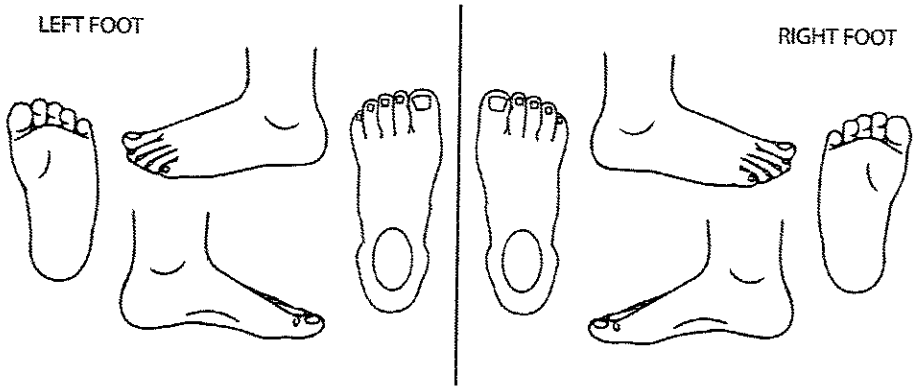
When did your main problem begin?: _____ Have you had any treatment?: _____

Is the pain: []Burning []Throbbing []Sharp []Dull []Aching []Tingling [] Numbness []Itching [] Other _____

How severe is your pain? 0 1 2 3 4 5 6 7 8 9 10

[No Pain] Please Circle [Extreme Pain]

Please indicate where your problem is located:



Social History

Do you smoke? Yes No How often? Never Occassionally Sometimes

Do you drink alcohol? Yes No How often? Never Occassionally Sometimes

Are you pregnant? Yes No How far along are you? _____

Family History

Father: Diabetic [] Arthritis [] Circulation Problems [] Heart Disease[] Cancer [] Decesased []

Mother: Diabetic [] Arthritis [] Circulation Problems [] Heart Disease [] Cancer [] Decesased []

Sibling: Diabetic [] Arthritis [] Circulation Problems [] Heart Disease [] Cancer [] Decesased []

Children: Diabetic [] Arthritis [] Circulation Problems [] Heart Disease [] Cancer [] Decesased []

Other: _____ Diabetic [] Arthritis [] Circulation Problems [] Heart Disease [] Cancer [] Decesased []

Patient Name: _____ Date: _____

Medication List

Please list medication and dosage. If you already have a list please provide copy to us.

_____

_____

_____

_____

_____

_____

_____

_____

Allergies

Please list all drug or food allergies including reaction.

_____

_____

_____

_____

_____

_____

Surgeries & Hospitalizations

Please list all previous surgeries & hospitalizations including dates.

_____

_____

_____

_____

REVIEW OF SYSTEMS

Patient Name: _____ DOB: _____ Date: _____

Are you experiencing or have you experienced any of the following? Please check all that apply.

CONSTITUTIONAL

- ○ CHILLS
- ○ WEAKNESS
- ○ FATIGUE
- ○ WEIGHT GAIN
- ○ WEIGHT LOSS
- ○ FEVER

HEAD

- ○ DIZZINESS
- ○ PAIN
- ○ FAINTING
- ○ SWEATS
- ○ HEADACHES

RESPIRATORY

- ○ ASTHMA
- ○ BRONCHITIS
- ○ COPD
- ○ TB
- ○ WHEEZING
- ○ SHORTNESS OF BREATH

HEMATOLOGIC

- ○ ANEMIA
- ○ SLOW HEALING
- ○ BLEED EASILY SWOLLEN GLAND(S)
- ○ BLOOD CLOT

NEUROLOGICAL

- ○ BURNING
- ○ CHARCOT
- ○ STROKE
- ○ UNSTEADY GAIT
- ○ NUMBNESS
- ○ TINGLING

CARDIOVASCULAR

- ○ CHEST PAIN
- ○ HAIR LOSS ON LEGS
- ○ RHEUMATIC FEVER
- ○ LEG OR FOOT ULCERS
- ○ VASCULAR GRAFTS
- ○ VARICOSE VEINS
- ○ HEART MURMUR
- ○ CRAMPS IN LEGS/FEET
- ○ PALPATIONS
- ○ EXTREMITY(S) COLD
- ○ HIGH BLOOD PRESSURE
- ○ REPLACEMENT OF HEART VALVE
- ○ HISTORY OF MYOCARDIAL INFARCTION

GASTROINTESTINAL

- ○ LIVER DISEASE
- ○ EXCESSIVE THIRST
- ○ DIARRHEA
- ○ GALL BLADDER DISEASE
- ○ JAUNDICE
- ○ ANTACID USE
- ○ NAUSEA

SKIN

- ○ ECZEMA
- ○ DRYNESS
- ○ ATHLETES FOOT
- ○ KELOID SCAR
- ○ RASH
- ○ FUNGAL NAILS
- ○ INGROWN NAILS
- ○ WARTS

MUSCULOSKELETAL

- ○ ARTHRITIS
- ○ LOWER BACK
- ○ PAIN JOINT PAIN
- ○ RESTRCTED MOTION
- ○ ARCH PAIN
- ○ BUNIONS
- ○ CORNS
- ○ HAMMERTOES
- ○ IN-TOEING
- ○ NEUROMA
- ○ TOE WALKING
- ○ JOINT STIFFNESS
- ○ KNEE PAIN
- ○ MUSCLE CRAMPS
- ○ WEAKNESS
- ○ BROKEN ANKLE
- ○ BROKEN FOOT
- ○ CALLUSES
- ○ FLAT FEET
- ○ HEEL PAIN
- ○ JOINT IMPLANTS
- ○ ORTHOTIC USE
- ○ GOUT
- ○ BACK PROBLEMS
- ○ PARALYSIS
- ○ ANKLE SPRAIN
- ○ GAIT (WALKING PROBLEMS)
- ○ HIGH ARCH
- ○ MUSCLE STIFFNESS
- ○ SHOE INSERT USE