Patient Name:_____ Date of Birth: _____

Patient Questionnaire *(continued)*:

Describe your primary foot problem:_____

_____

How long has it been bothering you: _____ Shoe size: _____ Weight:_____ Height:_____

Any other past foot problems:_____

Allergies: Please list **ALL** drug, food, and environmental allergies or any intolerances to medications (if no known allergies write "None")

_____

_____

Medications: Please list **ALL** current medications (including any vitamins and over-the-counter medications) with their corresponding dosages (if known). If currently not taking any medications, write "None". If you need more room, please write them on the back of this page.

_____ _____

_____ _____

_____ _____

Personal Medical History: Please check if you have any of the following conditions:

☐ Anxiety	☐ Arthritis	☐ High Blood Pressure	☐ Kidney Disease	☐ Hepatitis	☐ HIV
☐ Sleep Apnea	☐ Heart Disease	☐ High Cholesterol	☐ Heart Attack	☐ Stroke	☐ Gout
☐ Alcoholism	☐ Depression	☐ Circulation Problems	☐ Osteoporosis	☐ Neuropathy	☐ Asthma

Diabetics Only: ☐ Type 1 ☐ Type 2 Date of most recent HgA1c _____ HgA1c level _____

Do you have artificial joints? If so, where? _____

Do you have a pacemaker: ☐ Yes ☐ No Do you have an artificial heart valve? ☐ Yes ☐ No

Other (please specify): _____

Procedures

Please list any surgeries or procedures you have had:

_____

_____

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment I am responsible to notify the office of any and all updates to the information listed above.

X _____ _____

Signature of Patient, Guarantor, or Personal Representative Date

Patient Name:_____ Date of Birth: _____

Family History:

Please check all that apply. ☐ Unknown ☐ Adopted

Type	Mother	Father	Sister	Brother
	Alive or Deceased	Alive or Deceased	Alive or Deceased	Alive or Deceased
Arthritis				
Cancer				
Diabetes				
Heart Disease				
High Cholesterol				
High Blood Pressure				
Other (please specify)				

Social History:

Tobacco Use: ☐Current ☐Past ☐Never Type: ☐Cigarettes ☐Cigars ☐Oral ☐Pipe Frequency:_____

Do you drink alcohol? ☐Everyday ☐Occasionally / Socially ☐No / Rarely

What type of alcohol? ☐Beer ☐ Wine ☐Liquor

Review of Systems: Please check the box if you currently have any of these symptoms or check NONE.

Cardiovascular	☐ leg pain when walking ☐ fever ☐ chest pain/pressure ☐ leg swelling ☐ Fainting ☐ cold hands/feet ☐ palpations ☐ vascular disease ☐ valve problems ☐ NONE
Genitourinary	☐ blood in urine ☐ hesitancy ☐ Incontinence ☐ increased urgency ☐ decreased frequency ☐ excessive urination ☐ kidney disease ☐ NONE
Gastrointestinal	☐ abdominal pain ☐ heartburn ☐ blood in stool ☐ vomiting ☐ ulcers ☐ constipation ☐ diarrhea ☐ trouble swallowing ☐ decreased appetite ☐ increased appetite ☐ NONE
Integumentary	☐ athletes foot ☐ nail abnormalities ☐ keloids ☐ itchiness ☐ dry, scaly skin ☐ NONE
Hematologic	☐ lower leg ulcer ☐ sickle cell disease ☐ anemia ☐ blood thinners ☐ clotting disorder ☐ NONE
Neurological	☐ tingling ☐ weakness ☐ seizures ☐ numbness ☐ tremors ☐ paralysis ☐ headaches ☐ NONE
Musculoskeletal	☐ back pain ☐ joint swelling ☐ muscle weakness ☐ muscle pain ☐ neck pain ☐ sciatica ☐ joint stiffness ☐ joint pain ☐ joint instability ☐ arthritis ☐ NONE
Respiratory	☐ chest pain ☐ wheezing ☐ COPD ☐ shortness of breath ☐ snoring ☐ coughing ☐ emphysema ☐ NONE

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment I am responsible to notify the office of any and all updates to the information listed above.

X _____ _____

Signature of Patient, Guarantor, or Personal Representative Date

Patient Name:_____ Date of Birth:_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

Many of our patients allow family members such as their spouse, parents, or others to call and request information over the phone or to pick up written medical information. This information includes results of tests, results of procedures, and medical history. Under the requirements for HIPAA, we are not allowed to give this information to anyone without the patient's written consent. If you wish to have your protected health information released to family members, you must complete and sign this form. You have the right to revoke this consent, in writing, except where we have already made disclosures based on your prior consent. This consent will remain in force until revoked or requested in writing by you, our patient. I authorize First State Foot & Ankle, LLC to release all medical information over the phone and in writing about my care to the following individuals: (This information includes but is not limited to test results, procedures, medical history, etc.)

