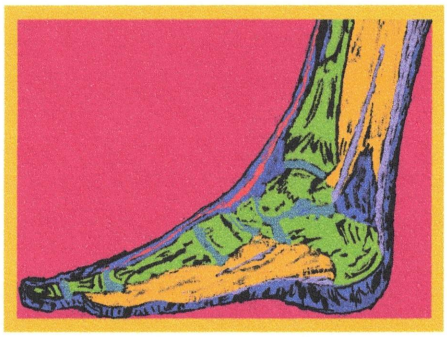


Welcome to our practice!

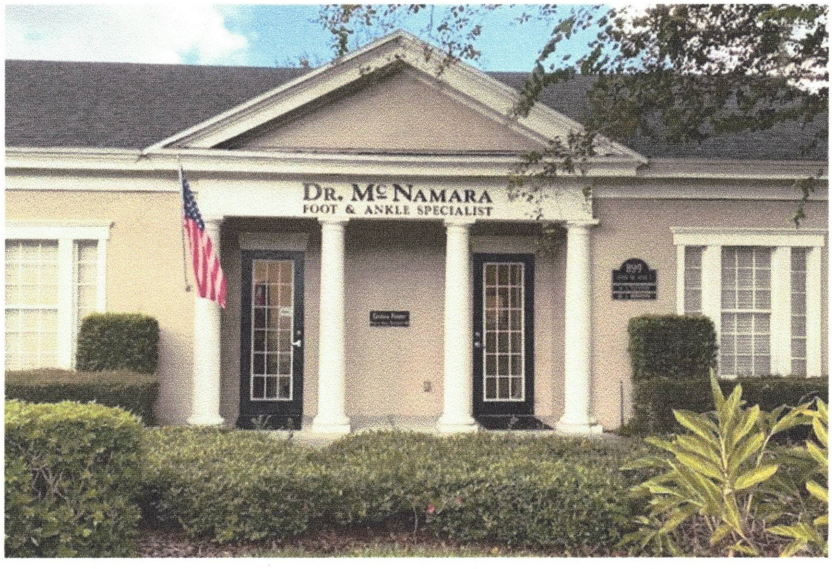
CENTRAL FLORIDA FOOT & ANKLE SPECIALISTS, PA

Alexandra Heidtmann Nobre, DPM, AACFAS

899 Outer Road, Suite C, Orlando, FL 32814

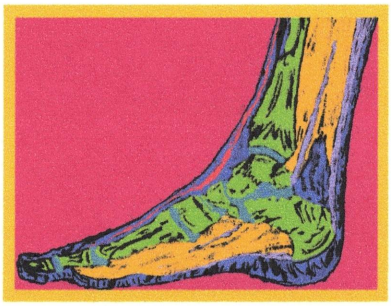
407-228-2838 Phone

This new patient documentation package is for appointments with Dr. Alexandra Heidtmann Nobre.



Please arrive 15 minutes prior to your appointment time; We strive to see patients on time. Our office requires 24-hour notice if you are unable to keep your appointment. Cancellation without 24-hour notice or no showing for appointment are subject to a $50.00 fee.

Our office does NOT face Outer Road. MapQuest and Google will direct you to the front of the building (Nuvia Weight Loss Clinic). We are in the back in front of the large parking lot.



CENTRAL FLORIDA FOOT & ANKLE SPECIALISTS, PA

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

Dr. Alexandra Heidtmann, DPM, AACFAS

899 Outer Road, Suite C, Orlando, FL 32814

407-228-2838 Phone

407-894-5151 Fax

Orlandofootcare.com

Welcome to our practice!

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 a 24 hours notice are subject to a $50.00 fee.

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

Patient information

Name: _____ Date of Birth:_____ Age:_____

Sex assigned at birth (for medical purposes): ( ) F ( ) M

If Minor, Responsible Party: _____ Relationship:_____

Patient Social Security #:_____

Best Phone number: _____

Address: _____

City, State: _____ Zip Code: _____

Email:_____

Employer: _____ Work Phone: _____

Family Physician: _____ Phone Number: _____

Diabetic Physician:_____ Phone Number:_____

Pharmacy Name: _____ Phone Number: _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

Insurance Company: _____

Referred By: Doctor_____ Friend/Family:_____ Ins Co:_____ Internet:_____ Website:_____

Authorization for Communication of Protected Health Information (PHI)

Purpose of Authorization: This authorization is for the purpose of enabling Central Florida Foot & Ankle Specialists to provide continuity of care and facilitate communication regarding my medical treatment, appointments, and billing matters.

