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

## PATIENT DEMOGRAPHICS

**First Name**_____ **M.I.**_____ **Last Name**_____ **DOB**____/___/____
**Street Address**_____ **Apt** _____ **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 ☐Hispanic ☐White
☐Black or African American ☐Native Hawaiian or other Pacific Islander ☐Other

**Primary Care Physician**_____ **Phone (**_____)_____
**Pharmacy** _____ **Pharmacy Phone (**_____)_____
**Pharmacy Address** _____ **City, St** _____ **Pharmacy Zip Code** _____
**Are you diabetic?** ☐Yes ☐No **If yes, name of physician managing diabetes**_____ **Date last seen**_____
**Employed** ☐PT ☐FT ☐Retired ☐None **Employer**_____
**Emergency Contact**_____ **Relationship to Patient**_____
**Cell Phone Number** (_____)_____ **Alternate Phone Number** (_____)_____

## HOW DID YOU HEAR ABOUT US

☐Primary Care Physician ☐Other Physician Name of Doctor_____ Practice Name_____
Practice Address_____ Practice Phone (_____)_____
☐Health Fair ☐Internet (Source_____) ☐Ad (Source_____)

## 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:_____

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

**Patient's Authorization and Assignment of Benefits:** I hereby authorize the processing of my medical insurance either by electronic or manual method by Foot & Ankle Specialists of the Mid-Atlantic, LLC (FASMA), and its management company U.S. Foot & Ankle Specialist, LLC (USFAS). 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/text as allowed by the FCC. 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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## CONSENT FOR TREATMENT 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 & Ankle Specialists of the Mid-Atlantic, LLC ("FASMA") to obtain medication history from community pharmacies and/or pharmacy benefit managers for the purpose of ongoing treatment. I give permission to FASMA to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet, ankles, and lower legs.

**Consent to Photograph/Film/Video:** I authorize the DPM and associates or assistants to photograph /film/video the site of treatment. Details of the photographing/filming/videotaping have been explained to me in terms I understand. I understand that the photos, films, or videos are the property of the above-mentioned doctor, and I may obtain a copy upon my written request. I agree and authorize the use of the photos, film or video for teaching purposes, which includes being shown to other patients, in the advertisements of the above-mentioned podiatrist, or to place my photo, film or video on his/her professional web site. *I am aware that my name and identity will not be disclosed.*

I deny consent to use my photo/video/film by initialing here:____

**Signature of Responsible Party**_____ **Date**_____

**Relationship (if not Patient)** _____

## PLEASE COMPLETE CONSENT FOR TREATMENT OF MINOR, IN ABSENCE OF PARENT/GUARDIAN

**Consent for Treatment of Minor Patient in Absence of Parent/Guardian:** I certify that I am the parent and/or legal guardian of _____. I authorize_____ to bring my child to office visits with Dr. _____and to consent to the examination and/or treatment of my child. This authorization is effective until revoked by me in writing.

**Signature of Responsible Party**_____ **Date**_____

**Relationship (if not Patient)** _____

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## FINANCIAL POLICY

Welcome to Foot & 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. We may offer a payment plan for outstanding patient balances. Failure to adhere to an agreed upon, and executed payment plan may result in further collection activity. There will be a $35.00 fee for all returned checks and credit payments.

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. 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 that you are not eligible for service, or determines that a service as "not covered" or you do not have an authorization, you will be responsible for all charges related to the services rendered. We will attempt to verify benefits for some specialized services; however benefits verification is not a guarantee of payment. 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, and will 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.

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 may be billed a $40.00 charge for missed appointments that are not cancelled within 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.

**Signature of Responsible Party**_____**Date**_____

**Relationship (if not Patient)**_____

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## MEDICAL FORM

**First Name**_____ **M.I.**_____ **Last Name**_____ **DOB**____/___/____
**Reason for Visit**_____ ☐**RIGHT** ☐**LEFT** ☐**BILATERAL (PLEASE CHECK ONE)**
**How long has this been a problem?**_____ **When does it occur?** ☐ Morning ☐Afternoon ☐ Evening ☐Off & On ☐All Day
**TREATMENTS:** Please list previous treatments (either prescribed or home remedies):

_____
_____

**Age**_____ **Height** _____ **Weight** _____ **Shoe Size**_____
**Is this visit related to an accident/injury** ☐Y ☐N **If yes, date of injury**_____

**MEDICAL HISTORY**: Please indicate: **S** (Self) or **F** (Family Member – Blood Relation) or **B** (if Both)

___Alcohol/Drug Addiction/Dependency
___Alzheimer's / Dementia
___Anemia – Type_____
___Arrhythmias – Type_____
___Arthritis – Type_____
___Bleeding / Clotting Problems – Type_____
___Cancer – Type_____
___Depression / Anxiety-disorder / Bipolar-depression / Other
___Diabetes (how long)_____
___Emphysema / COPD
___Glaucoma
___Gout
___GERD ☐Reflux / ☐GI Ulcers
___Headaches/Migraines
___Hearing Problems
___Heart Disease
___Hepatitis ☐A ☐B ☐C ☐Liver Disease
___High Blood Pressure
___High Cholesterol
___HIV / Aids / ARC
___ Kidney / Renal Disease – Type_____
___Lung Disease / Pulmonary Embolism
___Lyme's Disease
___Nervous Condition – Type_____
___☐Osteoporosis / ☐Osteopenia
___Phlebitis /DVT (blood clots in legs)
___Pregnancy / ☐Currently Pregnant Due Date_____
___Rheumatic Fever / Scarlet Fever
___Schizophrenia
___STD's (sexually transmitted dis.)
___Sickle Cell Trait / Disease
___Thyroid Problem ☐Hyper ☐Hypo
___Tuberculosis
___Other, Please Specify_____
_____
__☐ None of the above

