CENTRAL CAROLINA FOOT & ANKLE ASSOCIATES
A division of InStride Foot & Ankle Specialists

Chart No: _____
(staff use only)

Patient Registration Form

Date: _____

Patient Demographics

First Name: _____ M.I.: _____ Last Name: _____ Preferred Name: _____

Address: _____ Apt/Unit #:_____ City: _____ State: _____ Zip: _____

Email address: _____ Pref. Language: ☐English ☐Spanish ☐ Other: _____

Date of birth (MM/DD/YYYY): __ __/__ __/__ __ __ __

Phone: (_____) _____ ☐Home ☐Cell Secondary Phone: (_____) _____ ☐Home ☐Cell ☐Other: _____

Preferred Contact Method: ☐ Email ☐ Text ☐ Phone Call

Gender: ☐Male ☐Female Race: ☐White/Caucasian ☐ Black/African American ☐ Hispanic ☐Asian ☐Other:_____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Primary Care Doctor: _____ Phone: (_____) _____

Approximate date of last visit:_____ Information to be released: ☐ Any ☐ As follows:_____ ☐**NONE**

Patient currently in Hospice? Yes_____ No_____ **** IF YES, MEDICARE INFORMATION IS NEEDED**

Are you filing insurance for today's visit? YES ____ NO _____ IF YES, INSURANCE: _____

Who is responsible for patient's bills, if not the patient? ☐ Patient is responsible ☐ Another person (list below):

Name: _____ Phone: (_____) _____ Relationship to patient: _____

I, _____ (patient/guardian) hereby give consent for CCFA to provide medical treatment as deemed necessary by the physician to _____ (patient's name).

<u>Authorization for Release of Information to Family and/or Friends (*Optional* Section)</u>

I hereby authorize CCFA to discuss my medical care and release my confidential protected health information (PHI) to:

☐ Emergency Contact: _____ Phone: (_____) _____

Relationship to patient: _____ Information to be released: ☐ Any ☐ As follows:_____

☐ Other: _____ Phone: (_____) _____

Relationship to patient: _____ Information to be released: ☐ Any ☐ As follows:_____

Rights of the patient:

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect a copy of the protected health information to be disclosed as described in this document by sending written notification to **Central Carolina Foot & Ankle Associates, Medical Records, Attn: Security Officer; 2609 N. Duke St, Suite 301, Durham, NC 27704**. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward from the date on the revocation.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization.

This authorization shall be in force and effect until revoked by the patient or representative signing the authorization on behalf of the patient.

I acknowledge that I was offered, or provided, a copy of the Notice of Privacy Practice and that I have read (or had the opportunity to read if I so chose) and understand this Notice. (located in brochure holder at check-in area)

_____ _____

Patient Signature, or Parent or Authorized Representative Signature Date

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Patient Name: _____ Height: _____ Weight: _____ Shoe Size: _____

Reason for Visit

Chief foot complaint: _____How long have you had this problem? _____

Is the problem injury related? ☐ Yes ☐ No If yes, date of injury: _____ Was the injury at work? ☐ Yes ☐ No

Pharmacy: _____ **City/Street:** _____

Allergies Please check any drug/medication allergies you may have: or ☐ No known drug allergies

☐ Aspirin ☐ Codeine ☐ Latex ☐ Lidocaine ☐ Penicillin ☐ Sulfa ☐ Other: _____

Medications

List all current medications (if you have a list, we can copy it): or ☐ No current medications ☐ See attached list

Drug Name	Strength (mg)	Frequency (how often?)	Prescribed by:

Medical History Please check box on any of your current/past conditions: or ☐ None of the following apply

☐ Alzheimer's
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Cancer (type: _____)
☐ Diabetes ☐ I ☐ II
- Last A1C:_____
- Result:_____
☐ Esophageal reflux
☐ Irritable Bowel Syndrome
☐ Gout
☐ Heart disease
☐ Hypertension
☐ HIV
☐ Liver disease
☐ Hepatitis ___
☐ Osteoporosis
☐ Osteopenia
☐ Peripheral Vascular Disease (PVD)
☐ Renal (kidney) disease
☐ Blood Clots
☐ Stroke
☐ Thyroid disease
☐ Tuberculosis
☐ Other: _____

