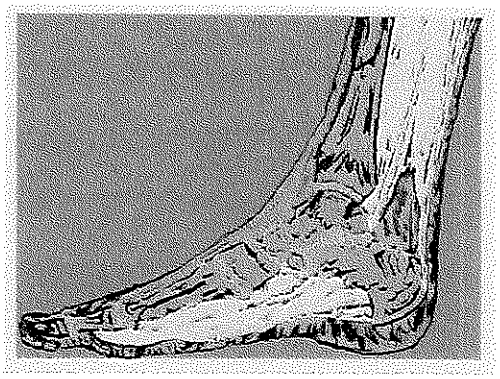


Welcome to our Practice

CENTRAL FLORIDA FOOT & ANKLE SPECIALISTS, PA

Victor F. McNamara, DPM, FACFAS, FCCWS

899 Outer Road, Suite C
Orlando, FL 32814

407-228-2838 Phone

Please arrive 15 minutes prior to your appointment time, we strive to see patients on-time.

Our office requires a 24 hour notice if you are unable to keep your appointment. Cancellation or broken appointments without 24 hours notice are subject to a $25.00 fee.

Our office **DOES NOT** face Outer Road. MapQuest and Google will direct to you the front of the building (AllState and Nuvia.) We are on the backside facing the large parking lot.

CENTRAL FLORIDA FOOT & ANKLE SPECIALISTS, PA

Victor F. McNamara, DPM, D.ABFAS, FACFAS

Patient Information

Name:_____**Date of Birth:**_____**Age:**_____

If Minor, Responsible Party:_____**Relationship:**_____

Patient Social Security #:_____**Gender: Male Female**

Address:_____

City:_____ **State:**_____**Zip code:** _____

Primary Phone #_____ **Home/Cell Secondary Phone #**_____ **Home/Cell**

Employer:_____ **Work Phone #:**_____

Email: _____

Family Physician:_____ **Phone #:**_____

Referred by: Doctor:_____ **Friend/Family:**_____ **Ins Co:**_____ **Internet:**_____ **Website:**_____

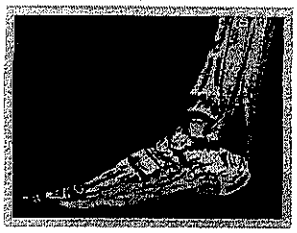
Emergency Contact:_____**Phone#:** _____ **Relationship:**_____

INSURANCE INFORMATION

Primary Insurance Co:_____

Primary Policy Holder:_____**DOB:**_____ **Copay $** _____

Secondary Insurance Co:_____



Central Florida Foot & Ankle
Specialists, PA
407-228-2838
Orlandofootcare.com

Authorization for Verbal Communication and/or to Leave Voice Mail Messages Regarding My Personal Health Information and Permission to Invite Me to Participate in Follow My Health Patient Portal

This does not authorize release of copies of medical records without a signed Authorization to Release Medical Records by patient or guardian

Patient Information

Name- Last, First, MI	Date of Birth:

Information to be disclosed: verbal communication only regarding patient's care-no copies of medical records provided
Please Provide your current telephone numbers

Home Phone	Cell Phone
Work Phone	Other Phone

We normally contact our patients between 8 a.m. and 5 p.m. Monday through Friday. Please ***check below*** where you would prefer to be contacted during these hours.

Home Phone_____ Cell Phone_____ Work Phone_____ Other Phone_____

If we need to reach you after hours, please ***check below*** where you prefer to be called:

Home Phone_____ Cell Phone_____ Work Phone_____ Other Phone_____

Your Protected Health Information Designees:
If you are not available at the time that we call, please list below those individuals (designees) with whom we can leave a message or briefly discuss your medical information (e.g. lab or test results, prescription information). This person (designee) will also be able to call the office on your behalf.
Please print the name and relationship to you/patient of each designee below:

Designee Name:	Relationship to Patient:
Designee Name:	Relationship to Patient:
Designee Name:	Relationship to Patient:

_____ Check here if you ***do not want*** your health care information discussed with anyone other than yourself.

Confidential Voice Mail:
Please ***check below*** where we have your permission to leave a confidential voice mail (e.g. lab or test results, prescription information). Leave the space(s) blank if you ***do not wish*** to receive voice mails.

