Florida Foot & Ankle Group, P.A.

Patient Information Sheet

Información del Paciente

Today's Date ______________________
Fecha

Name ____ Social Security #
____
Nombre — Seguro Social

Date of Birth ______________________________________ Sex ☐ Male ☐ Female Age
______
Fecha de Nacimiento — Sexo Masculino Femenino edad

Address ____
Dirección

City ______________________________ State ______________ Zip ________
Ciudad — Estado — zip

Home Phone ______________________ Marital Status ☐ Single ☐ Married ☐ Widow
(er) Telefono — Estado Civil Soltero Casado Vi udo

Cell Phone ______________________ Pharmacy Phone
____

Employer ______________________ Work Phone ______________________
Empleador — Telefono del trabajo

Job position ______________________
Posicion

Family Physician ______________________ Physician's Phone
______________ Medico Primario — Telefono del medico
primario

If minor, Rsponsible Party ______________________ Phone ______________________
Si es menor de edad, Persona responsible — Telefono

Emergency Contact ______________________ Phone ______________________
En caso de emergencia — Telefono

How were you referred to us? ☐ Doctor ☐ Friend / Family ☐ Yellow Pages ☐ Other
____
Como fue referido a nosotros — Medico — Amigo/familiar — Páginas amarillas — Otro

PLEASE READ AND SIGN

I understand that I am responsible for payment of devices provided to me or my dependent. I herby authorize assign insurance benefits, otherwise payable to me/my dependent, to be paid directly to **FLORIDA FOOT & ANKLE GROUP,P.A.** I authorize any holder of medical information about me/my dependent to release to Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand that Medicare or my insurance company may deny payment for services rendered to me or my dependent (s) due to frequency or lack of medical necessity. I therefore, assume full financial responsibility for all non-covered services. My signature below authorizes the release of pertinent medical information to insurance carriers and authorizes my insurance benefits to be paid directly to the doctor.

I herby give consent to FLORIDA FOOT & ANKLE GROUP, P.A. to provide whatever treatment the assign physician may deem necessary to the patient named below.

POR FAVOR LEA Y FIRME

Yo entiendo que soy responsable por pagos a servicios proveidos a mi o dependiente. Yo asigne beneficios de seguro, de otra manera pagadero a mi o mi dependiente a ser pagado directo a **FLORIDA FOOT & ANKLE GROUP, P.A.** y autorizo que cualquier informacion medica acerca de mi sea divulgada a "Health Care financial Administrator" y sus agentes y cualquier informacion necesitada con proposito de determinar beneficios pagaderos a servicios relativos.

Yo entiendo que Medicare o mi seguro medico puede negar pagos por servicios prestados a mi o mi dependiente debido a frecuencia de necesidad medica. Yo asumire completa responsabilidad financiera para todos los servicios no cubiertos por mi seguro medico. Mi firma autoriza el dar informacion pertinente a mi seguro medico y autorizo que mis beneficios de seguros sean pagados directo al medico asignado.

Yo doy consentimiento a **FLORIDA FOOT & ANKLE GROUP,P.A.** a proveer cualquier tratamiento asignado por el medico que sea necesario para el paciente.

____

Signature of Patient or Responsible Party / Firma del paciente o responsable — Date / Fecha

Florida Foot & Ankle Group., P.A.

Patient Health History

Historial de Salud del Paciente

Si necesita ayuda escribiendo en Ingles, porfavor dejenos saber

Name:________________________________ Age:_______ Sex:_________ Race:______________

Nombre Edad Sexo Raza

Reason For Today's visit ____

Razón de la visita de hoy

Did your injury occur at work?

____

Ud.se lastimó en su trabajo?

Height:__________________ Weight:____________________ Shoe Size:_________________________

Estatura Peso Tamaño de zapato

Current Medical Conditions or Illnesses:____

Condiciones Medicas al momento

Current Medications:____

Medicamentos que toma al momento

Allergies (drugs, iodine, tape, food):____

Alergias (Medicinas, comida, etc.)