I, _____, hereby authorize Central Florida Foot & Ankle Specialists to communicate any Protected Health Information (PHI) through the following methods (check all that apply):

( ) Phone calls (voice messages)
( ) Text messages
( ) Email

Voice Mail Messages: I authorize Central Florida Foot & Ankle Specialists to leave a confidential voicemail regarding my PHI (e.g. lab or test results, prescription information, appointment information) on my phone, as necessary.

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, appointment information). This person (designee) will also be able to call the office on your behalf. Please print the name and relationship to you/the patient of each designee below:

Designee Name: _____ Relationship to patient: _____
Designee Name: _____ Relationship to patient: _____

( ) Check here if you **DO NOT WANT** your healthcare information discussed with anyone other than yourself.

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

Patient's name: _____

Signature: _____ Date signed: _____

Central Florida Foot & Ankle Specialists, PA

Patient Name:_____

Reason for visit: _____

( ) RIGHT FOOT ( ) LEFT FOOT ( ) RIGHT ANKLE ( ) LEFT ANKLE

How long has this been present? _____

Is your visit related to a work injury? ( ) YES ( ) NO

**Our physicians do not treat work related injuries; you must go through your employer to receive medical care.*

Height: _____ Weight: _____ Shoe Size: _____

Check all that apply:

Past Medical History		HIV
NONE	CVA / Stroke	Hypercholesterolemia
Alcoholism	Depression	Hypertension
Anxiety Disorder	Diabetes Type I	Hypothyroidism
Arthritis	Diabetes Type II	Inflammatory Liver Disease
Arrhythmia	GERD (Reflux)	Leukemia
Atrial Fibrillation	Gout	Lung Disease
Asthma	Hearing Loss	Malignant Cancer
Back Pain	Heart Attack	Numbness in Feet
Blurred Vision	Heart Disease	Renal Disease
Cramping in Legs	Hepatitis	Raynaud's Syndrome

Other Past Medical History not mentioned above: _____

_____

Past Surgical History	Excision of Melanoma	Total Replacement Left Hip
NONE	Excision of Squamous Carcinoma	Total Replacement Right Hip
Bilateral Knee Replacement	Heart Valve Replacement	Total Replacement Left
Excision of Basal Carcinoma	Surgical Biopsy of Skin	Total Replacement Right Knee

Other Surgeries not mentioned above:_____

Central Florida Foot & Ankle Specialists, PA

Current Medication

Patient Name:_____DOB:_____

Circle here if you are not taking any medications: NONE

Please list all medications (including non-prescription) that you are currently taking:

Medication	Dose	Frequency	Route: Oral, injection, or topical

Central Florida Foot & Ankle Specialists, PA

Patient Name:_____

ALLERGIES: Circle here if you have no drug allergies: NONE

Please list all drug allergies and reaction to the drug:

Allergy	Reaction to medication

Smoking Status: Never Smoker

Current Smoker How many packs per day? _____ For how many years?_____

Former Smoker How many packs per day? _____ How many years did you smoke? _____

Alcohol Use: ( )NONE ( ) 1 drink a day ( ) 1-2 drinks a day ( ) 3 or more drinks a day

Do you use recreational drugs? ( ) YES ( ) NO

Driving Status: Drive in Daytime ( ) YES ( ) NO Drive at Night: ( ) YES ( ) NO

How often do you exercise? ( ) Never ( )Once a day ( )Several times a day
( )Few times a week

Occupation:_____

Financial Policy

Thank you for choosing **Central Florida Foot & Ankle Specialists, P.A.** as your healthcare 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.

REGARDING MEDICARE
We accept Medicare assignments. 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 rendered.

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

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.

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

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 $50.00.
Thank you for reading and understanding our Financial Policy. Please let us know if you have any questions or concerns. I have read, understood and agreed 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, PA. for medical claims and authorize release of medical information necessary to process my medical claims.

Name of Responsible Party: _____

Signature:_____ Date: _____

Notice of Privacy Practices: CENTRAL FLORIDA FOOT & ANKLE SPECIALISTS, P.A.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

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 healthcare provider from our office is not available) who provide "call coverage" for your healthcare 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.

Health Related Products and Services: We may tell you about health related 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 health related products and services. If you advise us in writing 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 a 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 work related 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, non accidental 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.

I_____, have reviewed/ received a copy of Central Florida Foot & Ankle Specialists, PA's Notice of Privacy Practices.

Signature of patient/ Guardian: _____ Date: _____