Surgical History Please check all that apply or ☐ None of the following apply

☐ Angio ☐ Stent placement ☐ Back surgery ☐ Bunion ☐ ORIF ☐ Hammertoe ☐ Hip replacement
☐ Knee replacement ☐ Pacemaker ☐ Other: _____

Social History

Tobacco: ☐ Current smoker - Type: ☐ Cigarettes (packs per day:_____) ☐ Cigar ☐ E-Cigarette ☐ Chewing tobacco
☐ Former Smoker - Age stopped: _____ ☐ Never smoker

Alcohol: ☐ Never ☐ Drinks alcohol ☐ Former

Family Medical History Which of your family members (Father, Mother, Brother, Sister) have/had the following:

Alcoholism	Father	Mother	Brother	Sister
Diabetes	F	M	B	S
Gout	F	M	B	S
Cancer	F	M	B	S
Type?	_____	_____	_____	_____

Heart Disease	F	M	B	S
Hypertension	F	M	B	S
Osteoarthritis	F	M	B	S
Osteoporosis	F	M	B	S

Peripheral Vascular Disease	F	M	B	S
Renal (kidney) disease	F	M	B	S
Stroke	F	M	B	S
☐ Other: _____	F	M	B	S
☐ No relevant family history				

Review of Systems: Please mark any current symptoms you are experiencing: or ☐ None of the following apply

☐ Fatigue
☐ Fever/Chills
☐ Night Sweats
☐ Recent weight loss
☐ Recent weight gain
☐ Vision worsening
☐ Vision loss
☐ Blurry vision
☐ Hearing loss
☐ Ringing in ears
☐ Chest pain
☐ Palpitations
☐ Leg pain with exercise
☐ Varicose Veins
☐ Cough
☐ Difficulty breathing
☐ Difficulty swallowing
☐ Heartburn
☐ Nausea
☐ Vomiting
☐ Abdominal pain
☐ Diarrhea
☐ Constipation
☐ Frequent urination
☐ Urinary incontinence
☐ Heat/cold intolerant
☐ Excessive sweating
☐ Loss of body hair
☐ Easy bleeding
☐ Easy bruising
☐ Loss of muscle strength
☐ Muscle weakness
☐ Joint pain
☐ Back pain
☐ Joint stiffness
☐ Muscle aches
☐ Headaches
☐ Memory loss
☐ Numbness/tingling
☐ Anxiety
☐ Depression
☐ Dry skin
☐ Itchy skin
☐ Rash

Have you had your flu shot this season?
☐ Y ☐ N

_____ _____
Signature of Patient or Person Completing Medical History Date

_____ _____
Signature of Physician Reviewing Medical History Date

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Financial Policy

We recognize it is difficult to understand many of the points in today's insurance policies, with new plans and companies emerging constantly. Our office staff will make every attempt to follow the guidelines required by your insurance company. However, please understand that the contract is made between the insurance company and the patient. Therefore, it is **your responsibility** to know and understand the details of your specific coverage.

INSURANCE:
As a courtesy to our patients, we will gladly file your insurance. In order to do this, we require a current copy of the patient's insurance card at time of service. We will scan your card(s) and photo ID for our files. **If you do not have proof of insurance at the time of your visit and wish to be seen by one of our providers, you will be required to pay the estimated charges your visit at the time you check out.** We require that you disclose all insurance information including primary, secondary, and tertiary insurances, as well as any recent changes in your insurance information or status on each visit. If you do not have proof of active insurance at the time of your visit, or do not have your insurance card with you, but wish to be seen by one of our providers, you will be required to pay out of pocket for any expenses incurred on that visit. Although we will always provide a good faith estimate of the amount that your insurance may or may not cover, **it is the insurance company that makes the final determination regarding your eligibility and benefits for service**. We do not file third party insurance, such as automobile or liability insurance