List any hospitalizations or surgeries you have had:____

Lista de Hospitalizaciones u operaciones

____

Do any family members have: ☐ Arthritis ☐ High Blood Pressure ☐ Diabetes ☐ Cancer ☐ Gout

Artritis Alta Presión Diabetes Cancer Gota

Algún miembro de su familia tiene ☐ Blood or Bleeding Problems ☐ Heart Problems ☐ Foot Problems

Problemas de sangre o sangramiento Problemas del Corazón Problemas de los pies

Do you smoke cigarettes? ☐ No ☐ Yes ____

Ud. Fuma cigarillos?

Have you ever smoked? ☐ No ☐ Yes

____

Ud a fumado?

Do you drink alcohol? ☐ No ☐ Yes

____

Ud toma alcohol?

Do you exercise? ☐ No ☐ Yes

____

Ud se ejercita?

Do you spend time on your feet at work? ☐ No ☐ Yes

____

Ud trabaja parado?

Family Doctor / Internist:______________________________________ Date last seen: ______________

Medico de cabecera Fecha

Do you have or have had any of the following conditions or illnesses:
Ud tiene o a tenido alguna de las siguientes condiciones o enfermedades:

Condition		Condition		Condition	
Arthritis Artritis	☐ No ☐ Yes	Poor circulation Pobre circulación	☐ No ☐ Yes	Lung or breathing problems Problemas de pulmones / respiratorios	☐ No ☐ Yes
Cancer Cancer	☐ No ☐ Yes	Bleeding Problems Problemas de sangramiento	☐ No ☐ Yes	Trauma to feet or legs Trauma en los pies o piernas	☐ No ☐ Yes
Gout Gota	☐ No ☐ Yes	Poor healing Problemas curandose	☐ No ☐ Yes	Cramping of feet or legs Calambres en los pies o piernas	☐ No ☐ Yes
Tuberculosis Tuberculosis	☐ No ☐ Yes	Nerve problems Problemas de nervios	☐ No ☐ Yes	Swelling of feet or legs Hinchazon de los pies o piernas	☐ No ☐ Yes
Diabetes Mellitus Diabetes Melitus	☐ No ☐ Yes	Numbness in feet Adormecimiento de los pies	☐ No ☐ Yes	Ear/eyes/nose/throat problems Problemas de oidos/ojos/nariz o garganta	☐ No ☐ Yes
Rheumatic Fever Fiebre reumatica	☐ No ☐ Yes	Low back pain Dolor de espalda baja	☐ No ☐ Yes	Infections/contagious disease Infecciones/ enfermedades contagiosas	☐ No ☐ Yes
Heart problems Problemas de corazón	☐ No ☐ Yes	Weight loss/gain Gano / perdida de peso	☐ No ☐ Yes	Hepatitis, AIDS, VD Hepatitis, SIDA, Enfermedades venereas	☐ No ☐ Yes
Stomach ulcers Ulceras en el estómago	☐ No ☐ Yes	High blood pressure Alta presión	☐ No ☐ Yes	Blood Transfusion Trasfusión de sangre	☐ No ☐ Yes
Phlebitis Flebitis	☐ No ☐ Yes	Liver problems Problemas del higado	☐ No ☐ Yes	Stroke Stoke	☐ No ☐ Yes
Anemia Anemia	☐ No ☐ Yes	Kidney problems Problemas de los riñones	☐ No ☐ Yes	Other Otro	☐ No ☐ Yes

The above information is complete and accurate to the best of my knowledge. I herby give permission to Florida Foot & Ankle Group, P.A., to examine, perform necessary diagnostic testing, and treat my foot or ankle condition. I authorize photographing my feet.

La siguiente información esta completa a lo major de mi entender. Autorizo a Florida Foot & Ankle Group, P.A., a examinar y hacer cualquier procedimiento necesario para tratar la condición de mi pie o mi tobillo. Autorizo que tomen fotos mis pies.

Patient/Parent/Guardian Sinature_________________________________
Date_______________________
Firma del Paciente / Padres / Enacargado Fecha

Florida Foot & Ankle Group, P.A.

