Foot & Ankle SPECIALISTS of Middle Tennessee

DEMOGRAPHICS

Date: _____

Patient Name: _____ Date of Birth: _____ Sex: M / F

Social Security Number _____-_____-_____ Preferred Language: _____

Race: (please circle) American Indian/Alaska Native Asian Black/African American White Hispanic
Native Hawaiian/Pacific Islander Other Decline

Ethnicity: (please circle) Hispanic or Latino NOT Hispanic or Latino Decline

Marital Status: [ ] Married [ ] Single [ ] Widowed [ ] Divorced [ ] Other

Address: _____Apt#:_____City:_____ State: _____Zip: _____

Home Phone: _____Work Phone: _____ Cell: _____

Primary (please circle) Home Work Cell E-mail Address: _____

Employment Status: [ ] Employed [ ] Unemployed [ ] Retired [ ] Disabled [ ] Student

Employer: _____ Occupation: _____

Employer Address: _____ Employer Phone: ( ) _____

ADDITIONAL INFORMATION

Emergency Contact Name: _____ Relationship: _____
Contact Phone: ( ) _____

Preferred Pharmacy Name & Address: _____
Pharmacy Phone: ( ) _____

Primary Care Physician Name & Address_____ Phone: ( ) _____
Date Last Seen: _____

Referring Physician Name & Address _____ Phone: ( ) _____
Date Last Seen: _____

How did you hear about our Practice? _____

FINANCIAL POLICY

- ***Payments for co-pays, deductibles and non-covered services are due at the time of service.***
- ***Insurance balances are billed to patient on receipt of notice from your insurance carrier and are due in 30 days from the date billed from Foot & Ankle Specialists of Middle Tennessee, PLLC.***
- ***It is your responsibility to provide accurate insurance information to our office. If we are unable to bill your insurance carrier, you are responsible for the charges.***
- ***Unpaid patient balances over 120 days will be turned over to our collection agency and a fee for collection will be added to the account. The collection fee is $75 or 20% of collection balance, whichever is greater.***
- ***Delinquent accounts will result in discharge from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative podiatric care. During that 30-day period, our physician will only be able to treat you on an emergency basis.***

Person Responsible for Account: _____Relationship to Patient: _____
DOB: _____ Social Security Number: _____
Address (if different from patient):_____

BILLING & INSURANCE INFORMATION

Primary Insurance Name: _____ Policy# (or Member ID): _____

Policyholder Name: _____ DOB: _____ Relationship: _____

Secondary Insurance Name: _____ Policy# (or Member ID): _____

Policyholder Name: _____ DOB: _____ Relationship: _____

ASSIGNMENT, RELEASE & AGREEMENT:

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above mentioned insurance company, and assign directly to Foot & Ankle Specialists of Middle Tennessee, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize payment of benefits to be made to the physician rendering services. I also understand that I will be held responsible for any costs, which are not covered by my insurance carrier, including any deductible, co-insurance, co-pay, denial, or any uncovered services. I understand that if I am examined by a physician who does not participate with my insurance, I will receive payment directly from the insurance carrier. I understand fully that it is my responsibility to sign over all payments, including the Explanation of Benefits (EOB), to the examining provider. I hereby authorize Foot & Ankle Specialists of Middle Tennessee to release all the information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand I am fully responsible for all fees incurred for service(s) rendered including collection agencies and attorney's fees. I also understand if I do not have insurance coverage all fees incurred for service(s) rendered are due at the time of service. I understand the payment policies as outlined above.

Patient/Responsible Party Signature: _____ Date: _____

MEDICARE AUTHORIZATION:

I request that payment of authorized Medicare benefits be made to Foot & Ankle Specialists of Middle Tennessee for any services furnished to me by Foot and Ankle Specialists of Middle Tennessee. I authorize the release of information about me or any information needed to determine benefits or the benefits payable for related services to the Health Care Financing Administration and its agents. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If another health insurance is indicated, or electronically submits claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient/Responsible Party Signature: _____ Date: _____

Foot & Ankle SPECIALISTS of Middle Tennessee

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Summary:
By law, we are required to provide you with our Notice of Privacy Practices (NPP). This Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to a report of disclosures of your information; and
6. The right to a paper copy of this notice.

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will insure that your information remains private.

If you have any questions or concerns about this Notice, please contact our Privacy Officer, at (615) 896-9493.