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  - I have provided correct insurance information. I understand a copy of my insurance card is needed in order to file today's visit. If I fail to provide accurate and current information, I understand I will be responsible for full payment of services provided.
  - It is my responsibility to obtain any necessary referrals/preauthorization for services provided. **Lack of required authorization may result in a denial of payment by your insurance company, and balance would become patient's personal responsibility**.
  - I authorize CCFA to file a computerized claim form (paper or electronic) on my behalf.
  - I authorize benefits to be paid to me or on my behalf to the provider for the covered services. I authorize the release of any medical information to my carrier or its agents needed to determine benefits. I authorize CCFA to pursue a formal appeal or grievance on my behalf for any denied claim that they feel should not have been denied. If my insurance fails to respond to the claim within **60 days**, CCFA reserves the right to collect full payment from me.
  - I am responsible to pay any copays, deductibles, coinsurance, or fees set forth by my insurance company and **payment is due at time of service.**

    Note: Please be aware that your office visit copay may not cover xrays, ultrasounds, injections, etc, and you may be responsible for deductibles/coinsurance for these charges.

- Outside Labs / Tests:
  - Your provider may deem it necessary to order additional labwork/tests to help aid in the diagnosis and treatment of your condition. In these cases, these will incur additional fees billed by the lab. CCFA is not responsible for verifying coverage or out of pocket costs associated with these, and you will be responsible for paying the lab directly. The lab we use is Broward Medical.

- For patients with Medicare
  - Medicare will only pay for services that they determine to be "reasonable and necessary" under Section 1862(a)(1) of the Medicare law. The following services are ones we know are not covered by Medicare and will be private pay:
    - Routine Foot Care (debridement, cutting, or trimming of corns, toenails, or calloused tissues)
    - Post-operative Surgical Shoes
    - Wound care supplies
    - Vitamin B-12 injections
    - Prescription Foot Orthotics
    - Laser treatments
    - Routine Pre-operative blood work/lab handling fees
    - Treatment of warts or benign lesions
    - Night Splints/podus boots)

- For patients with Medicare and that have changed to an HMO Insurance Policy (Medicare replacement plan):
  - I understand that if CCFA does not participate with my HMO plan, I may be responsible for **payment in full** if there are no out-of-network benefits.

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SELF PAY

For patients without insurance, or on a plan that CCFA does not participate with:

- I understand that CCFA's financial policy requires payment **in full at time of service**.

- Late Cancellation or No-Show Fees:
  - There will be a fee (according to the length of the appointment) for any appointment cancelled with less than 24 hours' notice or any appointment missed without prior communication to CCFA.
    - Less than 30 min: $35 ▪ 30 minutes: $50 ▪ 1 hour/orthotic casting: $75
  - There is a **cancellation fee** of $100 for surgeries cancelled with less than 1 full weeks' notice of the surgery date.

- Payments
  - CCFA accepts American Express, Discover, MasterCard, Visa, Honor Debits, personal check, money order and cash. CCFA also participates with the CareCredit 6-month, no interest plan.
  - I understand that a $25 fee will be applied to my account for returned checks.
  - If I am unable to pay my balance in full when due, it is my responsibility to contact the office ASAP to make other arrangements. I understand that failure to make payment on my account as required every 30 days will require further action to collect the balance in full and my credit rating will be affected. I understand that if regular monthly payments are not received, and no payment arrangements are made, CCFA will no longer be able to extend credit to you for future visits and that an additional collection agency fee will also be added to the outstanding balance at the time of transfer to collections.

