



Medical and Surgical Treatment of the Foot and Ankle

WELCOME TO OUR OFFICE

PATIENT INFORMATION

Date:

Patient Number:

Name _____			Gender: <input type="checkbox"/> M <input type="checkbox"/> F		Age _____		Date of Birth ____-____-____		
First	Middle		Last			City		State	Zip
Address _____									
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				Patient Social Security # _____-_____-_____					
Home Phone (____) _____			Cell Phone (____) _____			Work Phone (____) _____			
Email _____				Pharmacy Name/Phone _____					
Occupation _____				Employer _____					
Work Address _____									
						City		State	Zip
Parent/Spouse's Name _____				DOB ____-____-____		SS# _____-_____-_____			
Occupation _____				Spouse's Employer _____					
IN CASE OF EMERGENCY, CONTACT:									
Name _____			Relationship _____			Home Phone (____) _____			
Work Phone (____) _____			Ext _____		Cell _____				
PRIMARY INSURANCE INFORMATION									
Policy Holders Name _____				Policy Holders Date of Birth ____-____-____					
Insurance Company/Phone _____				Insurance ID # _____		Group # _____			
SECONDARY INSURANCE INFORMATION									
Policy Holders Name _____				Policy Holders Date of Birth ____-____-____					
Insurance Company/Phone _____				Insurance ID # _____		Group # _____			
WHOM MAY WE THANK FOR REFERRING YOU?									
<input type="checkbox"/> Phonebook	<input type="checkbox"/> Internet	<input type="checkbox"/> Newspaper		<input type="checkbox"/> TV	<input type="checkbox"/> Radio	<input type="checkbox"/> Insurance Provider Book			
<input type="checkbox"/> Dr. _____	<input type="checkbox"/> Relative/Friend _____								

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Lexington Foot And Ankle Center, PSC 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 my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party
Signature _____ **Relationship** _____ **Date** _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I 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.

Responsible Party
Signature _____ **Relationship** _____ **Date** _____

MEDICARE AUTHORIZATION (If Applicable)

I request that payment of authorized Medicare benefits be made to Lexington Foot And Ankle Center, PSC for any services furnished by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I request payment of authorized Medigap benefits be made to this provider and also authorize any holder of medical information about me to release to the below named Medigap insurer any information needed to determine benefits payable for services from this provider. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier 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.

Beneficiary
Signature _____ **Date** _____

REASON FOR TODAY'S VISIT: PLEASE INDICATE THE PROBLEM

What is your main foot or ankle problem today?:

Do you have any other foot or ankle problems that need attention?:

HISTORY OF PRESENT ILLNESS: BRIEFLY ANSWER THE FOLLOWING QUESTIONS

When did your main problem begin? _____

Locate the area of the problem: _____

Describe any pain and/or disability: _____

Is the pain: Burning Throbbing Sharp Dull Aching Other? _____

What causes the problem or makes it worse? _____

Is there any other pertinent background information? No Yes (explain) _____

Was it caused by an injury? No Yes (explain) _____

Are there any associated signs or symptoms? No Yes (explain) _____

Have you treated or had anyone else treat this problem? No Yes (explain) _____

Did it Help? No Yes (explain) _____

Past History

Injuries:

- No injuries of consequence
- List any serious injuries and approx. age _____

Major Illnesses:

- No serious past illnesses
- List serious illnesses Diabetes Arthritis Heart Hypertension Cancer HIV Hepatitis
- Family Physician** _____ **Last Visit Date** _____
- Are you under doctor's care for any reason _____

Surgeries & Hospitalization:

- Please list type and year _____
- None _____

Medications:

- Prescriptions: _____
- Over-the-counter medications and vitamins: _____
- Do you take oral contraceptives? Yes No Pharmacy Name _____ Phone _____

Allergies:

- Adhesive/Tape Anticoagulant Therapy Aspirin Codeine Demerol Iodine
- Local Anesthetics Morphine Novocaine Penicillin Seafoods Sulfa Other _____
- List what type reaction: Rash Trouble Breathing

