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

PATIENT DEMOGRAPHICS

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

DOB _____ **Street Address**_____ **City** _____

State _____ **Zip code** _____ **Home Phone** (___) _____

Work Phone (___) _____**Cell Phone** (___) _____

E-Mail Address _____

Gender □ F □ M

Marital Status □ **Married** □ **Divorced** □ **Separated** □ **Single** □ **Widowed**

1st Lang. □ **Engl.** □ **Other** _____

Race: (Choose all that apply)

□ American Indian or Alaska Native
□ Asian
□ Black or African American
□ White
□ Native Hawaiian or other Pacific Islander
□ Other

Ethnicity: (Also choose one that applies)

□ Hispanic □ Non-Hispanic

Pharmacy of Choice _____**Pharm. Phone**_____

Pharmacy Full Address _____

Primary Care Physician _____

Are you diabetic? □Yes □ No

If yes, name of physician managing diabetes _____

Date last seen _____

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

How did you hear about our practice?

□ Doctor Referral (Name of Doctor: _____)

□ Health Fair

□ Internet (Source_____)

□ Ad (Source _____)

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PATIENT DEMOGRAPHICS

□ Friend/Family Member/Patient (Name: _____)

□ Other: _____

Emergency Contact _____**Relationship to Patient** _____

Cell Phone Number (____) _____

Alternate Phone Number (____) _____

Insurance Information

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

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

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PATIENT DEMOGRAPHICS

Patient's Authorization and Assignment of Benefits: I hereby authorize the processing of my medical insurance either by electronic or manual method by Foot and Ankle Specialists of the Mid-Atlantic, LLC (FASMA). 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. I certify that the information I have reported with regard to my insurance coverage, is correct. I 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.

Financially Responsible Person <u>if not Patient</u>:
First Name _____ **Last Name** _____
Gender □ **F** □ **M Birth Date**_____/_____/_____
Street Address _____
City _____ **State** _____ **Zip code** _____
Home Phone (_____) _____ **Work Phone** (_____)
_____ **Cell Phone** (_____) _____

Signature of Responsible Party _____
Date_____

Relationship (if not Patient)

_____

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MEDICAL FORM

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

DOB _____ **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:

_____

MEDICAL HISTORY: please indicate: **S** (Self) or **F** (Family Member-blood relation). If both, put both.

____-Alcohol/Drug addiction/dependency
____-Phlebitis/DVT (blood clots in legs)
____-Alzheimer's/Dementia
____-Headaches/Migraines
____-Pregnancy: are you currently
Pregnant? Due date: _____
____-Anemia – type_____
____-Hearing Problems
____-Arrhythmias – type _____
____-Heart Disease
____-Rheumatic Fever/Scarlet Fever
____-Arthritis - type_____
____-Hepatitis □A □B □C (√ box)
____-Liver Disease
____-Schizophrenia
____-Asthma □adult □childhood
____-High Blood Pressure
____-Seizures/Epilepsy
____-Bleeding/Clotting Problems
____-High Cholesterol

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MEDICAL FORM

____-STD's (sexually transmitted ds.)
- type_____
____-HIV/Aids/ARC
____-Sickle Cell Trait/Disease
____-Cancer – type _____
____-Kidney/Renal Disease- type_____
____-Stroke/TIA's
____-Depression/Anxiety-disorder/
____-Lung Disease/Pulmonary Embolus
____-Thyroid Problems □Hyper □Hypo
Bipolar-depression/other
____-Lyme's Disease
____-Tuberculosis
____-Diabetes (how long _____)
(type_____)
____-Nervous Condition
____-Other, Please Specify _____
____-Emphysema/COPD
____-Other, Please Specify _____
____-Glaucoma
____□Osteoporosis/ □Osteopenia (√ box)
____-None of the above
____-Gout

SURGICAL HISTORY: □ Y □ N If yes, please list the surgeries you have had:

_____

_____

HOSPITALIZATION: □ Y □ N If yes, please list:

_____

_____

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MEDICAL FORM

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
If yes, how many years? ____ How long ago did you quit? _____
How many drinks will you consume in a day? _____ Week? _____

RECREATIONAL DRUG USE:
How long ago did you quit? _____
Do you or have you ever used illicit/recreational drugs? □ Y □ N
If yes, which ones? _____
How long ago did you quit? _____

Age _____ Height _____ Weight _____ Shoe Size _____

Reason for visit _____

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MEDICAL FORM

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

	YES	NO	***If YES, list REACTION
Adhesive Tape	_____	_____	_____
Anesthesia	_____	_____	_____
Aspirin	_____	_____	_____
Caffeine	_____	_____	_____
Codeine	_____	_____	_____
Cortisone	_____	_____	_____
Demerol	_____	_____	_____
Foods	_____	_____	_____
Iodine	_____	_____	_____
Latex	_____	_____	_____
Local Anesthetics	_____	_____	_____
Penicillin	_____	_____	_____
Sulfa Drugs	_____	_____	_____
Other, please list:	_____	_____	_____
			_____

MEDICATIONS: Please **list** (or **attach a list**) of your current medications and their dosages:

_____

_____

_____

_____

_____

_____

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MEDICAL FORM

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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FINANCIAL POLICY

Welcome to Foot and Ankle Specialists of the Mid-Atlantic, LLC (FASMA) 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.