- Collections
  - CCFA makes every attempt to avoid turning a patient's account over to an outside collection agency. In the event the account is sent to outside collections, the person who is financially responsible for the account will be responsible for all collection costs, including attorney fees and court cost. We recognize that issues occur that may make it difficult to pay account balances. However, it is the patient's responsibility to follow up on any bills received and make arrangements with the office for payment of the account immediately. Accounts will be sent to collections after 3 statements have been mailed with no attempt to pay. Once an account has been turned over to collections, CCFA no longer is responsible for the debt and it must be settled with the agency. Patient accounts that go to an outside collection agency, more than one time, will no longer be allowed to schedule an appointment or be seen by a CCFA provider.

- Account Refunds:
  - CCFA makes every attempt to provide a good faith estimate of the cost of services we provide. In the event that we over collect for these services, we are happy to provide a timely refund after all services have been properly adjudicated by your insurance company and the balance of the account has been paid in full. We write refunds checks once monthly as necessary.

I have read the above financial policy in full and agree to comply with all of the listed policies.

_____ _____

Signature of Patient or Authorized Representative Date

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Our practice is a division of the **InStride Foot & Ankle Specialists, PLLC**. We have divisions across North and South Carolina, and we operate under one tax ID number. As such, if you have seen any of the following physicians in the past **three years**, we need to know so that we will not file a new patient code for your visit today. Since the insurance carriers look at us as one large practice, if you have been seen at any of the following divisions, you will not be considered a new patient in our practice. **Visits prior to 2018 do not need to be disclosed**.

Please review the names of the divisions and podiatrists below and indicate if you have been seen at any of these divisions by putting a **√** on the line to the left of the practice name. Thank you for disclosing this information to us --it will allow us to be in compliance with nationally mandated correct coding initiatives.

	DIVISION	PODIATRIST
	Alta Ridge Foot Specialists **(on/after 1/1/20)**	Robert van Brederode, William Broyles, Thomas Verla
	Brunswick Foot & Ankle Surgery, PA	Joseph Kibler
	Capital Foot and Ankle Centers **(on/after 10/1/2018)**	Eldon Peters
	Carmel Foot Specialists **(on/after 1/1/20)**	Barbara Kaiser, Richard Lind, Richard Miller, Kevin Molan, Tori Simmons-Lewis
	Cary Foot and Ankle Specialists **(on/after 11/1/20)**	Michael Tomey
	Carolina Foot & Ankle Health Center	Millicent Brown
	Carolina Foot Care Associates, PLLC	Ashma Davidson, Terry Donovan **(on/after 1/1/18),** William O'Neill
	Carolina Podiatry Group	Brandon Percival, Julie Percival, William Harris, Katlin Jackson **(on/after 7/1/19),** Robert Ezewuiro **(on/after8/15/19)**
	Central Carolina Foot & Ankle Associates	Melissa Hill, Gary Liao, Alan Sotelo
	Chapel Hill Foot & Ankle Associates, P.A**. (on/after 9/1/20)**	Jane Andersen, Alan Bocko, Katherine Williams
	Coastal Carolina Foot & Ankle	Thomas Hagan, Tyler Hagan
	Coastal Carolina Foot & Ankle Associates	Jeffrey Pupp(on/after 12/31/2019), Kevin Bachman (on/after 1/1/2019), Derek Pantiel
	Comprehensive Foot & Ankle Center, P.A.	Zack Nellas
	Crystal Coast Podiatry	Thomas Bobrowski
	Family Foot & Ankle Center, P.A. **(on/after 10/1/20)**	Patrick Dougherty, Doug Smith
	Family Foot Care	Kevin McDonald, Neil Younce (on/after 10/1/2019), Erin Younce (on/after 12/19/2019)
	Foot & Ankle Center of Durham	Eric Simmons (on/after 11/1/20), Millicent Brown
	Foot & Ankle of the Carolinas, PLLC	Eric Ward, Blaise Woeste
	Gaston Foot & Ankle Associates, P.A. **(on/after 12/1/19)**	David Kirlin, Ryan Meredith, Wagner Santiago, Randell Contento
	Greensboro Podiatry Associates, P.A.	Martha Ajlouny, **Jonathan Simpson (on/between 1/1/18-5/10/18)**
	Hendersonville Podiatry	Russ Barone(before 2/2/18), Pam Stover, Graham Rigby
	James Mazur, D.P.M., P.A.	James Mazur, Erin Younce (on/after 12/19/2019)
	Kinston Podiatry	Dale Delaney
	Matthews Foot Care	Brian Killian, Kevin Killian, David Ellenbogen(before 10/23/19), Wesley Jackson (on/after 7/1/19)
	Mt. Airy Foot & Ankle Center, PLLC	Jim Shipley, David Collard, Walter Falardeau, Thurmond Siceloff before 10/23/2018) , Jeffrey Hunter (on/after 7/1/19)
	Myers Podiatric Clinic	William Myers
	Piedmont Foot & Ankle Clinic **(before 2/1/20)**	Rick Hauser, Rob Lenfestey, Jason Nolan, Joel Kelly, Elizabeth Bass Daughtry, Jacob Panici, Brian Futrell
	Piedmont Podiatry Associates	Subodh Choudhary, Nicholas Canoutas, Cassandra Pike, Sarah Fitzgerald
	Queen City Foot & Ankle Specialists, P.C.	Roxanne Burgess, Alison Garten(before 11/6/19), Neil Younce (on/after 7/1/19)
	Raleigh Foot & Ankle **(before 1/1/2018)**	Alan Boehm, Robert Hatcher, Jordan Meyers, Kirk Woelffer
	Roberson Foot Care, PC	Ainsley Rusevlyan (on/after 2/1/2019)
	Ryan Foot & Ankle Clinic **(before 7/1/20)**	David Garchar, Jeff Glaser, Michael Ryan, Scott Whitman, Matthew Borns, Bradley Lind (on/before7/23/19)
	Salem Foot Care	Scott Matthews
	Summit Podiatry	Derek Pantiel, Kevin Bachman
	Upstate Foot Care	Hans Blaakman
	Wake Foot & Ankle Center	Mike Hodos, Jim Judge
	Wilson Podiatry Associates, PA	Kendall Blackwell

