

PATIENT INFORMATION FORM

(PLEASE PRINT)

DATE: ____/____/____

PATIENT NAME: _____ DATE OF BIRTH: ____/____/____ AGE: ____ SEX: M F
LAST FIRST MI

HOME ADDRESS: _____ CITY/STATE: _____ ZIP: _____

PRIMARY PHONE _____ E-MAIL: _____

PRIMARY LANGUAGE: _____

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES No

IF YES, NAME: _____ RELATIONSHIP: _____ PHONE #: (____) ____ - ____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE #: (____) ____ - ____

PRIMARY CARE DOCTOR: _____ DATE LAST SEEN: _____

PHONE: _____

PHARMACY: _____ LOCATION: _____ PHONE #: (____) ____ - ____

WHO IS RESPONSIBLE FOR PAYMENT? _____ RELATIONSHIP TO PATIENT? _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____ - ____

WHO REFERRED YOU TO US? _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____ - ____

INSURED NAME: _____ DATE OF BIRTH _____ EMPLOYER _____

CONTRACT # _____ GROUP # _____

SECONDARY INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____ - ____

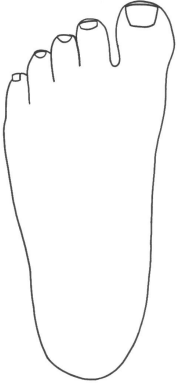
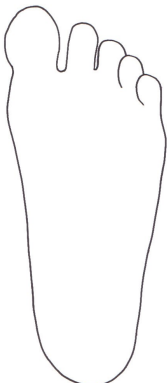
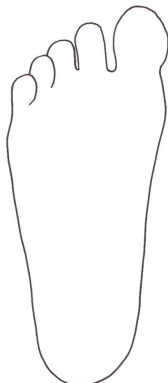
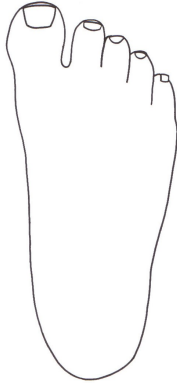
INSURED NAME: _____ DATE OF BIRTH _____ EMPLOYER _____

CONTRACT # _____ GROUP # _____

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

LEFT FOOT		RIGHT FOOT	
			
TOP OF FOOT	BOTTOM OF FOOT	BOTTOM OF FOOT	TOP OF FOOT
			
INSIDE OF FOOT	OUTSIDE OF FOOT	OUTSIDE OF FOOT	INSIDE OF FOOT

HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: ☐ BEGIN ALL OF A SUDDEN ☐ GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? ☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING
☐ RADIATING ☐ ITCHING ☐ STABBING ☐ OTHER _____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)

(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORST PAIN POSSIBLE)

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: ☐ STAYED THE SAME ☐ BECOME WORSE ☐ IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? ☐ WALKING ☐ STANDING ☐ DAILY ACTIVITIES
☐ RESTING ☐ DRESS SHOES ☐ HIGH HEELS ☐ FLAT SHOES ☐ ANY CLOSED TOE SHOE
☐ RUNNING ☐ OTHER _____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? _____

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? _____

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ YES (DESCRIBE) _____ ☐ No

YOUR MEDICAL HISTORY

HEIGHT: _____ WEIGHT: _____ SHOE SIZE: _____

RACE: _____ ETHNICITY: _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES: TYPE 1 OR TYPE 2 (CIRCLE)	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N
OTHER CONDITIONS: _____								

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY HISTORY

MOM DAD GRANDMOTHER GRANDFATHER

☐ DIABETES: TYPE 1 OR TYPE 2 ☐ CANCER ☐ HEART DISEASE

☐ HIGH BLOOD PRESSURE ☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE

☐ RHEUMATOID ARTHRITIS

☐ OTHER _____

SOCIAL HISTORY

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE

☐ CURRENT USE - Type _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ ☐ SMOKE _____ PACKS/DAY FOR _____ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ TYPE _____

☐ CURRENT USE - Type _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

EMPLOYER: _____ OCCUPATION: _____

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

EXERCISE: ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY

TYPES OF EXERCISE: _____

REVIEW OF SYSTEMS:

NAUSEA Y OR N
DIARRHEA Y OR N
COUGH Y OR N
CHEST PAIN Y OR N
FATIGUE Y OR N
FEVER Y OR N
NEUROPATHY Y OR N

HEADACHES Y OR N
WEIGHT LOSS/GAIN Y OR N
MUSCLE ACHES Y OR N
JOINT PAINS Y OR N
BACK PAIN Y OR N
SHORTNESS OF BREATH Y OR N
FREQUENT URINATION Y OR N

ALLERGIES: ☐ MEDICATIONS _____
☐ ANESTHESIA _____ ☐ FOODS _____
☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER _____
☐ NONE KNOWN

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME DOSE HOW OFTEN DO YOU TAKE?

