Foot & Ankle Specialists of the Mid-Atlantic
Keeping you on track...For Life!

PATIENT DEMOGRAPHICS

First Name _____ **M.I.** _____ **Last Name** _____

Street Address _____ **Apt. #** _____ **City** _____ **State** _____ **Zip code** _____

Home Phone (_____) _____ **Work Phone** (_____) _____ **Cell Phone** (_____) _____

E-Mail Address _____

Gender ☐ **F** ☐ **M** **Birth Date** ____/____/____ **Marital Status** ☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Widowed

Primary Language _____

Race: (Choose all that apply)

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White

Ethnicity: (Choose one that applies)

- ☐ Hispanic
- ☐ Not Hispanic

Employed PT / FT / Retired / None **Employer** _____

Pharmacy of Choice _____ **Pharmacy Address** _____

Primary Care Physician _____

Are you diabetic? Yes No **If yes, name of physician managing diabetes** _____ **Date last seen** _____

How did you hear about our practice? ☐ Health Fair ☐ Doctor Referral (Name of Doctor: _____)

☐ Internet (Source _____) ☐ Ad (Source _____)

☐ Friend/Family Member/Patient (Name: _____) ☐ Other: _____

Emergency Contact _____ **Relationship to Patient** _____

Cell Phone Number (_____) _____ **Alternate Phone Number** (_____) _____

Insurance Information

A. Insurance Company: _____
Insurance ID Number: _____
Group Number: _____
Primary Subscriber Name: _____
Primary Subscriber Birth Date: _____
Relationship to Patient: _____

B. Insurance Company: _____
Insurance ID Number: _____
Group Number: _____
Primary Subscriber Name: _____
Primary Subscriber Birth Date: _____
Relationship to Patient: _____

Financially Responsible Person First Name _____ **Last Name** _____
Gender ☐ **F** ☐ **M** **Birth Date** __/____/____ **Street Address** _____
City _____ **State** _____ **Zip code** _____
Home Phone (_____) _____ **Work Phone** (_____) _____ **Cell Phone** (_____) _____

Patient's Authorization and Assignment of Benefits: I hereby authorize the processing of the medical insurance either by electronic or manual method by FASMA, LLC. My signature authorizes payment for all major medical and/or durable medical equipment supplies and/or surgical benefits to which I am entitled from the listed insurer(s) above and/or by providing my insurance cards to the office to pay for services rendered to FASMA, LLC. I certify that the information, I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I grant permission to contact me via email. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. I recognize my financial obligation of any balance, co-insurance, deductible, and non-covered services that may be required.

Signature of Responsible Party _____ **Date** _____

Relationship (if not patient) _____

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MEDICAL FORM

First Name _____ **M.I.** _____ **Last Name** _____ **DOB** _____
Age _____ **Height** _____ **Weight** _____ **Shoe Size** _____ **Reason for visit**_____
How long has this been a problem? _____ **When does it occur?** Morning Afternoon Evening Off and On All Day
TREATMENTS: Please list previous treatments (either prescribed or home remedies):

_____

_____

Is this visit related to an accident/injury? Y N If yes, date of injury_____
LIST CURRENT SPORTS/ACTIVITIES: _____
MEDICATIONS: Please list (or attach a list) of your current medications and their dosages:

_____ _____ _____
_____ _____ _____
_____ _____ _____

ALLERGIES: Do you have a history of allergies/skin reaction/sickness following the administration of any of the following:

	Y	N	** If yes, list REACTION		Y	N	** If yes, list REACTION
Adhesive tape	__	__	_____	**Foods**	__	__	_____
Anesthesia	__	__	_____	**Iodine**	__	__	_____
Aspirin	__	__	_____	**Latex**	__	__	_____
Caffeine	__	__	_____	**Local Anesthetics**	__	__	_____
Codeine	__	__	_____	**Penicillin**	__	__	_____
Cortisone	__	__	_____	**Sulfa Drugs**	__	__	_____
Demerol	__	__	_____	**Other, please list:**			_____

MEDICAL HISTORY: please indicate: **S** (self), **F** (father), **M** (mother), **SI** (sister), **B** (brother), **G** (grandparent), **OFM** (other family member)

____Alcohol/Drug addiction/dependency
____Alzheimer's/Dementia
____Anemia – type_____
____Arrhythmias – type _____
____Arthritis - type_____
____Asthma circle (adult or childhood)
____Bleeding/Clotting Problems – type_____
____Cancer - type_____
____Depression/Anxiety disorder/Bipolar depression/other
____ Diabetes (how long? _____)
____Emphysema/COPD
____Glaucoma
____Gout
____GERD (Reflux)/GI ulcers (circle)
____Headaches / Migraines
____Hearing Problems
____Heart Disease
____Hepatitis A B C/Liver Disease _____
____High Blood Pressure
____High Cholesterol
____ HIV/ Aids/ARC
____Kidney/ Renal Disease
____Lung Disease/Pulmonary Embolus
____Lyme's Disease
____Nervous Condition (type?)_____
____Osteoporosis/Osteopenia (circle)
____Phlebitis (blood clots in legs)
____Pregnancy: are you currently pregnant? Due date: _____
____Poor Circulation/PVD
____Rheumatic Fever/Scarlet Fever
____Schizophrenia
____Seizures/Epilepsy
____STD's (sexually transmitted ds.)
____Sickle Cell Trait/Disease
____Stroke/TIA's
____Thyroid Problems (Hyper__ Hypo__)
____Tuberculosis
____Other, Please Specify _____
____Other, Please Specify _____
____ NONE of the above