1. Name: _____ Phone Number:_____

2. Name: _____ Phone Number:_____

Automatic "OPT Out": If you do not list any individuals above, our office will not release any verbal or written communication to anyone other than you the patient.

AUTHORIZATION AND ACKNOWLEDGEMENT

Authorization and Assignment of Benefits: I hereby give permission to First State Foot & Ankle, LLC and its employees, agents, and medical providers to release medical information to health plans, health organizations, governmental agencies, and other entities charged with fiscal responsibility for the payment of medical services rendered to me. I hereby authorize payment of the medical benefits otherwise payable to me to be directed to First State Foot & Ankle, LLC. I consent to have any monies received by the provider of services on my behalf to be applied to my outstanding accounts. I assume full responsibility for payment of any charges for the medical services provided. I understand that any or all of my medical information may be electronically submitted to any or all treating providers, hospitals, and/or health care entities. I permit a copy of this authorization to be used in place of the original.

Consent for Treatment: I consent and authorize First State Foot & Ankle, LLC to obtain my prescription history to render care. The doctor(s) and staff at First State Foot & Ankle, LLC are authorized to medically treat me and to exchange past, present, and future medical information with the patient's other medical caregivers for the purpose of enhancing and promoting the continuity of my care.

HIPAA Privacy Acknowledgement: I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: (1) conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly; (2) obtain payment from third-party payers; and/or (3) conduct normal healthcare operations such as the quality assessments and physician certifications. I have been informed of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent either by being given a hard copy to read or reading it online at www.firststatefootandankle.net. I understand that I may request in writing that you restrict how private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I also understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

By signing below, I hereby acknowledge that I have read the above information and that I understand and agree to its terms.

X _____ _____

Signature of Patient, Guarantor, or Personal Representative Date

Patient Name:_____ Date of Birth:_____

FINANCIAL POLICY

Thank you for choosing First State Foot & Ankle for your medical care. We are pleased to welcome you to our practice. We are committed to providing you with quality care.

We understand that occasionally some of our patients will experience financial difficulties. It is our hope that you will bring these situations to the attention of our staff to allow us to help you manage your account in the most effective manner. Please be advised that your health insurance is a contract between you and your insurance carrier. **If you have questions about your insurance, you will need to contact your carrier directly**. Please make sure you give us a copy of your current card at each visit. We will be glad to submit claims for payment; however, the final responsibility for payment due for services rendered is the sole liability of the patient or the guarantor.

The following is a statement of our financial policy effective 01/01/2023. We ask that you review and sign before treatment. Your signature indicates your agreement with our policy.

1. We accept cash, check, Visa, MasterCard, Discover, or American Express.
2. If we are contracted with your plan and have a verified policy on file, we will bill your insurance. You will receive an Explanation of Benefits (EOB) from your insurance company showing what your responsibility is for that date of service. We will bill you accordingly for balances due as dictated by your insurance company.
3. **If we do not participate with your insurance company, payment is due prior to services being rendered.**
4. All co-pays, coinsurance, deductibles, and fees for non-covered services will be your responsibility as determined by your insurance carrier. All co-pays, balances, and fees for non-covered services are expected at time of service, or your appointment will be rescheduled. Any statements received by our office are due within 30 days. If the balance exceeds 90 days without an attempt to address your account, your account will be turned over to a collection agency.
5. **Insurance Referrals:** This authorization must be obtained *before* your scheduled visit. If you do not have the proper authorization at the time of your visit, your appointment will be rescheduled, and you will be charged a $50 missed appointment fee. **It is your responsibility to obtain the referral prior to your appointment.** A referral from a primary care doctor is NOT the same as an insurance referral.
6. All forms, i.e. disability, leave of absence, etc., are subject to a $50.00 administrative fee. Forms will be completed as time permits, usually within a week.
7. There is a fee for all copies of medical records requested. The fee is based on the number of pages set forth by the State of Delaware. The fee for copies of x-rays is $40.00.
8. All returned checks will be assessed a $40.00 charge per returned item.
9. **If you need to cancel your appointment, we require at least 24 hours' notice. A $50.00 charge will be applied to your account for late cancellations or missed appointments.** Reminder calls are made as a courtesy, but it is ultimately the responsibility of the patient to keep their appointment and cancel in a timely fashion when necessary.
10. Surgeries require a large amount of preparation for all parties involved. If you cancel your surgery after preparations have been made, you will be charged either a $100.00 rescheduling fee or a $200 cancellation fee.

By signing below, I hereby acknowledge that I have read this policy and understand and agree to its terms.

X _____ _____

Signature of Patient, Guarantor, or Personal Representative Date

FIRST STATE FOOT & ANKLE, LLC
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