_____ I attest that I have been seen in the above indicated division of the InStride since 0**1/01/2018.**

_____ I attest that to my best recollection; I have **not** been seen by any of the above divisions/physicians since **01/01/2018.**

Signature of patient:_____Date:_____

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Name_____ **DOB** ___/___/_____

Do I Need a Test For PAD?

Peripheral Arterial Disease (**PAD**) is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain and kidneys, become narrowed or clogged. It affects over 8 million Americans, most over the age of 50. It may result in leg discomfort with walking, poor healing of leg sores/ulcers, difficult to control blood pressure, or symptoms of stroke. People with PAD are at significantly higher risk of stroke and heart attack. Answers to these questions will help determine if you are at risk for PAD and if a vascular exam will help us better assess your vascular health status.

Check All Applicable Boxes

1. Do you have foot, calf, buttock, hip or thigh discomfort (aching, fatigue, tingling, cramping or pain) when you walk which is relieved by rest? (I70209) ☐
2. Do you have a history of cardiovascular disease or diabetes and experience any pain or swelling at rest in your lower legs or feet? (I70229) ☐
3. Do you have a history of cardiovascular disease or diabetes and experience any leg, foot, or toe pain that often disturbs your sleep? (I70229) ☐
4. Do you have an ulcer or wound on your thigh, calf, ankle, foot or toe that is slow to heal? (I7025) ☐
5. Do you have an infection of the leg(s) or feet that may be gangrenous (black skin tissue)? (I7026) ☐
6. Do you have a disturbance of skin sensation? (R209) ☐

Please Circle All That Apply:

Hair Loss on Legs	Coolness/ Bluish Color on Feet	Diabetes
Hypertension	Lack of Toe Nail Growth	Over the Age of 70
Current or Past Smoker	Shiny Thin Skin on Legs	Circulatory Issues

Other comments or Notes:

_____

____ ABI ☐ Vascular Consult ☐

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

*Please include: insurance, demographics, med list, recent H&P/office notes, recent labs

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