PLEASE FILL OUT COMPLETELY

SMOKING:
Do you or have you ever smoked? Y N
If yes, how many years? _____How long ago did you quit? _____

ALCOHOL USE:
Do you or did you ever drink alcoholic beverages? Y N
How many drinks will you consume in a day? ____ Week? _____
How long ago did you quit? _____

RECREATIONAL DRUG USE:
Do you or have you ever used illicit/recreational drugs? YES NO
If yes, which ones? _____
How long ago did you quit? _____

HOSPITALIZATION: Y N If yes, please list: _____

SURGICAL HISTORY: Y N If yes, please list the surgeries you have had in the past 7 years:

_____

Consent for Treatment: I certify that the information above is true and correct to the best of my knowledge. I have been informed that if I am uncertain about any question on the form I should ask the doctor or a member of the office staff for assistance. By signing below, I hereby authorize Foot and Ankle Specialists of the Mid-Atlantic, LLC to obtain medication history from community pharmacies and/or pharmacy benefit managers for the purpose of ongoing treatment. I give permission to Foot and Ankle Specialists of the Mid-Atlantic, LLC to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet, ankles, and lower legs.

Signature of Responsible Party_____ **Date**_____
Relationship (if not patient) _____

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REVIEW OF SYSTEMS

Patient Name:_____

Please check any of the following that you are currently experiencing or have recently experienced.

Constitutional:	**Y**	**Musculoskeletal:**	**Y**
Do you feel fatigued during the day?		Do you have low back pain?	
Do you have headaches?		Do you have pain in your leg?	
Do you have a fever?		Do you have foot pain?	
Do you have chills?		Do you have joint pain?	
Do you have sweats?		Do you have bone pain?	
Do you have malaise?		Do you have general muscle aches or pains?	
Have you experienced any weight loss?		Have you had swelling in your legs?	
Do you feel any dizziness/fainting spells?		Have you had joint swelling or stiffness?	
Eyes:	**Y**	Have you noticed a change in the way you walk?	
Do you wear glasses?		Is it difficult to climb stairs?	
Do you wear contacts?		Are you experiencing a loss of strength in your leg?	
Do you have blurry vision?		Do you limp when you walk?	
Do you have burning eyes?		Do your shoes wear out quickly or unevenly?	
Do you have itchy eyes?		**Integumentary (Skin):**	**Y**
Do you have sensitivity to light?		Is your skin strongly sensitive when exposed to the sun?	
Are your eyes frequently red?		Do you have any skin rashes?	
Do you have eye pain?		Do you have any warts on your feet?	
Ears, Nose, & Throat:	**Y**	Do you have any moles, lumps, or bumps on your skin?	
Do you have ringing in your ears?		Do you have extremely dry skin or cracking?	
Do you get nosebleeds?		Do you have open skin sores?	
Do you have difficulty swallowing?		Are there unusual areas of discoloration on your skin?	
Cardiovascular:	**Y**	Do you have any corns or calluses on your feet?	
Have you noticed your legs or ankles swelling?		Are your nails unusually thick?	
Do you have cramping in your legs at night or at rest?		Are your nails deformed?	
Do you have cramping in your legs/calf when walking?		Are your nails ingrown and tender?	
Respiratory:	**Y**	Do your nails cause you pain?	
Do you have chest pain?		Do you have noticeable hair loss on your legs or feet?	
Do you have difficulty breathing?		**Neurological:**	**Y**
Do you have shortness of breath?		Do you ever feel dizzy?	
Have you had a cough lasting longer than 3 weeks?		Do you often feel confused or disoriented?	
Gastrointestinal:	**Y**	Do you have problems with your balance?	
Do you have a loss in appetite?		Do you have frequent or reoccurring headaches?	
Do you have increase in appetite?		Do you have seizures?	
Does Aspirin cause stomach pain?		Do you have tremors of your extremities?	
Do you have a history of stomach ulcers?		Do your legs often feel like they are going to sleep?	
Do you have heartburn?		Do you have numbness in your legs?	
Do you have bloody or dark stools?		Do you have a feeling of burning in your legs?	
Genitourinary:	**Y**	Do you have pain in the legs with walking or exercises?	
Do you have pain with urination (dysuria)?		Do you have leg pain that is worse at night or rest?	
Have you noticed blood in your urine (hematuria)?		Do you have leg pain all the times?	
Do you have any discharge?		Do you experience shooting pains down your legs?	
Do you urinate more frequently than before?		Do you have paralysis (complete loss of muscle strength in legs)?	
Do you have burning with urination?		**Psychiatric:**	**Y**
Hematologic/Lymphatic:	**Y**	Do you have a history of psychiatric problems?	
Do you bruise easily?		Are you subject to mood swings?	
Do you have any abnormal bruising?		Are you under a lot of stress?	
Are you bleeding?		**Endocrine:**	**Y**
Allergic/Immunologic:	**Y**	Are you excessively thirsty?	
If you get cut, does it take a long time to heal?		Do you have a history of bad breath?	
Do you have allergic reactions to medication(s)?		Are you experiencing night sweats?	
Do you have allergic reactions to foods?		Do you have swollen glands?	
Do you have allergic reactions to dye?		Have you had a significant weight change recently?	

