



**FOOT & ANKLE**  
Medical Center

## Patient Registration Form

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 5141 Deer Park Dr 1C  
 New Port Richey FL, 34653  
 727-847-2406 (Phone)

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 Spring Hill FL, 34606  
 352-596-3338 (Phone)

### Patient Information

Today's Date:	SS#	DOB:
Last Name:	First:	Middle Initial:
Race:	Language:	
Preferred Name:	Gender: M / F	
Phone Number:	Mobile #:	
Mailing Address:		
City, State, Zip Code:		
Email:		
Marital Status: (Circle One)    Single    Married    Divorced    Widow		
Primary Doctor:	Date You last Saw PCP:	
Pharmacy Name:	Address/Phone#:	
Emergency Contact:	Number:	
Relationship:		

### Insurance Information

Primary:	ID#
Secondary:	ID#
Additional:	ID#

**If patient is a minor, please complete this section:**

Parent/ Guarantor:	
Last Name:	First Name:

### Brief Medical History

Describe your problem and the duration of the symptoms: \_\_\_\_\_

\_\_\_\_\_

Any prior Treatment: \_\_\_\_\_



**Allergies:**


**Medication and Supplements:**

Medication	Dose	Frequenc y	Medication	Dos e	Frequenc y

Signature (Consent to retrieve Rx History): \_\_\_\_\_

**Surgical History:**

Date:	Surgeries		

**Family History:**

<b>Arthritis</b>	<b>Relative:</b>	<b>Alive / Deceased</b>
<b>Cancer:</b>	<b>Relative:</b>	<b>Alive / Deceased</b>
<b>Diabetes:</b>	<b>Relative:</b>	<b>Alive / Deceased</b>
<b>Gout:</b>	<b>Relative:</b>	<b>Alive / Deceased</b>
<b>Heart Disease:</b>	<b>Relative:</b>	<b>Alive / Deceased</b>
<b>High Blood Pressure</b>	<b>Relative:</b>	<b>Alive / Deceased</b>



**Current Medical History :( check boxes that apply)**

AIDS/HIV	Ear Problems	Neuropathy
Anemia	Eye Problems	Pneumonia
Anxiety	Foot or legs Cramps	Radiation Treatment
Arthritis	Gout	Respiratory Disease
Artificial Heart Valve	Headaches	Stroke
Asthma	Hearing Loss	Swelling Ankle and Feet

Back Problem		Heart Disease	Thyroid Disease
Bleeding Disorder		Hepatitis: A B C	Ulcer
Cancer Type:		High Blood Pressure	Psoriasis/Eczema
Charcot's Arthropathy		High Cholesterol	COPD
Chemo Therapy		Kidney Disease	Fungus Nails
Circulatory Problem		Liver Disease	
Diabetes A1c:		Foot Drop	

**Social History:**

Activity			Quantity
<b>Cigarettes:</b>	Y	N	How much:
<b>Quit</b>			
<b>Chewing Tobacco</b>	Y	N	How Much:
<b>Quit</b>			
<b>Vaping:</b>	Y	N	How Much:
<b>Quit</b>			
<b>Alcohol Use:</b>	Beer	Wine	How many:
<b>Liquor</b>			Day / Week/ Month ( <b>Circle One</b> )

**Immunization:**

<b>Influenza (Flu Shot):</b> Yes / No
<b>Pneumonia Vaccines:</b> Yes / No
<b>Covid Vaccine 1 / 2:</b> Yes /No

**Treatment Consent:**

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

Patient Signature: \_\_\_\_\_

Guardian Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_



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## Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996(HIPPA), I have certain rights regarding my protected health information. I understand that this information can and will be used to:

- Conduct, Plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you and your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practice* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practice*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry our treatment, payment, or health care operation.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

### Persons Authorized to access my information:

1. \_\_\_\_\_ Relationship: \_\_\_\_\_

2. \_\_\_\_\_ Relationship: \_\_\_\_\_

3. \_\_\_\_\_ Relationship: \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_



## Financial Agreement

**Thank you for choosing our office to provide you with medical care. We are committed to serving you with high quality care. The medical services provided by our office are service you have elected to receive which may imply a financial responsibility on your part.**

**Insurance:** We participate in most insurance plans. If you are not insured by a plan, we participate with; payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-dated insurance care, payment in full for each visit is required until we can verify your coverage. Knowing **your** insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

**Medicare:** We are a participating Medicare provider. We accept Medicare benefits amounts. Medicare as well as your secondary insurance (if any) will be billed for you, However, that does not mean that all service is covered. Patients are responsible for paying their annual deductible if it has not been met. You are responsible for any copayments, which are usually 20% of the allowed amount for an item or service.