Home Phone_____ Cell Phone_____ Work Phone_____ Other Phone_____

Your signature ***below*** confirms your approval of these updated HIPPA communication preferences. You may change your selections at any time, but must do so in writing by completing an updated form.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY **DATE SIGNED**

CENTRAL FLORIDA FOOT & ANKLE SPECIALISTS, PA
Victor F. McNamara, DPM, D.ABFAS, FACFAS

NAME:_____ AGE:_____ GENDER:_____ RACE:_____

Reason for today's visit:
1)_____ How long present?_____
2)_____ How long present?_____

IS YOUR VISIT RELATED TO A WORK INJURY? YES OR NO
(Our physicians **do not** treat work related injuries; you must go through your employer to receive medical care)

Height:_____ Weight:_____ Shoe Size:_____ Marital Status: S M W D

CIRCLE ALL CONDITIONS YOU HAVE OR HAVE HAD IN THE PAST:

Alcoholism	**Diabetes Type I**	**Hypothyroidism**
Anemia	**Diabetes Type II**	Kidney Disease
Anorexia	**Exercise Intolerance**	Liver Disease
Arrhythmia	Gout	**Numbness in Feet**
Arthritis	Heart Attack	Psychiatric Care
Asthma	**Heart Disease**	**Reynaud's Syndrome**
Back pain	**Hepatitis**	**Retinopathy**
Bleeding Disorders	High Risk Behaviors	**Renal Failure**
Cancer	HIV/AIDS	Stroke
Cramping in Legs	**Hypertension**	**Other**

Current Medications:_____
_____
_____

ALLERGIES to Medicine & Reaction:_____
_____
_____

Previous Hospitalizations, Surgery & Dates:_____
_____

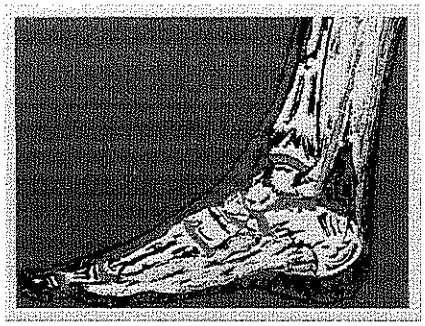
Do you **currently** smoke? YES NO If yes, How many packs per day: _____
Have you **ever** smoked? YES NO How may packs per day:_____ How many years did you smoke?: _____
Do you drink alcohol? YES NO How Much?_____
Do you exercise? YES NO Type:_____

Job Description:_____ How many hours are you on your feet daily?_____

FAMILY PHYSICIAN:_____ Phone number:_____
DIABETIC PHYSICIAN:_____ Phone number:_____

The above is complete and accurate to the best of my knowledge. I hereby give permission to the physicians of Central Florida Foot & Ankle Specialists, PA to examine, diagnose and treat my lower extremities.

Patient/Parent/Guardian SIGNATURE:_____ DATE:_____



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407-894-5151 fax
Orlandofootcare.com

CONSENT FOR TRANSFER OF BIOLOGICAL SPECIMEN

Florida law (Section 817.5655, Florida Statutes) prohibits the sale or transfer of a person's biological specimen from which DNA can be extracted to a third party without the express consent of such person.

Throughout your course of care at **Central Florida Foot & Ankle Specialists, PA**, it may be medically necessary to obtain a blood, tissue or other type of biological specimen for analysis. This analysis **will not** involve the examination of DNA to identify the presence and composition of genes in your body. After the analysis has been performed and the sample is no longer needed, it will be stored as medical waste and transferred to a third party for disposal in accordance with all local, state and federal requirements.

It may also be the case during a routine or surgical procedure, that biological specimens such your blood, urine, hair, or bodily fluids may be deposited on medical instruments, bedding, clothing or other objects. These objects may be transferred to a third party for cleaning or disposal.

By signing this document, you affirmatively state that it is your intentional decision to consent to the transfer of any and all biological specimens collected by or deposited with **Central Florida Foot & Ankle Specialists, PA** to a third party as described above. This consent does not authorize the sale or transfer of a biological specimen for the purpose of DNA analysis.

_____ _____

Patient signature/Parent or Legal Guardian signature Date

_____

Patient Printed Name

Central Florida Foot & Ankle Specialists, P.A.

FINANCIAL POLICY

Thank you for choosing Central Florida Foot & Ankle Specialists, P.A. as your health care provider. We are committed to the success of your treatment. Please understand that payment of your bill is considered part of your treatment; timely payment is imperative in assuring the continuation of the lowest possible cost to you.

All patients must complete our "Patient Information Form" before seeing the doctor.