Immunizations:

- Measles Mumps Polio Tetanus Typhoid Flu Pneumonia TB Hep B

Family History of

any of these disorders: TB Gout High blood pressure Diabetes Arthritis Kidney Disease Heart Attack Cancer

Social History:

Use of: Tobacco Pack/day _____ Alcohol How much per/day _____ Drugs Caffeine

Level of Education: Years of School _____ Degrees _____

Office Use Only:

Height _____ ft. _____ in. Weight _____ lbs. _____ oz. Shoe Size _____ Blood Pressure _____/_____
Heart Rate _____ Temp _____ SP02% _____

Patient Name: _____

Date: _____

Patient Number: _____

GASTROINTESTINAL**Review of Systems****Please check the boxes that apply to you:**

<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Excessive Hunger	<input type="checkbox"/> Difficult chewing	<input type="checkbox"/> Nausea
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Excessive thirst	<input type="checkbox"/> Difficult swallowing	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Constipation	<input type="checkbox"/> Black stool	<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Liver trouble	<input type="checkbox"/> Gallbladder trouble	<input type="checkbox"/> Bloody stool	<input type="checkbox"/> Weight loss
<input type="checkbox"/> Belching	<input type="checkbox"/> Stomach trouble	<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Weight gain
<input type="checkbox"/> Indigestion	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Gas	<input type="checkbox"/> Reflux

GENITOURINARY

<input type="checkbox"/> Bladder trouble	<input type="checkbox"/> Excessive urination	<input type="checkbox"/> Scanty urination	<input type="checkbox"/> Painful urination
<input type="checkbox"/> Discolored urine	<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Prostate trouble	<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Difficult urination	

NERVOUS

<input type="checkbox"/> Numbness	<input type="checkbox"/> Loss of feeling	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Fainting	<input type="checkbox"/> Headaches	<input type="checkbox"/> Muscle jerking	<input type="checkbox"/> Convulsions
<input type="checkbox"/> Forgetfulness	<input type="checkbox"/> Confusion	<input type="checkbox"/> Depression	<input type="checkbox"/> Tingling
<input type="checkbox"/> Stroke	<input type="checkbox"/> Weakness	<input type="checkbox"/> Seizure	<input type="checkbox"/> Burning

EYES

<input type="checkbox"/> Eye Strain	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Eye inflammation	<input type="checkbox"/> Glasses
<input type="checkbox"/> Eye disease	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Eye injury	<input type="checkbox"/> Impaired sight

EARS / NOSE / THROAT

<input type="checkbox"/> Ear pain	<input type="checkbox"/> Ear noises	<input type="checkbox"/> Ear discharge	<input type="checkbox"/> Hearing loss
<input type="checkbox"/> Nose pain	<input type="checkbox"/> Nose bleeding	<input type="checkbox"/> Nose discharge	<input type="checkbox"/> Sore mouth
<input type="checkbox"/> Breathing difficulty	<input type="checkbox"/> Sore gums	<input type="checkbox"/> Sore throat	<input type="checkbox"/> Hoarseness
<input type="checkbox"/> Speech difficulty	<input type="checkbox"/> Dental problems	<input type="checkbox"/> Other _____	

CARDIOVASCULAR

<input type="checkbox"/> Chest pain	<input type="checkbox"/> Pain over heart	<input type="checkbox"/> Leg pain on walking	<input type="checkbox"/> Heart attack
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Rapid heartbeat	<input type="checkbox"/> Varicose veins	<input type="checkbox"/> Heart problems
<input type="checkbox"/> Night sweats	<input type="checkbox"/> Tiredness	<input type="checkbox"/> Weakness	<input type="checkbox"/> Hands swell
<input type="checkbox"/> Feet swell	<input type="checkbox"/> Heart valve replacement	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Other _____

RESPIRATORY

<input type="checkbox"/> Persistent cough	<input type="checkbox"/> Difficult breathing	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Lung problems	<input type="checkbox"/> Coughing blood	<input type="checkbox"/> Coughing phlem	<input type="checkbox"/> Emphysema
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Hay fever	<input type="checkbox"/> Other _____