Acknowledgement of Notice of Privacy Practices

"I hereby acknowledge that I have received a copy of this practice's **NOTICE OF PRIVACY PRACTICES**. I understand that if I have questions or complaints regarding my privacy rights that I may contact the Privacy Officer. I understand that the practice will offer me updates to this **NOTICE OF PRIVACY PRACTICES** should it be amended, or changed in any way."

- I, _____, authorize my physicians and his/her staff to contact me by the designated means noted below.

  Please check all that apply:

  [ ] Home Phone [ ] Home Answering Machine/Voice Mail [ ] Cell Phone/Voice Mail [ ] Office/Work Place/Voice Mail

- I authorize my physicians and his/her staff to communicate information regarding appointments, medical results, and billing issues to the following person(s). Please print name and indicate your relationship.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Patient or Representative Signature: _____ **Date**: _____

OFFICE USE ONLY

[ ] Patient refused to sign [ ] Patient was unable to sign because _____

Foot & Ankle SPECIALISTS of Middle Tennessee

HEALTHCARE QUESTIONAIRE

Patient Name: _____ **DOB:** _____

CHIEF COMPLAINT

Why are you here today? _____

How long have you had this problem? _____

Have you been evaluated or treated for this problem elsewhere? **No** **Yes**

(If yes) When? _____ Where? _____

PERSONAL MEDICAL HISTORY

Please Circle All That Apply & Include Date of Onset {00/00/0000}

AIDS/HIV ___/___/____	Congestive Heart Failure ___/___/____	Hemophilia ___/___/____	Radiation/Chemo ___/___/____
Alcoholism ___/___/____	Depression ___/___/____	Hepatitis – A B C ___/___/____	Respiratory Disease* ___/___/____
Allergies/Hay Fever ___/___/____	Diabetes* ___/___/____	High Blood Pressure ___/___/____	Rheumatic Fever ___/___/____
Alzheimer's ___/___/____	Drug/Chemical Dependency ___/___/____	High Cholesterol ___/___/____	Sinus Problems* ___/___/____
Anemia ___/___/____	Ear Problems* ___/___/____	High Triglycerides ___/___/____	Skin Problems* ___/___/____
Arthritis* ___/___/____	Eye Problems* ___/___/____	Kidney/Bladder Problems* ___/___/____	Sleep Apnea ___/___/____
Asthma* ___/___/____	Fibromyalgia ___/___/____	Liver Disease* ___/___/____	Stroke ___/___/____
Back Problems* ___/___/____	Gallbladder Disease ___/___/____	Low Blood Pressure ___/___/____	Thyroid Problems* ___/___/____
Bleeding Disorders* ___/___/____	GERD/Hiatal Hernia ___/___/____	Medical Implants* ___/___/____	Tuberculosis (TB) ___/___/____
Blood Clots/DVT/PE* ___/___/____	GI Ulcers ___/___/____	Osteopenia ___/___/____	Varicose Veins ___/___/____
Cancer* ___/___/____	Gynecological Problems* ___/___/____	Osteoporosis ___/___/____	Venereal Disease ___/___/____
Chronic Diarrhea ___/___/____	Headaches ___/___/____	Nervous System Disorder ___/___/___	Vertigo ___/___/____
Circulatory Problems* ___/___/____	Heart Disease* ___/___/____	Psychiatric Care* ___/___/____	Other: _____ ___/___/___

ALLERGIES

Please Check All That Apply

[ ] No Known Allergies [ ] Iodine [ ] Penicillin [ ] Latex [ ] Aspirin

[ ] Adhesive Tape [ ] Demerol [ ] Codeine [ ] Sulfa [ ] Seafood

[ ] Local Anesthetics (example: Novocain) [ ] Other: _____

Foot & Ankle SPECIALISTS of Middle Tennessee

Review of Systems: Circle or explain any current symptoms:

