InStride Foot and Ankle Specialists, PLLC

NEW PATIENTS AND UPDATES

Today's Date____ / ____ / _____

PATIENT NAME______________________________ Date of Birth____ /____ / _____

Mailing Address____

City________________________State_________________Zip__________________

Phone: Home ________________Cell ________________Work_________________

E-mail Address____

SS#__________________________

Age________ Gender_________ Race_________ Primary Language______________

Emergency Contract Person: Name__________________ Phone#________________

How were you referred to our office? ______________________________________

INSURANCE INFORMATION

Primary Insurance________________________________

Secondary Insurance_____________________________

Name of Person who is the Primary Policy Holder__________________

Their Date of Birth _____/_____ /_____ Their Social Security Number____________________

MEDICAL INFORMATION

Primary Care Doctor's Name____

Primary Care Doctor's Address____

Date of last visit with Primary Care Doctor_____ /_____ / _____

Pharmacy Name____

Pharmacy Address____

Have you seen a podiatrist in the past 3 years? If so, who or where?______________________

____

SOCIAL HISTORY

Marital Status__________________ Occupation ________________________________

Tobacco use: ☐ Never ☐ Current Smoker ☐ Former Smoker: When did you quit?______________

Alcohol use: ☐ Never ☐ Occasional ☐ History of alcohol abuse

Recreational drug use: ☐ Never ☐ Occasional ☐ History of drug abuse: What type?____________

FAMILY HISTORY

☐ Cancer ☐ Heart Disease ☐ High Blood Pressure ☐ Diabetes ☐ Other________________

ALLERGIES

☐ None ☐ Tape ☐ Latex ☐ Shellfish ☐ Iodine ☐ Penicillin ☐ Codeine

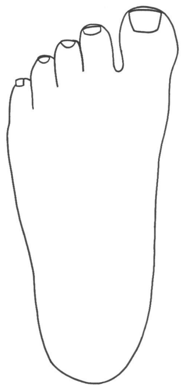
☐ Sulfa ☐ NSAID(Aspirin, Motrin, Advil, Ibuprofen, etc) ☐ Other__________________

Height_________ Weight________ Shoe size________ Women, are you pregnant or nursing?_______

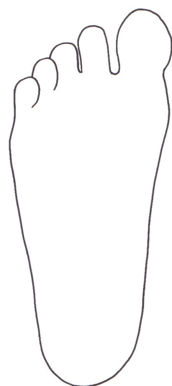
What SPECIFIC reason brings you to our office today?________________________________

MARK THE PROBLEM AREA BELOW

Left Foot



Top



Bottom

Right Foot

Top

Bottom

MEDICATIONS

MEDICATION NAME	STRENGTH	HOW OFTEN

SURGERIES

TYPE OF SURGERY	DATE OF SURGERY

HOSPITALIZATIONS

REASON FOR HOSPITALIZATION	DATE OF HOSPITALIZATION

Do you have any of the following Symptoms?

Symptom				Symptom				Symptom		
Headache	Y	N		Shortness of breath	Y	N		Leg/foot open sores	Y	N
Blurry Vision	Y	N		Heartburn	Y	N		Paralyzed	Y	N
Ringing in Ears	Y	N		Diarrhea	Y	N		Muscle spasms	Y	N
Sore Throat	Y	N		Constipation	Y	N		Muscle weakness	Y	N
Sinus Problems	Y	N		Burning during urination	Y	N		Low back pain	Y	N
Pain in legs after walking	Y	N		Frequent urination Infrequent urination	Y Y	N N		Joint pain	Y	N
Irregular heart beat	Y	N		Bruise/bleed easily	Y	N		Broken bones	Y	N
Cough	Y	N		Nausea/vomiting	Y	N		Anxiety/Depression	Y	N

Do you have a history of these Medical Conditions?

Condition				Condition				Condition		
Diabetes	Y	N		Fibromyalgia	Y	N		Neuropathy	Y	N
High Blood Pressure (Answer yes if you take medication)	Y	N		Stroke	Y	N		Open Sores	Y	N
Arthrtis	Y	N		Heart Attack	Y	N		Pneumonia	Y	N
Rheumatoid Arthritis (Auto Immune Disease)	Y	N		Heart Disease	Y	N		Polio	Y	N
Back Trouble	Y	N		Hepatitis A, B, or C Specify	Y	N		Rheumatic Fever	Y	N
Stomach Ulcer	Y	N		HIV+/AIDS	Y	N		Sickle Cell Disease	Y	N
Acid Reflux/GERD	Y	N		Congestive Heart Failure	Y	N		Skin Disorder	Y	N
Blood Clots	Y	N		Kidney Disease	Y	N		Sleep Apnea	Y	N
Trouble Healing Cuts	Y	N		Liver Disease	Y	N		Stomach Ulcers	Y	N
Multiple Sclerosis	Y	N		Low Blood Pressure	Y	N		High Cholesterol	Y	N
Asthma	Y	N		Poor blood flow	Y	N		Thyroid Disease	Y	N
Lupus	Y	N		Mitral Valve Prolapse	Y	N		Tuberculosis	Y	N
Crohn's/Colitis	Y	N		Gout	Y	N		Cancer	Y	N

List any other medical conditions____

____

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<u>COMPLETE ONLY IF YOU HAVE DIABETES OR POOR CIRCULATION</u>

Consent for Treatment

If I should have poor circulation or diabetes, I understand that this is a condition that may/will get worse. I know that I have a risk of disease or complications because I have poor circulation or diabetes, even with professional care and treatment.

