Welcome To Our Office

Today's Date: _____ Patient Name: _____

By what Name would you like our office staff to address you? _____

Home Address: _____ City: _____ State : _____ Zip code: _____

Home Phone: _____Cell: _____ May we leave a detailed message? Yes ___ No ____

Birthdate: _____ M ___ F ___ Maritial Status: Single ___ Married ____ Other _____

Social Security Number: _____

Emergency Contact: _____ Relationship: _____ Phone # _____

Primary Care Physician: _____ Date Last Seen: _____

Are you the policy holder on your insurance? Yes ____

If No, please provide Name _____, Date of Birth _____ and SSN _____ of policy holder.

Financially Responsible Party: Self _____ , *If not "self" please complete the following section.*

First and Last Name of Responisble Party: _____

Relationship to Patient: _____ Date of Birth: _____

Social Security Number: _____ Phone Number: _____

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

Signature of parent/guardian: _____

Would you like appointment reminders by phone or email? (Check and complete only one option)

Choosing the email option requires set up with our Patient Portal. Please be aware that if email is selected, you will not receive phone call reminders.

Home Phone ____ , Cell Phone ____ (Please list phone number above)

Email Address _____ (please list email address here, if this option is chosen)

Race:
American Indian or Alaska Native ___, Asian ___, Native Hawaiian or Other Pacific Islander ____, Black or African American ____, White ____, Other ____, Not Specified ___

Ethnicity:
Hispanic or Latino ____, Not Hispanic or Latino ____, Not Specified _____

Preferred Language: English ____, Spanish _____, Other _____

Did your primary care physician refer you to us? Yes ____ , No _____. If no how did you hear about us?

Other Physician:_____ Advertising:_____

Website/Internet:_____ Patient at our office:_____

Sign or event:_____ Other:_____

Phone Book:_____ Insurance company:_____

A Step Ahead Foot & Ankle Center

To insure a complete medical history, please complete ALL sections of this form.

Patient Name: _____ **Height:** _____ **Weight:** _____ **Shoe Size:** _____

Please list names and dosages of any medication that you are currently taking (or provide a list that may be photocopied)
(Example: Feldene 20 mg, 1 x daily)

1. _____ 5. _____ 9. _____
2. _____ 6. _____ 10. _____
3. _____ 7. _____ 11. _____
4. _____ 8. _____ 12. _____

Have you had or do you now have any of the following: (Please check all applicable)

□ Measles □ Chicken Pox □ Mumps □ Alcoholism □ Drug Addiction □ Tuberculosis □ Polio □ Epilepsy □ Gout

□ Raynaud's □ Diabetes, Type: _____ □ Peripheral Vascular Disease □ High Blood Pressure □ High Cholesterol

□ Congestive Heart Failure □ Kidney Failure □ Hepatitis, Type: _____ □ Rheumatic Fever

□ Rheumatoid Arthritis □ Heart Attack, Year: _____ □ Blood Clot, Location: _____

□ Cancer: (type) _____

Have you suffered any injuries to?

□Feet □Hip □Head □Legs □Back □Neck □Knees □Other

Have you had or do you now have allergies to:

□ Local Anesthesia □ Sulfa Drugs □ Erythromycin □ Iodine □ Penicillin □ Latex □ Foods _____

□ Tapes or band aids □ Clindamycin □ Morphine □ Codeine □ Aspirin □ Silver □ Other _____

Please list any surgeries/hospitalizations that you have had. (Indicate procedure, date, where performed and attending physician, if known. (*Example: Tonsillectomy, 1984, Dr. Smith, Loveland)*

Family History, please check all that apply.

	Mother □ Living □ Deceased	**Father** □ Living □ Deceased
Diabetes		
High Blood Pressure		
Heart Disease		
Stroke		
Cancer		
Gout		
Other (please explain)		

How much alcohol do you consume? □ None □ Daily □ Weekly □ Occasionally

Do you use tobacco products? □ No □ Former Smoker □ Yes: How much per day? _____

Signature of Patient or Responsible Party: _____ **Date:** _____

A Step Ahead Foot & Ankle Center

Patient Name: _____

What is your present foot or ankle problem? _____

If female, could you be pregnant? □ Yes □ No

Have you experienced any of the following within the last year? Please check all that are applicable.

□ change in weight □ lack of energy □ chills

□ chest pain □ shortness of breath when lying down □ swelling □ irregular heartbeat

□ excessive thirst □ fatigue □ unexplained weight loss

□ dry eyes □ loss of vision □ wears glasses

□ ringing in ears □ hearing loss □ difficulty swallowing

□ nausea □ vomiting blood □ diarrhea □ blood in stool □ constipation □ hemorrhoids

□ painful urination □ blood in urine □ frequent urination

□ sores □ itching or rash □ color change in skin □ nail changes □ changes in moles

□ enlarged glands □ lymphedema □ easily bruised □ inability to stop bleeding

□ back pain □ joint pain □ muscle pain □ bone pain □ difficulty walking □ cramping pain in calves with walking

□ seizures □ tremors □ tingling □ numbness □ loss of balance/coordination □ loss of sensation

□ anxiety □ depression □ paranoia

□ shortness of breath □ excessive coughing

A STEP AHEAD FOOT & ANKLE CENTER

Authorization to Treat a Minor

If the patient is a minor, I hereby authorize A Step Ahead Foot & Ankle Center to treat the named minor for any medical care without any adult present.