- Constitutional
  - fatigue, fever, chills, weight loss, _____
- Eyes
  - discharge from eye, eye discomfort, changes in vision, _____
- HENT
  - headaches, vertigo, lightheadedness, hearing loss, _____
- Cardiovascular
  - chest pain, dyspnea on exertion (shortness of breath), claudication, irregular heart beats, _____
- Respiratory
  - shortness of breath, wheezing, cough, _____
- Gastrointestinal
  - nausea, vomiting, diarrhea, _____
- Genitourinary
  - urgency, frequency, dysuria, _____
- Integument
  - History of foot ulcerations, rash, itching, _____
- Neurologic
  - muscular weakness, incoordination, loss of balance, memory difficulties, _____
- Musculoskeletal
  - back pain, ankle pain, foot pain, _____
- Endocrine
  - polyuria, polydipsia, weight gain, weight loss, _____
- Psychiatric
  - anxiety, depression, _____
- Heme-Lymph
  - blood thinners, easy bleeding, easy bruising, lymph node enlargement or tenderness, _____
- Allergic-Immunologic
  - sinus allergy symptoms, allergic dermatitis, _____

MEDICATIONS

PLEASE LIST ALL PRESCRIBED AND OVER THE COUNTER MEDICATIONS INCLUDING ORAL CONTRACEPTIVES, VITAMINS/SUPPLEMENTS. PLEASE USE THE BACK OF PAGE IF NEEDED.

	Name of Medication	Dosage	How often do you take?
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

SURGERIES

Have you had **any surgeries** in the past? **No** **Yes --- Please list below**

1) _____ Date: _____
2) _____ Date: _____
3) _____ Date: _____
4) _____ Date: _____
5) _____ Date: _____
6) _____ Date: _____

FAMILY HISTORY Please Circle All That Apply

[ ] Heart Disease; Please indicate relationship: Father Mother Brother Sister Son Daughter

[ ] Cancer; Please indicate relationship: Father Mother Brother Sister Son Daughter

Type of cancer _____

[ ] Diabetes; Please indicate relationship: Father Mother Brother Sister Son Daughter

[ ] Other: _____ Relationship: Father Mother Brother Sister Son Daughter

SOCIAL HISTORY

Current Height: _____ (Ft) Current Weight: _____ (Lbs) Shoe Size: _____N M W

Do you participate in any exercise regimen on a regular basis? Please Circle

No Yes If yes, what type and how often? _____

Do you or have you ever smoked or chewed tobacco? Please Circle

Never

Not Currently Date quit: _____ How long was tobacco used for: _____ How much : _____

Yes If yes, how many / much per day? _____ Year started: _____

Do you use recreational drugs? No Yes
Do you consume any alcohol? No Yes If yes, how much and how often? _____

CONSENT TO TREAT

I hereby consent to be routinely treated by the doctors of Foot and Ankle Specialists of Middle Tennessee, PLLC, who are deemed necessary to evaluate and/or treat foot and ankle injuries for myself or the patient mentioned above for who I am responsible. I acknowledge that no guarantees have been made as to the nature of examination and/or procedures recommended or performed. If further diagnostic testing or outside referral is required, it is my decision whether to proceed with the testing recommended after it has been fully explained to me by the physician. Initial _____

X-RAYS & PHOTOGRAPHS

I understand that in the course of my treatment I may have radiographs (X-Rays); I agree to inform the doctor or technologist if I am or may be pregnant. I authorize the physician and his assistant to take photographs. The term "photograph" includes Polaroid's, digital, 35mm slide, standard photographs, videotapes, etc. These photographs are property of Foot and Ankle Specialists of Middle Tennessee and will be a permanent part of the record. These may be used for teaching, lectures, educational conferences, or publications. Initial _____

CONSENT TO RELEASE OF PATIENT INFORMATION AND RECORDS

I hereby give my permission for the release of my records, including but not limited to radiographs, for the purpose of professional consultation or referrals to another provider. Transmission of these records may be completed via mail, fax and/or unencrypted email. No information obtained from the medical history form will be transmitted via unencrypted email; however, patient name, age, birth date and gender may be used to identify radiographs. Initial _____

CANCELLATION POLICY

When we make your appointment, we are committed to honoring your time. We may be unable to hold your reserved time if you are 15 minutes late. If you must change an appointment, we ask that you give us at least 24 hours notice. This courtesy makes it possible to give your reserved room to another patient. After the second missed appointment, without 24 hours notice, a $25 fee will be applied to your account. Repeated cancellations or missed appointments will result in dismissal from the practice. Initial _____

I certify that all of the above information provided is true, correct, and complete to the best of my knowledge, and belief.
Signature of Patient or Legal Guardian _____ Date: _____

Foot & Ankle SPECIALISTS of Middle Tennessee