REGARDING HMO, PPO, AND MANAGED CARE INSURANCE
If we are contracted with your HMO, PPO, or Managed Care insurance, insurance claim filing will be automatic. You will be responsible for any deductible, coinsurance, co-payments, supplies, and/or non-covered services at the time services or procedures are rendered. _____*Patient Initials*

REGARDING MEDICARE
We accept Medicare assignment. We will file your Medicare claims for you. With Medicare, you are responsible for any deductibles, coinsurance, supplies, and/or non-covered services or procedures are rendered.

_____*Patient Initials*

REGARDING PATIENTS WITHOUT INSURANCE
Full payment is due at the time of service. We accept cash, checks, Mastercard, Discover, American Express, and Visa.

_____*Patient Initials*

REGARDING PRIVATE INSURANCE
Your insurance policy is a contract between you and your insurance company. We are not a party to that contact. Therefore, you are financially responsible for your initial visit in full at time of service. On your subsequent visits we will gladly file your insurance claims for you. You will be responsible to meet any deductibles, coinsurance, supplies and non-covered services at time of service. Any balance remaining after your insurance company pays is your responsibility. If your insurance company has not made payment within 45 days, the balance will be transferred to your responsibility. _____*Patient Initials*

MINOR PATIENTS
All minor patients must be accompanied by a parent of legal guardian or treatment will not be rendered.

_____*Patient Initials*

MISSED APPOINTMENTS
Your appointment time is reserved exclusively for you. We require 24 hours notice if unable to keep your appointment. Cancellations or broken appointments without 24 hours notice will be subject to a broken appointment fee of $25.00. _____*Patient Initials*

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 the Financial Policy above. _____*Patient Initials*

SIGNATURE ON FILE FORM

I understand that I am responsible for payment of services provided to me. I hereby assign insurance benefits, otherwise payable to me, to be paid directly to Central Florida Foot & Ankle Specialists, PA for Professional Physicians fees. I authorize release of medical information for insurance purposes. I understand that I am responsible for charges not covered by my insurance policy.

I hereby request payment of authorized Medicare benefits and/or any other insurance benefits to be made to Central Florida Foot & Ankle Specialists, P.A. on my behalf for any services furnished by Central Florida Foot & Ankle Specialists, P.A. 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 to related services. In Medicare assigned claims, 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 their deductible, coinsurance, and non-covered services.

I understand my signature authorizes that payment be made to Central Florida Foot & Ankle Specialists, P.A. for my medical claims and authorize release of medical information necessary to process my medical claims.

Name of Responsible Party:_____

Signature:_____ Date:_____

Central Florida Foot & Ankle Specialists, P.A.

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I, _____, have reviewed/received a copy of
Patient Name

Central Florida Foot & Ankle Specialists, P.A. 's Notice of Privacy Practices.
Practice Name

_____ _____
Signature of Patient / Guardian Date

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Central Florida Foot & Ankle Specialists, P.A.

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff and other office personnel. The practices described in this notice will also be followed by health care providers you consult with by telephone (when your regular health care provider from our office is not available) who provide "call coverage" for your health care provider.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the health care and services you receive at this office.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment

We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have.

For Payment

We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

For Health Care Operations

We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. for example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

Appointment Reminders

We may contact you as a reminder that you have an appointment for treatment or medical care at the office.

Non-Medical Communications.

Our practice may use your PHI to contact you for non-medical reasons. For example, we may send you a birthday card, a holiday greeting or thank you for referrals via mail.

Treatment Alternatives

We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

HealthRelated Products and Services

We may tell you about healthrelated products or services that may be of interest to you.

Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or healthrelated products and services. If you advise us in writing (at the address listed at the top of this Notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

You may revoke your *Consent* at any time by giving us written notice. Your revocation will be effective when we receive it, but it will not apply to any uses and disclosures which occurred before that time.

If you do revoke your *Consent*, we will not be permitted to use or disclose information for purposes of treatment, payment or health care operations, and we may therefore choose to discontinue providing you with health care treatment and services.

SPECIAL SITUATIONS

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety

We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required By Law

We will disclose health information about you when required to do so by federal, state or local law.

Research

We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

Organ and Tissue Donation

If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

Military, Veterans, National Security and Intelligence

If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation

We may release health information about you for workers' compensation or similar programs. These programs provide benefits for workrelated injuries or illness.

Public Health Risks

We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, nonaccidental physical injuries, reactions to medications or problems with products.

Health Oversight Activities

We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.