Welcome to Central Florida Foot and Ankle Center, LLC

PATIENT INFORMATION

Date_____
Patient Name_____
_____
Address_____
City_____ State_____ Zip_____
Mailing Address_____
City_____ State_____ Zip_____
SS#_____DL#_____
E-Mail_____
Sex ☐M ☐F Age_____ Birth Date_____
☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced

Patient
Employer/School_____
Employer/School Phone (_____)_____
Spouse's Name_____
Birth Date_____ SS#_____-_____-_____
Spouse's Employer_____

How did you hear about us? _____
_____
Google,Yahoo,Commercial,Internet,Newspaper,Patient,RefDoctor, YellowBook, YellowPages, Family, Friend, Billboard, Chit Chat, etc

INSURANCE INFORMATION

Who is responsible for this account_____
Relationship to Patient_____
Insurance Co._____
Group#_____
Is patient covered by additional insurance? Yes ☐ No ☐
Subscriber's Name _____
Birth Date _____ SS# _____
Relationship to Patient _____
Insurance Co. _____
Group # _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with _____
Name of InsuranceCompany(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.

_____
Signature of Patient, Guardian or Personal Representative

_____
Please print name of Patient, Guardian or Personal Representative

_____ _____
Date Relationship to Beneficiary

PHONE NUMBERS

Home Phone (____)_____
Cell Phone(____)_____
Best time and place to reach you_____
In case of emergency, contact
Name_____
Relationship_____
Home Phone(_____)_____
Work Phone(_____)_____

Office use only:

Verified by:_____ Date:_____

Checked by:_____ Date:_____

DL: _____ INS: _____

PODIATRIC HISTORY

What is the chief complaint for which you came to have treated?
_____
_____

Have you ever been to a Podiatrist before?
☐Yes ☐No
If yes, please list.
Name_____
Last Visit_____
Shoe size:____ Weight:____ Height: ___

Is this injury/problem related to:
Work ☐Yes ☐No
Car Accident ☐Yes ☐No
Personal Injury Case? ☐Yes ☐No

Is there an ongoing lawsuit regarding this injury? ☐Yes ☐No

Is there any personal or family history of diabetes? Yes☐ No ☐
Occupation/Job_____
Cigarette/Tobacco use_____
Years Smoked_____
Athletic activities in which you participate (please list and indicate frequency)
_____
_____
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) _____

Please indicate which foot problems you have now or have had in the past.

Ankle Pain ☐Yes ☐No
Athlete's Foot ☐Yes ☐No
Bunions ☐Yes ☐No
Corns and Calluses ☐Yes ☐No
Numbness in Feet or Legs ☐Yes ☐No
Flat Feet ☐Yes ☐No
Foot or Leg Cramps ☐Yes ☐No
Heel Pain ☐Yes ☐No
Ingrown Toenails ☐Yes ☐No
Plantar Warts ☐Yes ☐No
Swelling in Ankles or Feet ☐Yes ☐No
Tired Feet ☐Yes ☐No

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:	☐ Adhesive/Tape	☐ Local Anesthetic
_____	☐ Novocain	☐ Aspirin
_____	☐ Penicillin	☐ Codeine
_____	☐ Seafood	☐ Demerol
_____	☐ Sulfa	☐ Iodine
Pharmacy Name(s)_____	☐ Anticoagulant Therapy	☐ No Known Allergies
Pharmacy Phone(s) (_____)_____	Other_____	
Do you take oral contraceptives? ☐ No ☐ Yes	_____	
Do you take any blood thinners? ☐ No ☐ Yes what_____		

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

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 $.25 per page thereafter. X-Rays are a $10.00 cost per CD. 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. Purchases. Per OSHA guidelines: **ALL** supplies purchased in office are **non-returnable** and **non-refundable** due to sterile purposes by law.

16. 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

Acknowledgment of Notice of Privacy Practices, Policies and Procedures and Permission Form

I have received /had the opportunity to read and understand this practice's Notice of Privacy Practices written in plain language. The notice was updated on 9/23/2013 and provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information, resident at, or controlled by, this practice. If changes to the policy occur, this practice will provide me with a revised Notice of Privacy Practices upon written request.

_____ _____

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

CONSENT TO USE OR DISCLOSE INFORMATION
FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

The Patient hereby consents to the use or disclosure of his/her individually identifiable health information ("protected health information") by Central Florida Foot and Ankle Center, LLC. in order to carry out treatment, payment, or health care operations. The Patient should review the Practice's Notice of Privacy Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information, and the Patient has the right to review such Notice prior to signing this consent form.

Practice reserves for itself the right to change the terms of its Notice of Privacy Practices for Protected Health Information at any time. If the Practice does change the terms of its Notice of Privacy Practices, Patient may obtain a copy of the revised Notice.

Patient retains the right to request that the Practice further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Practice is not required to agree to such requested restrictions; however, if the Practice does agree to Patient's requested restriction(s), such restrictions are then binding on the Practice.