1. 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.

2. We participate in a number of health insurance plans, including Medicare. 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. It is our standard procedure to send all pathology samples to a lab that is owned and operated by FASMA. We might also use other pathology labs, as necessary. MEDICARE PATIENTS 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.

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FINANCIAL POLICY

3. In order for us to service your account and/or to collect any amounts you may owe, we, FASMA, 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.

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

5. 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, _____ (Print Name of Patient or Legal Representative--**Patient DOB** _____), have read and I understand the above financial policies. These policies are subject to change without prior written confirmation.

_____ _____

Signature of Patient or Legal Representative **Date**

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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.

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SUMMARY NOTICE OF PRIVACY PRACTICES

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: our Privacy Officer, at 301-933-7133 or PrivacyOfficer@footandankle-usa.com.

I, _____ (Print Name of Patient or Legal Representative--**Patient DOB** _____), acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have 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 people access to my personal health information upon request (including leaving a detailed message):

□Spouse □Other: Name/ Relationship: _____

Leave a detailed message on these voicemails/ cell:

_____

_____

_____

Signature of Patient or Legal Representative: _____

Date: _____

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REVIEW OF SYSTEMS

Patient Name_____ Patient DOB _____

Please check any of the following that you are currently experiencing or have recently experienced	
GENERAL/ CONSTITUTIONAL:	**EAR, NOSE & THROAT:**
□ Fatigue?	□ Ringing in your ears?
□ Weakness	□ Loss of hearing?
□ Fever?	□ Frequent sore throats?
□ Chills?	□ Hoarseness?
□ Night Sweats?	□ Difficulty in swallowing?
□ Malaise?	□ Pain in jaw?
EYES:	□ Nose bleeds?
□ Pain?	**CARDIOVASCULAR:**
□ Redness?	□ Chest pain?
□ Loss of vision?	□ Palpitations?
□ Double or blurred vision?	□ Swollen legs or feet?
□ Dryness?	□ Fainting
KIDNEY/ URINARY/ BLADDER:	**PSYCHIATRIC:**
□ Frequent or painful urination?	□ Depression?
□ Blood in urine	□ Stress?
GASTROINTESTINAL/ STOMACH:	□ Anxiety?
□ Black stools?	**ENDOCRINE:**
□ Blood in stools?	□ Thirsty?
□ Increasing constipation?	□ Night sweats?
□ Persistent diarrhea?	□ Swollen glands?
□ Heartburn?	□ Recent weight gain? **How Much? :
□ Nausea?	□ Recent weight loss? **How Much? :
□ Vomiting?	
□ Stomach pain?	
□ Yellow jaundice?	

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REVIEW OF SYSTEMS

Patient Name_____ Patient DOB _____

Please check any of the following that you are currently experiencing or have recently experienced	
HEMATOLOGIC/LYMPHATIC (BLOOD):	**INTEGUMENTARY/ SKIN:**
□ Anemia?	□ Sensitive skin with sun exposure?
□ Clots?	□ Rashes?
□ Bleeding problems?	□ Warts on feet?
MUSCULOSKELETAL:	□ Moles/lumps/bumps?
□ Low back pain?	□ Extremely dry skin/ cracking?
□ Pain in your leg?	□ Open skin sores?
□ Foot pain?	□ Unusual areas of discoloration?
□ Joint pain?	□ Calluses?
□ Bone pain?	□ Nail Problems?
□ General muscle aches and pains?	□ Noticeable hair loss on legs or feet?
□ Swelling in the legs?	**RESPIRATORY:**
□ Joint swelling?	□ Shortness of breath?
□ Joint stiffness?	□ Cough?
□ Change in gait?	**ALLERGIC/ IMMUNOLOGIC:**
□ Difficulty with climbing stairs?	□ Healing issues?
□ Loss of leg strength?	□ Reactions to dyes?
□ Limping?	□ Reactions to foods?
□ Shoes wear out quickly?	□ Reactions to medicine?
□ Shoes wear out unevenly?	
NEUROLOGIC:	
□ Headaches?	
□ Dizziness?	
□ Fainting or loss of consciousness?	
□ Numbness or tingling or burning? *** Where?	

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REVIEW OF SYSTEMS

Patient Name_____ Patient DOB _____

Please check any of the following that you are currently experiencing or have recently experienced
OTHER/ NOTES?