



Welcome to Central Florida Foot and Ankle Center

PATIENT INFORMATION	INSURANCE INFORMATION	
<p>Date _____ Patient Name _____ _____ Address _____ City _____ State _____ Zip _____ Mailing Address _____ City _____ State _____ Zip _____ SS# _____ DL# _____ E-Mail _____ Sex <input type="checkbox"/> M <input type="checkbox"/> F Age _____ Birth Date _____ <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Minor <input type="checkbox"/> Separated <input type="checkbox"/> Divorced</p> <p>Patient Employer/School _____ Employer/School Phone (_____) _____ Spouse's Name _____ Birth Date _____ SS# _____ - _____ - _____ Spouse's Employer _____</p> <p>How did you hear about us? _____ _____ Google, Yahoo, Commercial, Internet, Newspaper, Patient, Ref Doctor, YellowBook, YellowPages, Family, Friend, Billboard, Chit Chat, etc</p>	<p>Who is responsible for this account _____ Relationship to Patient _____ Insurance Co. _____ Group# _____ Is patient covered by additional insurance? Yes No Subscriber's Name _____ <input type="checkbox"/> <input type="checkbox"/> Birth Date _____ SS# _____ Relationship to Patient _____ Insurance Co. _____ Group # _____</p> <p>INSURANCE ASSIGNMENT AND RELEASE I certify that I have insurance coverage with _____ Name of Insurance Company(ies) and assign directly to Central Florida Foot and Ankle Center, LLC. 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 my signature on all insurance submissions. Central Florida Foot and Ankle Center may use my health card 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.</p> <p>_____ Signature of Patient, Guardian or Personal Representative _____ Please print name of Patient, Guardian or Personal Representative _____ Date _____ Relationship to Beneficiary _____</p>	
<p style="text-align: center;">PHONE NUMBERS</p> <p>Home Phone (_____) _____ Cell Phone(_____) _____ Best time and place to reach you _____ In case of emergency, contact Name _____ Relationship _____ Home Phone(_____) _____ Work Phone(_____) _____</p>	<p>Office use only:</p> <p>Verified by: _____ Date: _____ Checked by: _____ Date: _____ DL: _____ INS: _____</p>	
PODIATRIC HISTORY		
<p>What is the chief complaint for which you came to have treated? _____ _____</p> <p>Have you ever been to a Podiatrist before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list. Name _____ Last Visit _____ Shoe size: _____ Weight: _____ Height: _____</p> <p>Is this injury/problem related to: Work <input type="checkbox"/> Yes <input type="checkbox"/> No Car Accident <input type="checkbox"/> Yes <input type="checkbox"/> No Personal Injury Case? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is there an ongoing lawsuit regarding this injury? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Is there any personal or family history of diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No Occupation/Job _____ Cigarette/Tobacco use _____ Years Smoked _____ Athletic activities in which you participate (please list and indicate frequency) _____ _____</p> <p>How long have you had the problem? _____ What type of pain are you experiencing? Please Circle: Burning Numbness Throbbing Stabbing Pain Pain Level on a scale of 1-10 (10=worst) _____</p>	<p>Please indicate which foot problems you have now or have had in the past.</p> <p>Ankle Pain <input type="checkbox"/> Yes <input type="checkbox"/> No Athlete's Foot <input type="checkbox"/> Yes <input type="checkbox"/> No Bunions <input type="checkbox"/> Yes <input type="checkbox"/> No Corns and Calluses <input type="checkbox"/> Yes <input type="checkbox"/> No Numbness in Feet <input type="checkbox"/> Yes <input type="checkbox"/> No or Legs Flat Feet <input type="checkbox"/> Yes <input type="checkbox"/> No Foot or Leg Cramps <input type="checkbox"/> Yes <input type="checkbox"/> No Heel Pain <input type="checkbox"/> Yes <input type="checkbox"/> No Ingrown Toenails <input type="checkbox"/> Yes <input type="checkbox"/> No Plantar Warts <input type="checkbox"/> Yes <input type="checkbox"/> No Swelling in Ankles or Feet <input type="checkbox"/> Yes <input type="checkbox"/> No Tired Feet <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Please **CIRCLE** to indicate if you have had any of the following:

AIDS/HIV	Chest Pain	High Blood Pressure	Respiratory Disease
Allergies to Anesthetics	Chronic Diarrhea	Kidney Problems	Rheumatic Fever
Allergies to Medicine or Drugs	Circulatory Problems	Liver Disease	Shortness of Breath
Anemia	Diabetes Yrs____ type____	Low Blood Pressure	Sinus Problems
Angina	Ear Problems	Neuropathy	Special Diet
Arthritis	Epilepsy	Pacemaker	Stroke
Artificial Heart Valves	Eye Problems	Phlebitis	Swollen Neck Glands
Artificial Joints	Fainting	Problems taking aspirin products	Thyroid Disease
Asthma	Gout	Psychiatric Care when_____	Tuberculosis
Back Problems	Headaches	Radiation Treatment	Ulcers
Bleeding Disorders	Heart Disease	Rash	Varicose Veins
Cancer	Hemophilia		Venereal Disease
Chemical Dependency to what?_____	Hepatitis or Jaundice type_____ when_____		Weight Loss, unexplained

Surgeries you have had _____

Hospitalization other than for the surgeries listed _____

Family Physician _____ Date of last visit _____

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 _____

MEDICATIONS	ALLERGIES	
Include prescriptions, over-the-counter medications and vitamins: _____ _____ _____	<input type="checkbox"/> Adhesive/Tape	<input type="checkbox"/> Local Anesthetic
Pharmacy Name(s) _____	<input type="checkbox"/> Novocain	<input type="checkbox"/> Aspirin
Pharmacy Phone(s) (_____) _____	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Codeine
Do you take oral contraceptives? <input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Seafood	<input type="checkbox"/> Demerol
Do you take any blood thinners? <input type="checkbox"/> No <input type="checkbox"/> Yes what _____	<input type="checkbox"/> Sulfa	<input type="checkbox"/> Iodine
	<input type="checkbox"/> Anticoagulant Therapy	<input type="checkbox"/> No Known Allergies
	Other _____	

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 deems necessary.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Date

Central Florida Foot and Ankle Center, LLC.