**Secondary Insurance:** Your medical claim will be forwarded to your secondary insurance (if any) after payment and/ or explanation of benefits (EOB) is received from your primary insurance company.

**Self-Pay:** Payment in full is due at the time of service, if you do not have health insurance.

**Non- Covered Service:** Please be aware that some of the service you receive may not be covered or not considered reasonable or necessary by Medicare or other insurances. You are responsible for full payment of these services at the time of service.

**Referrals/Authorizations:** We are required to follow the guidelines of your managed care plan which mandates us that when you visit a specialist such as ours, you must have a referral from your primary care physician prior to seeking specialty care. Therefore, you are financially responsible for the service received. Unless a referral is presented at the time of this visit. If you do not have a referral from your primary care physician at the time of a visit, you will be financially responsible for all services received due in full upon completion of the visit. Full credit will be given of a referral is present to our office within 48 hours of this visit. You will be given the option to reschedule your appointment.

**Claim Submission:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

**Patient Billing:** All co-payment, co-insurance, or deductible amounts must be paid. This arrangement is part of your contract with your insurance company. Failure to collect co-pay and deductibles from our patients can be considered fraud. Please help us in upholding the law by

paying your portion of the insurance benefits at each visit. It is recommended that you verify your benefits with your carrier as well.

**Non Custom Durable Medical Equipment's Returns:** If a patient is unsatisfied with any noncustom Durable Medical Equipment item, it must be returned within 30 days per Medicare Guidelines. Return after 30 days will not be permitted. The item will only be accepted as a return if it is in returnable condition. Any custom durable medical Equipment may not be returned.

**Cancelled/Missed Appointment Fee:** If you cannot keep your appointment time, please call our office at least 60 minutes prior to your scheduled appointment time. There may be a \$25 fee if you miss your appointment. If you miss 3 or more appointments, you may be required to pay a \$50 deposit to hold any future appointment time slots. If you arrive late for an appointment, we may need to reschedule your appointment. Repeated missed or late appointment may results in dismissal from our practice.

**Collections Fee:** You will be sent up to three notices for your financial responsibility (co-insurance, deductible) after payment and /or explanation of benefits (EOB) is received form your insurance company/companies. After the third and last notice, your account will be forwarded to our collection agency.

Payment arrangements can be made on a case by case basis.

I have read the above policy regarding my financial responsibility to Foot and Ankle Medical Center, PLLC for medical services provided. I agree to pay any balances unpaid by my insurance carrier for myself or the below names person.

**Privacy Statement:** Any information disclosed in your record will remain confidential and will not be used for any other reason except in providing quality care and treatment as well as to submit your claims to your insurance company.

**Patient Acknowledge of Notice of Privacy Practice:** By signing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practice and that I have (or had the opportunity to read if I so chose) and understand the Notice and agree to its terms.

**Assignment of Benefits:**

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to Foot and Ankle Medical Center, PLLC all insurance benefits payable to me for service rendered. I understand that I am responsible for payments of deductibles, co-pay, co-insurance, non-covered services and other fees at the time of service. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize Release of Medical Information to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_



Name: \_\_\_\_\_

Date: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Check or Circle your answers below

Do you have any dizziness, confusion or disorientation?	None (0)	Mid-Mod (2)	Interfered with daily life (4)
Any history of fall within last 12 months?	None (0)	1-2 Falls (2)	3 or more falls (9)
Any vision or hearing issues?	Normal (0)	Poor or hearing Aids(2)	Legally blind or deaf (4)
How is your sleeping status?	Normal (0)	Disturbed sleep (1)	Lack of sleep (2)
Do you have gait or balance issues?	Normal (0)	Pain and instability walking or standing (1)	Requires assistance (1) jerking or instability (2)
How is your range of motion and strength in feet or legs?	Normal (1)	Limited motion in feet/ankle (2)	Ankle instability or weakness (4)
Do you take opiates, antihistamines, hypnotics, diuretics, sedatives, and blood pressure meds?	None (0)	1-2 of these Medication(2 )	3 or more of these medication (4)
Do you have neurological disorder including: peripheral neuropathy, MS, Parkinson's, Drop foot, Sciatica, ALS?	None (0)	1-2 of these (2) Medication	3 or more of these medication (4)



Do you have any Amputation, Vertigo, and Arthritis, seizures, short limb, stroke , Obesity or joint replacement?	None (0)	1-2 of these (2) Medication	3 or more of these medication (4)	
When rising from a chair, are you able to?	Rise in a single motion (0)	Rise after 1 push (1)	Multiple attempts (4)	No walking, (4)
How many times do you urinate at night?	None (0)	1-2 Trips (1)	3 or more	
How is your judgment?	Normal (0)	Slow or impaired (1)		
How is your living surrounding?	Familiar (0)	Recent Move (2)		