I understand that I have the following treatment options:

1. No treatment
2. Special/wider shoes
3. Padding
4. Periodic treatment to make me more comfortable
5. Antibiotics and/or other medications
6. Limit my walking/weight-bearing time
7. Change in occupation
8. Surgery
9. ___________________________________

I understand that with any treatment of my condition, including surgery, the following risks are present:

1. Infection
2. Delayed healing
3. Wound deterioration or breakdown
4. Additional danger of artery/vein clotting (blood clot)
5. Skin tissue death/skin ulcer
6. Loss of toe, foot, limb, or life
7. Drug reaction
8. ____

These risks are present in all operations/treatment. However, I understand that my poor circulation/ diabetes increases my risk for complications. If I have one or more of these complications, I UNDERSTAND THAT MY FUTURE CARE AND TREATMENT MAY BE MORE DIFFICULT AND THE OUTCOME MORE UNCERTAIN.

NON-TREATMENT OF MY FOOT PROBLEMS also presents serious risks to me. My foot problems could get worse, and I might have new complications such as infection, skin ulcer/breakdown and loss of toe, foot, limb, or life.

I certify that I know or have been informed that I have a systemic condition (peripheral vascular disease/ diabetes). I UNDERSTAND AND ACKNOWLEDGE MY PODIATRIST WILL TREAT ONLY MY FOOT AND ANKLE CONDITIONS AND WILL NOT TREAT DIRECTLY MY SYSTEMIC CONDITIONS (peripheral vascular disease/diabetes).

The above information and the alternatives/material risks was provided. I understand this explanation, and I authorize my podiatrist to treat my foot condition(s).

Signature of Patient/Responsible Party X_____________________________ Date:__/___/___

Patient Financial Policy

Foot and Ankle Center of Durham, A Division of InStride Foot and Ankle Specialists, PLLC

- As our patient, you are responsible for all authorizations/referrals 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 are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check. Copay, co-insurance, or deductible will be due at the time services are rendered. You may receive a bill for any fees deemed as a patient responsibility after the claim has been settled with your insurance provider.
- 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 benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We made prior arrangements with certain insurers and health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will require you to pay the copay/coinsurance/deductible at the time of service.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due 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 benefits for some specialized services or referrals; however, you are responsible for charges for 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. In the event the office is not informed, you will be responsible for any denied charges.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are certain elective surgical procedures for which we require prepayment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the 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 this office.
- **Self pay patient**s will be asked to pay a deposit before services are rendered. A final patient responsibility will be collected after treatment is completed.
- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.
- I agree to pick-up and pay for any custom orthotics or braces for which I am casted or 3D scanned.
- **MEDICAID** patients: We do not accept Medicaid as a primary insurance for adults (anyone over the age of 18). This form acknowledges that you have been made aware. You agree to pay any fee or cost deemed as a patient responsibility.
- There is a **$50.00 "NO SHOW"** fee for failure to reschedule or cancel your appointment at least 24 hours in advance of your scheduled appointment.
- I understand **NAIL AND CALLUS TRIMMING** are not automatically covered by my insurance. They are not automatically covered even if I pay a Copay, Co-insurance, or Deductible that is applied towards my office visit. I understand that nail and callus trimming are two different services and are billed separately.

Signature of Patient/Responsible Party X____

Printed Name of Patient/Responsible Party______________________ **Date:**___/___/___

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION
InStride Foot and Ankle Specialists, PLLC

I authorize the physician and staff to disclose the following protected health information to:

☐ Myself only
☐ Other (specify name & relationship)___________________________________

Information to be disclosed:

☐ Any and all information Or Only options selected below:
☐ Laboratory results
☐ Diagnosis
☐ Appointments

I agree to be contacted at my:

☐ Home Phone
☐ Work Phone
☐ Cell Phone
☐ Email

Indicate which permission you give the office regarding your voicemail system.

☐ I give my permission for any and all information to be left on my voicemail system.

☐ I give my permission for only non-medical messages such as appointment reminders and requests to contact the office be left on my voicemail system.

☐ I do not want any information left on my voicemail system.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Officer at the below address. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by the federal HIPAA Privacy Rule or state law.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I acknowledge that a copy of the Notice of Privacy Practices has been made available to me as it is posted in the lobby in full view. I also had the opportunity to request a person copy of the notice. I state that I understand the Notice of Privacy Practices.

ACCURACY OF INFORMATION PROVIDED

To the best of my knowledge, I have answered the questions in these forms accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

Nail and Callus Trimming

I understand that nail and callus trimming are two different services and may not be covered by my insurance. I understand that the doctor will determine coverage based on my insurance plan’s guidelines, an in-office physical exam, a review of past medical history. I agree to pay for costs if it is deemed as a non-covered service.

Signature of Patient/Responsible Party X_____________________________________

Printed Name of Patient/Responsible Party______________________**Date:**___/___/___