Patient acknowledges and agrees that the Practice may disclose Patient's protected health information and patient medical record information to the following individuals who are the Patient's family members, legal representatives, guardians, health care surrogates, or have power of attorney on behalf of the Patient:

☐ PCP _____ ☐ REFERRING DOCTOR _____

☐ INSURANCE _____ ☐ FAMILY MEMBER _____

☐ OTHER _____ ☐ ALL (NO RESTRICTIONS)

The Patient **agrees that the Practice may disclose** the following types of information contained in the Patient's medical records (please initial the appropriate categories listed below):

_____ HIV/AIDS Information
_____ Mental Health Information
_____ Substance Abuse Information
_____ Sexually Transmitted Disease Information
_____ If Patient is under the age of eighteen (18), Pregnancy Information
_____ All current and past medical conditions/treatment

Patient agrees and consents to the Practice releasing information to Patient in the following alternative manners (please initial the appropriate spaces below):

_____ Via e-mail to the Patient's designated e-mail address which is:
Email _____.

_____ Via Regular Mail with any envelopes being marked personal and confidential and addressed to Patient.

_____ Via telephone, if Patient contacts the Practice and provides the appropriate information (including the Patient's name, social security number and unique personal identifier).

At all times, Patient retains the right to revoke this Consent. Such revocation must be submitted to the Facility in writing. The revocation shall be effective except to the extent that the Practice has already taken action in reliance on the Consent.

The Practice may refuse to treat Patient if he/she (or an authorized representative) does not sign this Consent Form (except to the extent that the Practice is required by law to treat individuals). If Patient (or authorized representative) signs this Consent Form and then revokes Consent, the Practice has the right to refuse to provide further treatment to Patient as of the time of revocation (except to the extent that the Practice is required by law to treat individuals).

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS SEALED DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

Date:_____ Time _____AM/PM

_____
Signature of Patient (or Authorized Representative*)

_____
Please print name

_____ _____
Signature of witness Person Signing on behalf of Patient *****

*Please explain Representative's Relationship to Patient and included a description of Representative's Authority to act on behalf of the Patient:

_____
_____
_____
_____
_____

Central Florida Foot and Ankle Center
Credit Card Authorization Form

Patient Name: _____ **DOB**: _____

Guardian's Name (if applicable): _____

Email: _____

Phone number: _____ **Alt #**: _____

The purpose of this form is to authorize Central Florida Foot and Ankle Center to retain a valid credit card number on file for you our patient**.** ***If you are paying for copays, deductibles, coinsurance, balances, non-covered services, etc. by card today, the credit card information will be automatically saved to the bank's secure database at the time of processing.***

Your supplied credit card will be charged **ONLY** under the following circumstances:

1.) If you, as the patient receives services within our office that are non-covered, denied, applied to deductible, or for any reason not paid by your insurance carrier, CFFAC reserves the right to charge the credit card on file for charges that you are responsible for. A message will be sent to the email that you have provided above and you will have 5 business days to respond. If no email address is present or the email is rejected, then you will receive a phone call at the number on file. If no response to email/phone call after 5 business days, the credit card on file will be charged the full balance amount. A receipt will be mailed at your request. If you're balance is $100 OR LESS, we will reach out to you by phone one time and you will have 24 hours to get back to us. (If you are called on a Friday, we must hear from you by the end of the day on Monday). If we do not hear back from you, your card will be charged the full balance. We highly encourage you to make sure your information on file is accurate at all times. **(Patient Initials _____)**

2.) If you, as the patient, miss a scheduled appointment without 24 hour notice to cancel or reschedule, CFFAC reserves the right to charge the credit card listed below, $35.00 for our standard no-show fee. This notice serves as your consent to be charged for all no-shows. A receipt will be mailed upon your request. *(As is customary, an automated system for CFFAC will call the phone number on file to remind you of your scheduled appointment. this reminder is usually done 24 hours prior to your scheduled appointment. It is the patient's responsibility to ensure that we have a correct, current telephone number on file)*

3.) If you, as the patient, request paper records and do not pick the records up after preparation, CFFAC reserves the right to charge the credit card on file for the fees involved. *(Medical Record Policy will be followed: consent must be signed, pt will be notified of the cost prior to preparation, CFFAC will release within 5 business days or receipt of request, pt will be notified once ready)*

Other than the conditions mentioned above, under **NO** circumstance will CFFAC charge your credit card for anything not discussed with you personally. In conjunction with HIPAA regulations, all credit card information will be confidentially kept within your medical chart in our office. Only authorized staff will be able to access this information.

Acknowledged, Agreed, and Accepted:
Having read this form and talked with the physician, and/or staff, my signature below acknowledges that I voluntarily give my authorization and consent to providing the requested information for my credit card to be charged accordingly for the conditions listed above.

****** Please note: If you are paying by CASH, Flex Spending Card or HSA Visa/Mcard today for your copay, deductible, coinsurance, non-covered services, supplies, etc., you will still be required to place a credit card on file that is saved to the bank's secure database or complete info below. Please be prepared to provide this information to the front desk at check-in prior to being seen******

Circle One: VISA MCARD DISCOVER

Name on Card (name must match signature on file): _____

Card Number: _____ Expiration: _____ Zip: _____

*x*_____ _____
Patient Signature *Date* *(eff 2/2018)*