IMMUNIZATIONS/TESTING:

FLU: _____ PNEUMONIA: _____ HGA1c: _____
COLONOSCOPY: _____ EYE EXAM: _____

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM 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.

PRINT NAME OF PATIENT, PARENT OR GUARDIAN

SIGNATURE OF DOCTOR

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

SIGNATURE

DATE

Medical Information Release Form
(HIPAA Release Form)

Name: _____ Date of Birth: ____/____/____

Release of Information

☐ I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

☐ Spouse _____

☐ Children _____

☐ Other _____

☐ Information is not to be release to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing

Messages

Please call ☐ my home _____ ☐ my work _____ ☐ my cell number: _____

If unable to reach me:

☐ you may leave a detailed message

☐ please leave a message asking me to return your call

☐ _____

The best time to reach me is (day) _____ between (time) _____

I have been provided a copy of this office's Notice of Privacy Practices, available upon request

Signed: _____

Date: ____/____/____

Witness: _____

Date: ____/____/____

Foot & Ankle Specialists of Mid-Michigan, PC

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 our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office. · Cancellation Policy: Please allow at least 24 hours' notice for all cancelled appointments. If 24 hours' notice is NOT provided, you will be charged a \$25 late cancellation fee.
- 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.
- 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 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 copay/co-insurance/deductible.
- 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 remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

We DO NOT BILL MEDICAID/MEDICAID HMO'S for services provided in our office. We will provide you with any/all information that is needed to bill them directly yourself.

- 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 charges denied.
- 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 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 the surgery.

We do request a credit card or debit card on file. Any balance over 90 days that DOES NOT have a payment plan initiated will be charged at a maximum of \$100 per month until the account is paid in full. This will be charged on the Card on file. If you want the Credit Card removed, you must notify our office in writing that you would like it removed.

- 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.
- There is a service fee of \$25.00 for all returned checks. Your insurance company does not cover this fee.

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party _____ Date: _____

_____ Patient initials to indicate copy received.



Consent for Treatment

I give Foot & Ankle Specialists of Mid-Michigan consent to treat me today. I want to receive health care services from Foot & Ankle Specialists of Mid-Michigan including medical, podiatric, and/or other health care services. Services may include: Surgeries and Procedures, Medications, Tests, Telemedicine Services, and Other treatment necessary for my care.

I agree that Foot & Ankle Specialists of Mid-Michigan can share my information as needed for care or billing and to facilitate my care and medical needs, Foot & Ankle Specialists of Mid-Michigan may need to provide necessary information about me to other healthcare providers.

I understand that I have the right to agree to or refuse any care recommended. My health care providers will make all attempts to review known risks, expected benefits, and alternatives to therapies recommended. I may need to give additional consents for invasive procedures and special treatments. I understand the practice of medicine is uncertain. It is impossible to avoid certain risks and clinical outcomes may be different for each patient.

I understand and agree that patients, their families, and their friends are not guaranteed a right to photograph or record on Foot & Ankle Specialists of Mid-Michigan premises, and must stop immediately if directed by staff. Photographs or recordings taken by family or visitors may not be entered into the medical record

I give permission for Foot & Ankle Specialists of Mid-Michigan to photograph me as they see necessary for my medical care.

I understand that services that are normally covered by my insurance will be billed but are not guaranteed to be paid. I am responsible for the charges for these services if they are not covered by my insurance.

If an authorization or Precertification is required with my contract, I understand that this is my responsibility.

Any questions about what benefits or coverage under my contract I am responsible for inquiring. By signing this consent, I understand that Foot & Ankle Specialists of Mid-Michigan will bill my insurance for services provided today.

Patient Signature

Date