

Ankle and Foot Sports Medicine Institute

New Patient Information

Patient Name: _____ Date of Birth: _____
 Address: _____ City: _____ State: _____ Zip code: _____
 Home phone: _____ Cell phone: _____ Email: _____
 Language: _____ Race: _____ Ethnicity: Hispanic Yes or NO Gender: _____
 SSN: _____ Insurance Company Name: _____
 Name on Insurance Card: _____ Date of Birth of Policy Holder: _____

Please answer the following questions regarding your Social History

How did you hear about us? Describe in detail what brings you into the office.	Date of last pneumonia vaccine: Emergency Contact: Relationship: Phone Number:
Primary Care Doctor's First and Last Name	Pharmacy Name/Location
Last Visit to Primary Doctor	Laboratory Name/Location
Primary Care Doctor's Location	Imaging Facility Name/Location (XR, MRI, etc.)
HBA1C (Diabetics Only)	Height
Date of last eye exam?	Weight
You may discuss my health information with:	Shoe size

Please check the following problems regarding your Medical History

<ul style="list-style-type: none"> • AIDS/HIV • Alzheimer's • Dementia • Anemia • Arrhythmia • Arthritis • Artificial Joints • Asthma • Back Pain • Bipolar • Bleeding Disorder • Blind (legally) • Blood Clot • Cancer 	<ul style="list-style-type: none"> • Coronary Artery Disease • Depression • Anxiety • Diabetes Type 1 • Diabetes Type 2 • Dialysis • Ear Problems • Fibromyalgia • COPD • Foot Deformity • GERD • Gout • Headaches • Heart Disease 	<ul style="list-style-type: none"> • Hepatitis • High Cholesterol • Hypertension • Kidney Disease • Leg or Foot Ulcers • Liver Disease • Lung Disease • Mental Illness • Myocardial Infarction • Neuropathy • OCD • Organ Transplant • Osteoporosis • Pacemaker 	<ul style="list-style-type: none"> • Parkinson's • Polio • Raynaud's Disease • Rheumatoid Arthritis • Seizures/Epilepsy • Sleep apnea • Stents • Stroke • Thyroid Problems • Tuberculosis • Varicose Veins • Circulation problems • Venereal Disease • Heart Problems
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Please check the following problems regarding your Surgical History.

<ul style="list-style-type: none"> • Amputation • Ankle Surgery • Appendectomy • Arthroscopic Surgery • Back Surgery • Cancer Surgery • Cardiac bypass • Carpal Tunnel Surgery • Cataract Surgery 	<ul style="list-style-type: none"> • Foot Surgery • Gall Bladder • Hand Surgery • Heart surgery • Hernia Surgery • Hysterectomy Joint Replacement • kidney Surgery • Knee Surgery 	<ul style="list-style-type: none"> • Lower extremity bypass • Lung Surgery • Neck surgery • Pacemaker • Plastic Surgery • Prostate surgery • Shoulder Surgery • Stent • Other
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Please answer the following regarding your Family History. Check Mother (M) or Father (F)

Family history of Autoimmune disease	M	F	Family history of High cholesterol	M	F
Family history of Blood Disorder	M	F	Family history of Hypertension	M	F
Family history of Cancer	M	F	Family history of kidney disease	M	F
Family history of cardiovascular disease	M	F	Family history of Osteoporosis	M	F
Family history of foot deformity	M	F	Family history of Rheumatoid arthritis	M	F
Family history of Diabetes mellitus	M	F	Family history of respiratory disease	M	F
Family history of Epilepsy	M	F	Family history of Tuberculosis	M	F
Family history of Glaucoma	M	F	Family history of stroke	M	F
Family history of Gout	M	F			

Please list all Medications you are on. (If you have a list, please provide to front desk)

Please list all your Allergies. (Include Metal and Shellfish)

Social History

Substance use

Do you or have you ever smoked tobacco?	How many years have you smoked tobacco?
At what age did you start smoke tobacco?	How much tobacco do you smoke?
Do you or have you ever used any other forms of tobacco or nicotine? (Please specify)	What was the date of your most recent tobacco screening?
How much alcohol do you consume in a week?	Do you use an illicit or recreational drugs?
How much caffeine do you consume a week?	If so, what recreational drugs do you use?

