ADAMS FOOT & ANKLE

FOR OFFICE USE ONLY:
MR# ________________

3435 Pine Ridge Road, Suite 102, Naples, FL. 34109 • **Office** (239) 260 - 7476 • **Fax** (239) 260 - 7608

PATIENT INFORMATION

First Name	Last Name	Date of Birth (mm/dd/yyyy)
		/ /
Address (including City, State & Zip Code)		
Home Phone	Mobile Phone	Email Address

Emergency Contact Name (First & Last)	Emergency Contact Phone

Primary Care Physician Name		
Physician Phone	Last Visit (mm/dd/yyyy)	May we contact physician about your health?
	/ /	YES NO

Pharmacy Name	Pharmacy Phone
Pharmacy Address (including City, State & Zip Code)	

Briefly describe your foot / ankle problem(s), include time length:
Briefly describe any PAST foot / ankle problem(s), such as injuries or circulation problem(s):

PATIENT INSURANCE

Primary Insurance Company:	Policy No. / Group No. :	Member ID:	Effective Date:
	/		/ /
Secondary Insurance Company:	Policy No. / Group No. :	Member ID:	Effective Date:
	/		/ /

SIGNATURE OF PATIENT OR LEGAL GUARDIAN	DATE
	/ /

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GENERAL HEALTH INFORMATION

Do you take Insulin?	If so, what was your last HbA1C?	How many years have you been diabetic?
YES NO		
Are you feeling depressed?	Flu Vaccination Date (mm/dd/yyyy)	Pneumococcal Vaccination Date (mm/dd/yyyy)
YES NO	/ /	/ /
Any recent X-Rays / MRIs of foot / ankle?	Where?	When? (mm/dd/yyyy)
YES NO		/ /
Any recent falls?	Treated?	When? (mm/dd/yyyy)
YES NO		/ /
Show Size	Your Weight (in LBS)	Your Height (in Feet & Inches, ex: 5' 8")
		' "

ALLERGIES / SENSITIVITIES TO MEDICATIONS (*Please check any problem items*)

[ ] None [ ] Adhesive Tape [ ] Advil [ ] Aspirin [ ] Betadine [ ] Codeine [ ] Iodine [ ] Latex
[ ] Epinephrine [ ] Morphine [ ] Penicillin Sulfa Drugs [ ] Local Anesthetics (Novocain / Lidocaine)

Others:

MEDICATION LIST (*If you have a list we can copy, please provide and skip to Medical History.*)

MEDICAL HISTORY (*Check any of the following that apply*)

[ ] None [ ] Anemia [ ] Artificial Joints [ ] Asthma [ ] Bladder [ ] Depression [ ] Gout
[ ] Frequent Infections [ ] Healing [ ] Heart Valve Implant [ ] High Blood Pressure [ ] Cholesterol
[ ] Hormone [ ] Intestine [ ] Kidney [ ] Liver [ ] Lung [ ] Neurologic Disorder [ ] Reflux
[ ] Rheumatic Fever [ ] Skin [ ] Stomach Ulcer [ ] Tuberculosis [ ] Weight Loss

Arthritis type:	Cancer:

Others:

FAMILY HISTORY (*Check any of the following that apply*)

[ ] None [ ] Bleeding Disorder [ ] Bunions [ ] Circulation Issues [ ] Clubfeet [ ] Diabetes
[ ] Depression [ ] Flatfeet [ ] Hammertoes [ ] Heart Disease [ ] Neurologic Disorder [ ] Stroke
[ ] Osteoarthritis [ ] Rheumatoid Arthritis

Cancer:

SOCIAL HISTORY

Do you smoke?	Previously Smoked?	Smokeless Tobacco?	# of Packs/Day	# of Years
YES NO	YES NO	YES NO		

Alcohol Consumption	Employment Environment
[ ] None [ ] Light [ ] Moderate [ ] Heavy	[ ] Sitting [ ] Standing [ ] Walking [ ] Retired [ ] Disabled

SURGICAL HISTORY (*Please specify procedures and dates*)

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OUR FINANCIAL POLICY

This policy covers office visits, procedures, lab or other testing performed. By signing below, I am agreeing to the terms of this Financial Policy.