INTEGUMENTARY

<input type="checkbox"/> Itching	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Bruises	<input type="checkbox"/> Skin rash	<input type="checkbox"/> Moles
<input type="checkbox"/> Abrasions	<input type="checkbox"/> Ulcerations	<input type="checkbox"/> Discolorations	<input type="checkbox"/> Skin cancers	<input type="checkbox"/> Eczema
<input type="checkbox"/> Deformed nails	<input type="checkbox"/> Birth marks	<input type="checkbox"/> Hives	<input type="checkbox"/> Other _____	

MUSCULO-SKELETAL

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Stiffness	<input type="checkbox"/> Club foot	<input type="checkbox"/> Atrophy
<input type="checkbox"/> Artificial joints	<input type="checkbox"/> Joint disease	<input type="checkbox"/> Bursitis	<input type="checkbox"/> Fractures
<input type="checkbox"/> Muscle pain	<input type="checkbox"/> Lumbago	<input type="checkbox"/> Sprains	<input type="checkbox"/> Sciatica
<input type="checkbox"/> Gout	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Other _____	

HEMATOLOGIC

<input type="checkbox"/> Anemia	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> Venereal disease
<input type="checkbox"/> Take coumadin	<input type="checkbox"/> Take aspirin	<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Hepatitis _____
<input type="checkbox"/> Sexually transmitted disease	<input type="checkbox"/> Other _____		

Patient's(or my dependent) _____

Date _____ - _____ - _____

I certify that the above information is true and correct to the best of my knowledge. I give my permission to Lexington Foot And Ankle Center, PSC to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment.

Patient Name(print): _____

Date: _____

Patient Number: _____

FINANCIAL POLICY

Welcome to Lexington Foot and Ankle Center, P.S.C. We are glad you've chosen us to provide you with your health care. We are a professional service organization that is dedicated to the practice of medicine, specializing in podiatry. The mission of our practice is to provide high quality medical care at a fair and reasonable cost to those in the area. We charge what are usual and customary fees for our area.

Your insurance policy is a contract between you and your insurance company. Please understand our office cannot accept responsibility for collecting your insurance claim or negotiating a settlement on a disputed claim. Whatever the outcome of your insurance claim, you are responsible for payment of your account. Past-due accounts are an extra cost in operating an office. Our costs, and therefore your costs, are substantially increased when bills are not paid promptly.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE IF YOU ARE SELF-PAY. WE ACCEPT CASH, PERSONAL CHECKS, AND CREDIT CARDS. WE OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL.

An exception to the above is the select insurance companies we bill directly or health maintenance organizations and preferred provider organizations we participate in. If we are a participating provider for your insurance company we will submit your claim directly to your managed care insurer. Co- payments, if any, will be collected at the time of your visit. Please be aware there is a possibility that some and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary under your medical insurance. If you receive a service your insurance does not cover or if you have a deductible you have not met, we will request payment in full from you at the time you receive the service. Some insurance companies require a pre-certification with the insurance company prior to our doctors treating you. Please check your policy for this requirement.

Finance charges will accrue at a rate of 2% **per month** on the remaining balance and the balance may fluctuate depending upon applicable insurance payments, co-insurance, co-pays, deductibles, additional services provided or other responsibilities as indicated by your insurance carrier.

Credit History: You give us permission to check your credit and to answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency such as a credit bureau. If we have to refer your account to an outside collection agency, you agree to pay all of the collection costs which are incurred.

EXTENDED PAYMENT PLAN:

We also understand that financial problems arise from time to time. Please let us know if you need to arrange a payment plan that allows you to pay off your balance in monthly installments. Our Patient Accounts Representative can assist you with these arrangements.

Thank you for reading and understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read, understand, and agree to this Financial Policy.

Patients Name: _____

Responsible Party (if not the patient): _____

SIGNATURE: _____

Date: _____