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

_____

**HOSPITALIZATION** ☐Y ☐N If yes, please list:_____
**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 do you consume a day? _____ week?____ How long ago did you quit?_____
**RECREATIONAL DRUG USE** Do you or have you ever used illicit/recreational drugs? ☐Y ☐N
If yes, which ones? _____ How long ago did you quit? _____
**MEDICATIONS** Please list (or attach a list) of your current medications including over the counter medications and their dosages:

_____
_____
_____
_____
_____
_____
_____
_____

**ALLERGIES** Do you have a history of allergies/skin reaction/sickness following the administration of the following? If checked list reaction.

☐Adhesive Tape _____
☐Anesthesia _____
☐Aspirin _____
☐Caffeine _____
☐Codeine _____
☐Cortisone _____
☐Demerol _____
☐Food _____
☐Iodine_____
☐Latex _____
☐Local Anesthetics _____
☐Penicillin_____
☐Sulfa Drugs_____
Other Please List:_____
_____

**Signature of Responsible Party**_____ **Date**_____

**Relationship (if not Patient)** _____

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# REVIEW OF SYSTEMS

**First Name**_____ **M.I.**_____ **Last Name**_____ **DOB**___/___/____

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

| GENERAL / CONSTITUTIONAL | KIDNEY / URINARY / BLADDER | PSYCHIATRIC |
|---|---|---|
| ☐Fatigue | ☐Frequent or painful urination | ☐Depression |
| ☐Weakness | ☐Blood in urine | ☐Stress |
| ☐Fever | **MUSCULOSKELETAL** | ☐Anxiety |
| ☐Night sweats | ☐Low back pain | **ENDOCRINE** |
| ☐Malaise | ☐Pain in leg | ☐Thirsty |
| **EYES** | ☐Foot pain | ☐Night sweats |
| ☐Pain | ☐Joint pain | ☐Swollen glands |
| ☐Redness | ☐Bone pain | ☐Recent weight gain |
| ☐Loss of vision | ☐General muscle aches and pains | How much_____ |
| ☐Double or blurred vision | ☐Swelling in the legs | ☐Recent weight loss |
| ☐Dryness | ☐Joint swelling | How much_____ |
| **EARS, NOSE & THROAT** | ☐Joint stiffness | **HEMATOLOGIC / LYMPHATIC (BLOOD)** |
| ☐Ringing in ears | ☐Change in gait | ☐Anemia |
| ☐Loss of hearing | ☐Difficulty climbing stairs | ☐Clots |
| ☐Frequent sore throats | ☐Loss of leg strength | ☐Bleeding Problems |
| ☐Hoarseness | ☐Shoes wear out quickly | **ALLERGIC / IMMUNOLOGIC** |
| ☐Difficulty swallowing | ☐Shoes wear out unevenly | ☐Healing issues |
| ☐Pain in jaw | **INTEGUMENTARY / SKIN** | ☐Reactions to dyes |
| ☐Nose bleeds | ☐Sensitive skin with sun exposure | ☐Reactions to foods |
| **CARDIOVASCULAR** | ☐Rashes | ☐Reactions to medicine |
| ☐Chest pain | ☐Warts on feet | **OTHER / NOTES** |
| ☐Palpitations | ☐Moles / lumps / bumps | |
| ☐Swollen legs or feet | ☐Extremely dry skin / cracking | |
| ☐Fainting | ☐Open skin sores | |
| **RESPIRATORY** | ☐Unusual areas of discoloration | |
| ☐Shortness of breath | ☐Calluses | |
| ☐Cough | ☐Nail problems | |
| **GASTROINTESTINAL / STOMACH** | ☐Noticeable hair loss legs / feet | |
| ☐Black stools | **NEUROLOGIC** | |
| ☐Blood in stools | ☐Headaches | |
| ☐Increasing constipation | ☐Dizziness | |
| ☐Persistent diarrhea | ☐Fainting or loss of consciousness | |
| ☐Heartburn | ☐Numbness / tingling / burning | |
| ☐Nausea | Where_____ | |
| ☐Vomiting | _____ | |
| ☐Stomach pain | | |
| ☐Yellow jaundice | | |

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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.

**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 that notice. This authorization may be revoked by me at any time in writing.

In addition, I authorize the following people access to my personal health information upon request (including leaving a detailed message):
Name/Relationship:_____

_____ _____

**Signature of Patient or Legal Representative** **Date**