



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 _____)



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: _____



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 if not Patient:

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)



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 (v box)

_____-Liver Disease

_____-Schizophrenia

_____-Asthma adult childhood

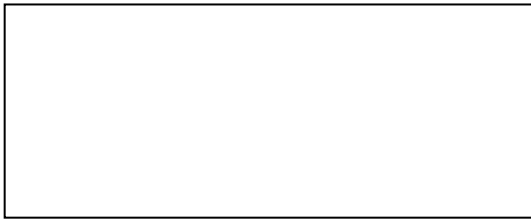
_____-High Blood Pressure

_____-Seizures/Epilepsy

_____-Bleeding/Clotting Problems

_____-High Cholesterol

MEDICAL FORM

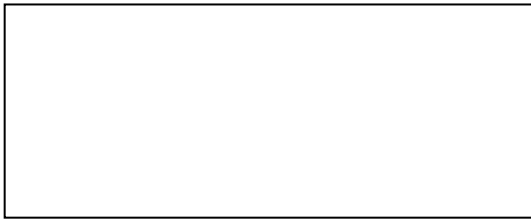


- ___ -STD's (sexually transmitted ds.)
- type _____
- ___ -HIV/Aids/ARC
- ___ -Sickle Cell Trait/Disease
- ___ -Cancer – type _____
- ___ -Kidney/Renal Disease- type _____
- ___ -Stroke/TIA's
- ___ -Depression/Anxiety-disorder/
- ___ -Lung Disease/Pulmonary Embolus
- ___ -Thyroid Problems Hyper Hypo
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:

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? _____

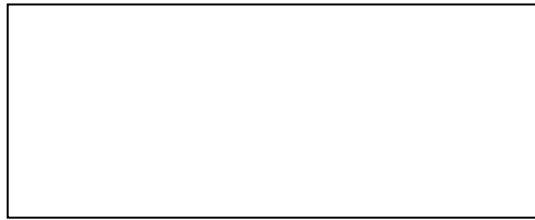
Do you or have you ever used illicit/recreational drugs? Y N

If yes, which ones? _____

How long ago did you quit? _____

Age _____ Height _____ Weight _____ Shoe Size _____

Reason for visit _____

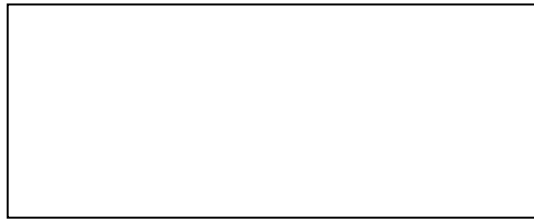


MEDICAL FORM

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:



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)

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.

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

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.

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: _____

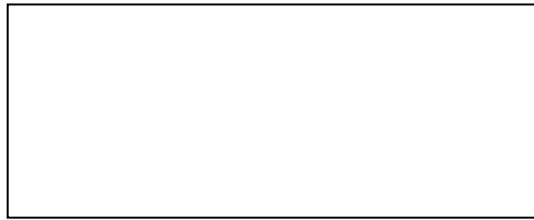
Date: _____

REVIEW OF SYSTEMS

Patient Name _____ Patient DOB _____

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

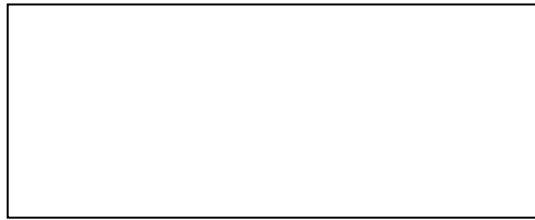
GENERAL/ CONSTITUTIONAL:	EAR, NOSE & THROAT:
<input type="checkbox"/> Fatigue?	<input type="checkbox"/> Ringing in your ears?
<input type="checkbox"/> Weakness	<input type="checkbox"/> Loss of hearing?
<input type="checkbox"/> Fever?	<input type="checkbox"/> Frequent sore throats?
<input type="checkbox"/>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



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:
<input type="checkbox"/> Anemia?	<input type="checkbox"/> Sensitive skin with sun exposure?
<input type="checkbox"/> Clots?	<input type="checkbox"/> Rashes?
<input type="checkbox"/> Bleeding problems?	<input type="checkbox"/> Warts on feet?
MUSCULOSKELETAL:	<input type="checkbox"/> Moles/lumps/bumps?
<input type="checkbox"/> Low back pain?	<input type="checkbox"/> Extremely dry skin/ cracking?
<input type="checkbox"/> Pain in your leg?	<input type="checkbox"/> Open skin sores?
<input type="checkbox"/> Foot pain?	<input type="checkbox"/> Unusual areas of discoloration?
<input type="checkbox"/> Joint pain?	<input type="checkbox"/> Calluses?
<input type="checkbox"/> Bone pain?	<input type="checkbox"/> Nail Problems?
<input type="checkbox"/> General muscle aches and pains?	<input type="checkbox"/> Noticeable hair loss on legs or feet?
<input type="checkbox"/> Swelling in the legs?	RESPIRATORY:
<input type="checkbox"/> Joint swelling?	<input type="checkbox"/> Shortness of breath?
<input type="checkbox"/> Joint stiffness?	<input type="checkbox"/> Cough?
<input type="checkbox"/> Change in gait?	ALLERGIC/ IMMUNOLOGIC:
<input type="checkbox"/> Difficulty with climbing stairs?	<input type="checkbox"/> Healing issues?
<input type="checkbox"/> Loss of leg strength?	<input type="checkbox"/> Reactions to dyes?
<input type="checkbox"/> Limping?	<input type="checkbox"/> Reactions to foods?
<input type="checkbox"/> Shoes wear out quickly?	<input type="checkbox"/> Reactions to medicine?
<input type="checkbox"/> Shoes wear out unevenly?	
NEUROLOGIC:	
<input type="checkbox"/> Headaches?	
<input type="checkbox"/> Dizziness?	
<input type="checkbox"/> Fainting or loss of consciousness?	
<input type="checkbox"/> Numbness or tingling or burning? *** Where?	



REVIEW OF SYSTEMS

Patient Name _____ Patient DOB _____

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

OTHER/ NOTES?

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