101 6th Street N.W. ~ Winter Haven, FL 33881
1115 Lakeland Hills Blvd. ~ Lakeland, FL 33805
2211 North Blvd. West ~ Davenport, FL 33837

Main: 863-299-4551
FAX: 863-299-2310



Central Florida Foot and Ankle Center, LLC

01 6th St. NW ~ Winter Haven, FL 33881 / 1115 Lakeland Hills Blvd. ~ Lakeland, FL 33805
2211 N. Blvd. W. ~ Davenport, FL 33837

POLICIES AND PROCEDURES

Thank you for choosing Central Florida Foot and Ankle Center as your foot care provider. We are committed to providing you with quality and affordable health care. Please read the following office payment policy and feel free to ask us any questions that you may have. Once you accept this policy, kindly sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. 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-to-date insurance card, 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.

2. Medicare. Those with who do not have a secondary insurance will be responsible for their 20% at the time of service, unless other arrangements have been made. If you have a secondary insurance that we are not contracted with, you will also be responsible for your 20% coinsurance.

3. Co-payments and deductibles. We do require you to pay your co-payment, co-insurance or deductibles at the time of service. If you are unaware of what your benefits are, you should contact your benefits department prior to your appointment. It is your responsibility to understand the terms and benefits of your contract.

4. Non-covered services. Please be aware that some - and perhaps all - of the services you receive may be uncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit or if deemed non-covered after services submitted to your insurance, you will be responsible and billed for the services.

5. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. If required, obtaining the proper referral from your Primary Care Physician is your responsibility. Patients presenting to our office without a valid referral will be asked to pay in full. This payment will be held for 48 hours and will become nonrefundable if the proper referral is not obtained by then.

6. Claims 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. For secondary payers', we will submit the claim one time as a courtesy to you if they do not pay within 35 days of submission, it will then become your responsibility.

7. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

8. Nonpayment. Invoices are sent out every 30 days. Your prompt payment will assist us in keeping the cost of healthcare down. If your account is over 60 days past due, you will receive a letter

requesting immediate payment. A \$ 10.00 rebilling fee will be charged for each additional invoice sent out after 30 days. Partial payments will not be accepted unless otherwise approved by our Billing Department. Please be aware that if a balance remains unpaid, we may refer your account to small claims court and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative podiatric care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

9. Referral/Authorization. In the event your insurance requires a referral or authorization from primary physician, it is *YOUR* responsibility to make arrangements with that office to get the referral/authorization to us prior to your appointment. *Your appointment will be rescheduled if the appropriate referral/authorization is not received.*

10. Missed appointments. Our policy is to charge \$35.00 for missed appointments not canceled within a reasonable amount of time or for an understandable reason. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

11. Medical Records. All medical record requests must be submitted in writing. After the patient signs an authorization of release, we will provide any doctor's office with a copy of your medical records free of cost. If you or your legal representative will need copies of medical records we will provide them for the cost of \$1.00 per page for the first 20 pages then \$.50 per page thereafter. X-Rays are a \$10.00 cost per CD. Please allow 7-10 business days for records processing. Prepayment is required.

12. Forms and Documents. A fee of \$25.00 per form is required for the completion of forms, including but not limited to disability forms & FMLA. Please allow 7-10 business day's turnaround time for form completion. If any medical records will be needed with disability form or FMLA, to be attached or sent, it will be an additional cost of \$.50 per page. Prepayment is required.

13. Outpatient Scheduling. Please allow business days for ancillary scheduling ordered by our doctors (E.g. MRI, Pain management, etc.) If your insurance carrier requires authorization it may delay scheduling.

14. Surgery Scheduling. Please allow 5-7 business days for surgery scheduling, once cleared.

15. Fees. Our fees are representative of the usual and customary charges for our area.

I have read and understand the above policies and procedures and will adhere to them.

Also, I authorize the release of any medical information necessary to my insurance company, hospitals or physicians involved in my care. I also authorize payment of medical benefits to Central Florida Foot and Ankle Center and any/all doctors of Central Florida Foot and Ankle.

Printed Name of patient or responsible party

Signature of patient or responsible party

Date



**Central Florida Foot & Ankle Center, LLC
Acknowledgment of Notice of Privacy Practices,
Policies and Procedures
and Permission Form**

I acknowledge that a copy of the "Notice of Privacy Practices" is displayed in the office by which I have read (or had the opportunity to read if so chose to), and understand the notice. Upon request I will be provided a copy of the "Notice of Privacy Practices". I have read and signed the "Policies and Procedures" and if requested I will be provided a copy of the "Policies and Procedures". I understand the policies and procedures and know my financial responsibility towards Central Florida Foot and Ankle Center, LLC.

Printed Name of patient or responsible party

Date

Signature of patient or responsible party

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits will be made on my behalf to Central Florida Foot and Ankle Center, LLC for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown in Medicare assigned cases, the physicians or suppliers agree to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and no covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Printed Name of patient or responsible party

Date

Signature of patient or responsible party

Permission Form

I _____ give Central Florida Foot and Ankle Center, LLC permission to speak/mail/electronic communication with _____ on my behalf concerning my account and/or treatment.

Printed Name of patient or responsible party

Date

Signature of patient or responsible party