Activities of Daily Living

Are you able to care for yourself ?	Are you blind or do you have difficulty seeing?
Are you deaf or do you have serious difficulty hearing?	Do you have difficulty concentrating, remembering or making decisions?
Do you have difficulty walking or climbing stairs?	Do you have difficulty dressing or bathing?
Do you have difficulty doing errands alone?	Are you able to walk?
Do you have transportation difficulties?	Which of your hands/feet is dominant?

Advance Directive

I Do you have an advance directive? (Living will)	Is blood transfusion acceptable In an emergency?
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Patient Consent

Patient 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 a procedure upon me as the doctor deems necessary.

Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment if you have any questions, please discuss them with the front office staff.

- As our patient, you are responsible for all authorizations/referral needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services is due at the time of service. We will accept Visa, MasterCard, Discover, AMEX, CareCredit, cash or check. With your permission, your credit card information may be saved to process outstanding balances.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefit to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay for the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify the benefit for some specialized services or referrals; however, you remain responsible for charges for any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all-Insurance changes and authorization/referral requirements. If the office is not Informed, you will be responsible for any charges denied.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are elective surgical procedures for which we require pre-payment. You will be informed in advance If your procedure is one of those. In that event, payment will be due one week prior to surgery.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due to this office.
- There is a service fee of \$30.00 for all returned checks. There is a \$25.00 NO SHOW/LATE CANCELLATION FEE (less than 24 hrs). There is a fee of \$20 fee for all disability paper work.

HIPAA/Policy

YOUR RIGHTS: As a patient of the Ankle and Foot Sports Medicine Institute LLC, you have a right to:

- Request an electronic or paper copy of your medical record and other health information, which shall be provided to you within thirty (30) days at a reasonable cost-based fee.
- Request that updates and corrections be made to your health information.
- Request that confidential communications be conveyed to you in a specified, reasonable manner.
- Request that certain treatment you receive, payments you make, or operations you undergo be shared with other entities, unless approving your request would adversely affect your care.
- Request a list of individuals and entities with whom we have shared your health information for the last five (5) years, at a reasonable, cost-based fee.
- Request a paper copy of this privacy notice; Request a medical power of attorney; and
- File complaints with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C., 20201 or by calling 1-877-696-6775, or by visiting www.hhs.gov/ocr/privacy/hlppa/complaints/.

YOUR CHOICES: As a patient of the Ankle and Foot Sports Medicine Institute, you may request that we:

- Share your information with your family, close friends, and others involved in your care, or during a disaster relief situation.
- Require written consent to use your health information for marketing purposes, the use of psychotherapy notes, or for sale; and
- That we discontinue contacting you for fundraising efforts.

USES AND DISCLOSURES: The Ankle and Foot Sports Medicine Institute shall use or share your health information to:

- Treat you; Run our practice, improve your care, and contact you when necessary.
- Procure payment for services rendered.
- Aid public health and safety concerns in preventing disease, helping with product recalls, reporting adverse effects to medications, reporting abuse, neglect or domestic violence, or in preventing or reducing serious threats to anyone's health or safety.
- Further health information research.
- Comply with federal and state laws.

- Respond to organ and tissue donation request
- Work with a medical examiner or funeral director.
- Further worker's compensation claims and other government requests; or
- Respond to lawsuits and court proceeding requests.

OUR PROMISES TO YOU: We promise and ensure that:

- Pursuant to privacy and security law, we shall maintain and protect your health information.
- We will Inform you if a breach occurs that potentially comprises the privacy and security of your information.
- We shall follow the privacy practices and duties delineated in this notice; and
- We will not use or share your Information without your written consent, and at any time, you may change your mind, provided you do so in writing.

This notice is subject to changes, which shall apply retroactively to all Information we have about you. Any changes will be reflected in the most current version of this notice, which you may request a copy of.

I acknowledge that I have read and fully understand this notice of Privacy Practices and consent to all practices contained herein.