- **MEDICARE PATIENTS:** I am a participating physician with Medicare. This means that you will be responsible for the 20% of the Medicare approved fee for covered services, the yearly deductible and full payment of any non-covered services. Non-covered services include but are not limited to most diagnostic test performed for screening purposes. We will provide Medicare with your supplemental (secondary) Insurance so that they may file that for you (Medigap policies only) if you do not have Medigap crossover policy you will be responsible for filing your secondary insurance.

- **PAYMENT IS DUE AT TIME OF SERVICE:** Payment is due in full at the time of service unless you are covered by Medicare or an insurance company with which we participate (please see insurance below). Returned checks will be charged a $25.00 service fee, no exceptions. If a check is returned to my office, you will no longer be able to pay by check for services rendered.

- **INSURANCE:** Patients will be asked to present their insurance card for copying upon check-in at the office the first time they are seen for medical services. Please inform us on subsequent visits if your insurance has changed. Claims not paid within 45 days by your insurance company will become your responsibility. You will receive a statement for these services, and you will need to contact your insurance company for reimbursement.

For those patients in insurance plans with which we ARE a participating provider, all co-payments, deductibles, and non-covered services are due at time of service. We will file the insurance claim to the insurance company. If your insurance coverage changes to a plan where I am not a participating provider, we will require payment in full at the time of service. **Due to the thousands of insurance plans available it is impossible for us to know the coverage details of all the policies. It is your responsibility to know what type of coverage, benefits, deductibles, and co-payments you have with your insurance plan.**

CANCELLATION / NO SHOW POLICY FOR DOCTOR APPOINTMENT

We understand that there are times when you must miss an appointment due to emergencies or obligations with work or family. However, when you **DO NOT** call to cancel an appointment, you may be preventing another patient from getting much-needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly “full” appointment book. Also, when you **DO NOT** call 24 hours in advance, **you will be charged a $50 fee**.

Pathology Notice: Certain tests that you have done in the office will be sent to a pathologist for diagnostic evaluation. The pathologist will submit a bill to your insurance company and bill you directly if there is a balance due.

Surgery Cancellation Policy: A **$250 fee** will be charged if you cancel a scheduled surgical procedure with less than a 30-day notice.

Assignment to Pay for Services: I agree to pay for all charges for services rendered today, or any future date of service, in this office. I understand that any unpaid charges will be billed to my credit card. I further understand, in the event this account is referred to an agency of attorney for collection, I will be responsible for all collection fees, attorney’s fees and/or court costs.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN	DATE
	/ /

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AUTHORIZATION TO RELEASE / OBTAIN HEALTHCARE INFORMATION

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

Patient Name	Birth Date (mm/dd/yyyy)	Social Security No.
	/ /	
Address	City & State	Zip Code

- For the purpose of patient care, I hereby request and authorize the following organization or individual to release my medical records as specified in this release:

RECORDS RELEASED FROM

Name (Health Facility, Provider)			
Address	City	State	Zip Code
Phone Number	Fax Number		

- For the purpose of patient care, I hereby request and authorize the following organization or individual to release healthcare information of the patient named above to:

RECORDS RELEASED TO

Name of Recipient			
ADAMS FOOT AND ANKLE ATTENTION: MEDICAL RECORDS			
Address	City	State	Zip Code
3435 PINE RIDGE ROAD, **SUITE 102**	NAPLES	FLORIDA	34109
Phone Number:	Fax Number:		
(239) 260 - 7476	(239) 260 - 7608		

Healthcare information relating to the following treatment, condition, or dates:
[ ] All healthcare information
Other:

- I understand that my authorization will remain effective from the date or my signature for 365 days after, and that the information will be handled confidentially in compliance with all applicable federal laws.
- I understand that I may see the information that is to be sent and that I may revoke the authorization at any time by written, dated communication. I have read and understand the nature of this release.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN	**DATE**
	/ /