FINANCIAL POLICY

Thank you for choosing Florida Foot & Ankle Group, P.A., as your foot care provider. The following information discusses our current financial policy and procedures.

1. It is your responsibility to provide accurate demographic and insurance information and a picture ID at the time of your visit. If you do not have insurance or do not present a valid insurance card, you will be responsible for payment at the time of service. A copy of our billing form will be provided if requested.

2. If your insurance plan requires a referral, it is your responsibility to obtain the referral prior to being seen by our physicians. Failure to provide a referral may necessitate rescheduling of your appointment.

3. It is your responsibility to ensure that our physicians are in your insurance network.

4. Copayments are due at the time of your visit. Also, co-insurance, unmet deductibles and outstanding balances are due at the time of your visit or prior to scheduled surgeries and procedures. We accept cash, checks and credit/debit cards. Post-dated checks are not accepted.

5. We will bill your insurance company on your behalf. You agree to assign payment to Florida Foot & Ankle Group and authorize Florida Foot & Ankle Group to bill your insurance plan in accordance with your insurance benefits in place at the time services are rendered.

6. Your insurance plan may not cover all services and/or supplies provided to you during your visit. These "non-covered" charges will be your responsibility, and due at the time of your visit or upon receipt of a billing statement.

7. You are ultimately responsible for payment of charges for services you receive from our office and/or physicians .

8. Cancellations for office appointments and procedures must be received at least 24 hours prior to the scheduled appointment. Cancellations for scheduled surgery must be received at least 2 weeks days prior to the scheduled surgery date.

9. A $25 no-show fee will be charged to patients who do not cancel or reschedule at least 24 hours before their scheduled appointment. A $100 fee may be charged for surgeries cancelled less than 2 weeks prior to the scheduled surgery.

10. The returned check fee is $30.

11. Medical records requests must be received in writing at least one week prior to the date needed. Fees for medical records are set in accordance with allowable amounts as defined by the State of Florida, and must be received prior to record delivery. No more than five pages may be faxed.

12. X-ray copy requests must be received at least one week prior to the date needed. There will be a $15 fee for each x-ray copied.

13. There will be a prepaid fee of $20 for completing individual medical leave forms, disability forms, work restriction forms, employer forms, school forms, insurance forms, etc. All form requests require 5 to 7 business days to process.

14. Durable medical equipment (DME) consists of items such as crutches, surgical shoes, and removable casts. Once dispensed, these items cannot be returned or exchanged.

15. Over-the-counter products and medical supplies purchased from our office cannot be returned or exchanged.

Your signature certifies that you have read the foregoing policy and accept its terms.

____ ______________________

Patient or Patient's Representative or Responsible Party — Date

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of the Notice of Privacy Practices (see link on website) and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

______________________________________ ____________________
Patient Name (please print) Date

____
Parent or Authorized Representative (if applicable)

____
Signature

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: ________________

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITYS IN THE FUTURE.**

______________________________ ______________________________

Please ***print*** your name Please ***sign*** your name

______________________________ ______________________________

Legal Representative Description of Authority

Your comments regarding Acknowledgements or Consents: ______________________________

____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Sir Name ☐ Other ________________

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: ________________ Relationship: ________________

Name: ________________ Relationship: ________________

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- ☐ Cell Phone Confirmation
- ☐ Home Phone Confirmation
- ☐ Work Phone Confirmation
- ☐ Text Message to my Cell Phone
- ☐ Email Confirmation
- ☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

- ☐ Cell Phone Confirmation
- ☐ Home Phone Confirmation
- ☐ Work Phone Confirmation
- ☐ Text Message to my Cell Phone
- ☐ Email Confirmation
- ☐ **Any of the Above**

! APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

- ☐ Phone Message
- ☐ Text Message
- ☐ Email
- ☐ **Any of the Above**
- ☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- It was emergency treatment ___
- I could not communicate with the patient ___
- The patient refused to sign ___
- The patient was unable to sign because ___
- Other (please describe) ___

____

Signature of Privacy Officer