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FINANCIAL POLICY

(Please Read, Initial Each Financial Policy Line Sign At the Bottom of the Form)

Welcome to Foot and Ankle Specialists of the Mid-Atlantic, LLC and thank you for selecting our practice. We are committed to providing you with the best possible care. If you have medical insurance, we want to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our policy.

_____(initial) Your insurance is a contract between you and the insurance company. It is your responsibility to understand the benefits of your plan for any and all services. We cannot guarantee payment of your claims that we file. We file as a courtesy to you and your insurance company will not give us a guarantee of coverage. If your insurance company pays only a portion of your claim or rejects your claim, you and/or the policyholder should make an inquiry to your insurance company. Payment delays or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred. Unfortunately, delays in reimbursement may make you subject to: a $5.00 per month fee for balances older than 30 days plus a 10% administrative fee, a $35.00 fee for returned checks, and a fee not to exceed 10% for the establishment of a payment plan.

_____(initial) We participate in a number of health insurance plans. All patients are required to pay their co-pay, co-insurance, deductibles, and any patient balances owed of all visits, at the time of their visit. Patients that do not pay their co-pay at time of visit will be charged an additional $5.00 statement fee. In addition, HMO patients must present a valid referral/authorization from their primary physicians at check in. 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 entire charge for all services rendered. We will attempt to verify benefits for some specialized services; however you remain responsible for charges to any service rendered. Patients are encouraged to contact their insurance company for clarification of benefits prior to services rendered. In the event you do not satisfy your financial responsibilities, the practice may use a collection agency, may provide protected health information to that agency. If such agency is used, you will be responsible for a 35% balance-based collection fee and any additional costs related to satisfying that debt, including, but not limited to, court costs, and/ or reasonable attorney fees that may be incurred in the collection of an outstanding balance affiliated with satisfying your financial responsibility.

_____(initial) MEDICARE PATIENTS – Please understand that we participate with Medicare. However, you are responsible for your co-insurance, deductible, and any non-covered services. If Medicare has provided reimbursement for services rendered, and if your supplemental insurance does not respond within 30 days, then you become responsible for the balance.

_____(initial) In order for us to service your account and/or to collect any amounts you may owe, we, The Foot and Ankle Specialists of the Mid-Atlantic, LLC, and our agents may contact you by telephone at any phone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide us to use. Methods of contact may include using pre-recorded or artificial voice messages and/or use of an automatic dialing device, as applicable.

_____(initial) Missed appointments: You will be billed a $40.00 charge for missed appointments not cancelled with at least 24 hours' notice.

_____(initial) If you believe your insurance company has made an error or not adequately addressed your claims you may contact the insurance company and/or file a grievance or appeal with your state: for Maryland, contact the Maryland Insurance Administration at 410-468-2244 and/or The Health Advocacy Unit of the Maryland Attorney General at 410-528-1840; for Pennsylvania, contact the Bureau of Consumer Services, Pennsylvania Department of Insurance at 1-877-881-6388; for North Carolina, contact the Consumers Services Division, N.C. Department of Insurance at 1-855-408-1212; for Virginia, contact the State Corporation Commission, Virginia Bureau of Insurance at 1-877-310-6560; and for the District of Columbia contact the Department of Insurance, Securities and Banking at 202-727-8000.

I, _____, have read and I understand the above financial policies. These policies are subject to change without prior written confirmation.
(Name of patient)

_____ _____

Signature of patient or legal representative Date

SUMMARY NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information according to the Health Information Portability and Accountability Act (HIPAA).

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law;
- To a collection agency and may provide protected health information to that agency in the event you do not satisfy your financial responsibilities.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please contact: Deborah Nealon, Privacy Officer, at 301-933-7133 or PrivacyOfficer@footandankle-usa.com

I, _____, acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have
(Name of patient)
read or had the opportunity to read if I so chose and understood the Notice. This authorization may be revoked by me at any time in writing. By signing below, I hereby authorize Foot and Ankle Specialists of the Mid-Atlantic, LLC to obtain Medication History related to the patient above, from Community Pharmacies and/or Pharmacy Benefit Managers for the purpose of Continued Treatment.

In addition, I authorize the following, _____ access to my personal health information upon request.

_____ _____

Signature of patient or legal representative Date