Signature of parent/guardian:_____

Consent To Allow Access To Your Pharmacy And Medication History

The providers at A Step Ahead Foot & Ankle Center use an electronic medical record system that allows electronic prescribing of medications. To optimize the use of this electronic capability, and coordinate your care between us, your family practice physician and other specialists, we ask that patients allow us to access their external medication history through the RX Hub.

Please check only one of the following:

_____ I consent to allow A Step Ahead Foot & Ankle Center to access all of my medication history.

_____ I DO NOT consent A Step Ahead Foot & Ankle Center to access any of my medication history.

Authorization Of Additional Treatments

I authorize A Step Ahead Foot & Ankle Center to perform examination or treatment needed to diagnose and/or treat my foot/ankle problem. I also authorize the taking of and the use of clinical photographs. It is understood that these photos may be used to further medical education and my identity will not be revealed. I further understand that these X- rays are the property of A Step Ahead Foot & Ankle Center.
X-rays taken in this office are part of the patient's permanent record and are the property of A Step Ahead Foot & Ankle Center. Copies of original **X-rays may be obtained with at least 24 hours prior notice.** These copies are available for pick- up at our office, or mailing, but a release form will need to be signed by the patient or responsible party beforehand.

Authorization To Release Protected Health Information

My emergency contact may be added to receive my protected health information if necessary? □ Yes □ No

I authorize the following additional people who may receive my protected health information. I understand I may revoke this authorization at any time by giving written notification to this office.

Name:_____ **Relationship to Patient**: _____

Name:_____ **Relationship to Patient**: _____

Acknowledgement of Receipt of Notice of Privacy Practices (HIPAA)

I acknowledge that I was provided a copy of the Notice of Privacy, which is located on the office website, and that I have read (or had the opportunity to read if I so choose) and understand the notice.

Signature of Patient/Responsible Party: _____ Date: _____

Financial Policy

Thank you for choosing A Step Ahead Foot & Ankle Center for your care. Due to increased insurance company demands, we ask you to read and agree to the following provisions:

REFERRALS- If your insurance plan requires a referral from your primary care physician, it is **your** responsibility to obtain it prior to your appointment and have it faxed to our office. If you do not obtain your referral, you will be responsible for the visit charges **in full at the time of service**.

APPOINTMENTS- As a courtesy, we attempt to contact every patient to remind them of their appointment. **Two missed appointments result in a missed appointment fee of $25.00 and/or dismissal from our practice.**

INSURANCE-Your insurance policy is a contract between you and the insurance company. As a courtesy, we will file your insurance claim for you. This allows the insurance company to pay the doctor's office directly. **Any amount remaining after filing with the insurance will be your responsibility.**

CO-PAYMENTS- Our policy is to collect your portion of the insurance designated co-payments **at the time of the service.**

OUT OF NETWORK BENEFITS- If we do not participate with your plan, but you would like to be treated in our office, we will send a courtesy bill to your carrier on your behalf. **Payment for services provided is required in full at the time of service.**

SERVICES NOT COVERED BY YOUR INSURANCE PLAN- Services not covered by your insurance plan are **your responsibility and are to be paid in full at the time of service.**

PRIVATE PAY PATIENT- If you have no insurance coverage, or do not wish to bill your insurance company, **full payment for services provided is required in full at the time of service.** We accept personal checks (no third party checks), cash & VISA, MasterCard, Discover and American Express. We also participate with Care Credit.

SURGERY PATIENTS- Surgical procedures may require a deposit of deductible and co-insurance payments. You will be informed if this applies to your surgery.

DELINQUENT ACCOUNTS- Account balances are to be paid off within 30 days. A billing charge of $5.00 per month will be added to your account on any unpaid balance after 30 days. **Past due accounts are subject to collection proceedings without further notice if unpaid after 60 days. In the event your account is turned over to collections, you are responsible for all associated collection cost and late fees.**

RETURNED CHECKS-Returned checks are subject to a **$25.00** fee

LABORATORY FEE- Laboratories bill separately for their services. Any Lab services that are not covered by your insurance will be your responsibility.

ADDRESS AND INSURANCE CHANGES-Please let up know if you have changes in your address, phone numbers, insurance, etc, so that your information is always current in our records.

DIVORCE/CUSTODY-Our policy is to hold the parent who brings in the child for medical treatment responsible for payment at the time of service. Our office does require documentation from the court for all legal matters that relate to your child's care; *i.e*., custody, medical decisions, medical record access, etc.

I have read and understand this financial policy and I agree to the terms. I understand that I am financially responsible for all charges incurred in the event my insurance denies payment after a claim has been submitted by A Step Ahead Foot & Ankle Center. I understand that my insurance is an arrangement between myself and my insurance company, and that it is my responsibility to understand my benefits.

I hereby authorize A Step Ahead Foot & Ankle Center to release medical information and necessary data pertinent to the filing of insurance papers in the interest of the patient and the facility. I authorize my insurance carriers to pay benefits directly to A Step Ahead Foot & Ankle Center on any unpaid services filed on my behalf by A Step Ahead Foot & Ankle Center. I also understand that A Step Ahead Foot & Ankle Center is not ultimately responsible for collecting my insurance or negotiating settlements of claims.

Signature of Patient/Responsible Party: _____ Date: _____