Authorization for Release of Health Information

ANKLE & FOOT SPORTS MEDICINE INSTITUTE LLC uses SureScripts, Inc., a prescription system that allows prescriptions and related Information to be exchanged between my providers and the pharmacy. The information sent between these systems may include details of any and all prescription drugs I am currently taking and/or have taken in the past. This Information will be utilized to ANKLE AND FOOT SPORTS MEDICINE INSTITUTE LLC.

This authorization may include disclosure of prescription information related to alcohol and drug abuse, mental health treatment, and/or confidential HIV related information by SureScripts, Inc. to ANKLE AND FOOT SPORTS MEDICINE INSTITUTE LLC.

I have the right to revoke this authorization at any time by writing to ANKLE AND FOOT SPORTS MEDICINES INSTITUTE LLC. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

Information disclosed under this authorization might be re-disclosed by the recipient, and this re-disclosure may no longer be protected by state or federal law.

This authorization expires one year from the date of my signature below.

THIS AUTHORIZATION DOES NOT AUTHORIZE ANKLE AND FOOT SPORTS MEDICINE INSTITUTE LLC TO DISCUSS MY HEALTH INFORMATION OR, MEDICAL CARE WITH ANYONE OTHER THAN THOSE PERMITTED UNDER APPLICABLE LAW.

"Please sign and date the item below"

Acknowledgment and Authorization

I have read and understand the HIPAA/Privacy Policy for ANKLE AND FOOT SPORTS MEDICINE INSTITUTE LLC. I hereby assign my Insurance benefits to be paid directly to the healthcare provider. I authorize ANKLE AND FOOT SPORTS MEDICINE INSTITUTE LLC to release medical information required to process my insurance claim. I have read and understand the Financial Policy for ANKLE AND FOOT SPORTS MEDICINE INSTITUTE LLC. I authorize ANKLE AND FOOT CENTER SPORTS MEDICINE INSTITUTE LLC to obtain/have access to my medication history. All the information provided on my health history forms is true. I authorize my provider's office to contact me by phone, email, text, and mail. I have read and understand the Patient Treatment Consent.

Print Name of Person Signing _____

Relationship to Patient _____

Signed _____

Date _____

Cancellation/No show/Rescheduling Policy

Ankle and Foot Sports Medicine Institute respectfully asks that you give us 48 hours' notice if you are unable to make your appointment so that we may have the appropriate time to reschedule you as soon as possible. Your scheduled appointment is reserved just for you and your needs.

When you schedule your appointment, it is a "Promise to Appear" that we take very seriously. Any missed appointment is one that you do not keep or one that is not cancelled or rescheduled within 48 hours' notice.

A missed appointment has negative consequences both for your health and our practice by creating an inconvenience to other patients, as well as charges that may be applied to us from outside agencies. Therefore, if you miss your appointment and do not cancel or reschedule within 48 hours before the appointment time, you will be charged the total amount that may be passed on to us. (Ex: Interpreting Services.)

We make every effort to accommodate your needs when scheduling. In return, we ask that you help us by keeping your scheduled appointments, arriving on time, and notifying us in a minimum of 48 hours in advanced if you are unable to do so

I have read and understand the "Cancellation/No show/Rescheduling Policy" set forth by Ankle and Foot Sports Medicine Institute, LLC and agree to abide by the policy.

Please sign below that you have read and understand this policy.

Sign: _____

Date: _____

ANKLE AND FOOT SPORTS MEDICINE INSTITUTE, LLC
929 N. Spring Garden Ave. Ste. 927 A
Deland, Fl. 32720
Phone: 386-279-0450 Fax: 386-279-0571

RELEASE OF MEDICAL INFORMATION

Primary Care MD/DO: _____

Address: _____

City: _____

Phone Number: _____ Fax: _____

Patient Name: _____ Date of Birth: _____

I, _____ authorize and request the release of my medical records in your possession to Ankle and Foot Sports Medicine Institute. This authorization is to include OFFICE NOTES, LAB WORK, IMAGING, AND SURGICAL NOTES concerning my treatment. This authorization is good for two years from the date of my signature below.

SIGNATURE OF PATIENT: _____

SIGNATURE OF PARENT IF A MINOR: _____

WITNESS: _____