PATIENT INFORMATION

Today's Date: _____ Patient Name: _____Date of Birth: _____

Address: _____ City/State: _____Zip: _____

Home Phone: (_____) _____-_____ Cell: (_____) _____-_____ We will call/text appointment reminders.

Email Address: _____ (For internal use only)

Sex: ☐ M ☐ F Primary Language: _____ Race: _____ Ethnicity: _____

Who is responsible for payment? _____Relationship: _____

Who referred you? _____ ☐Friend ☐Insurance Co ☐Facebook ☐Google ☐Yelp ☐Instagram

EMERGENCY CONTACT

Patient's Emergency Contact: _____ Relationship: _____ Phone: (_____) _____-_____

PHARMACY INFORMATION

Pharmacy Name: _____ Address City/Street: _____Phone: (_____) _____

PRIMARY CARE PROVIDER: (**Required** for ALL Medicare/Advantage Plans) ☐ I Do Not Have a Primary Doctor

Primary Care Provider Name: _____ Date Last Seen: _____

Primary Care Provider Address: _____

INSURANCE POLICY INFORMATION - (Required info by insurance companies)

Is the patient the primary policy holder? ☐ Yes ☐ No -> **IF NO, please complete the following section:**

What is the name of the person who is the insurance policy holder?: _____

Policy Holder Sex: ☐ M ☐ F Policy Holder DOB: _____

What is the *patient's* relationship to policy holder?: ☐ Spouse ☐ Child ☐ Other

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DESIGNATION OF RELATIVES, CLOSE FRIENDS, CAREGIVERS AS REPRESENTATIVE:

I agree that the practice may disclose certain of my health information to a Personal Representative of my choosing, since this person is involved with my health care or payment relating to my health care. In that case, the practice will disclose only information that is directly relevant to the person's involvement with my health care or payment.

Print Name: _____ **Phone Number** _____ **Relation** _____

Print Name: _____ **Phone Number** _____ **Relation** _____

Print Name: _____ **Phone Number** _____ **Relation** _____

Patient Name: _____Date of Birth: _____

CURRENT PROBLEM: ☐ LEFT ☐ RIGHT ☐ BOTH FEET/ANKLES

Describe your current problem? _____

Current Pain Scale 1-10: ____ How did this problem begin? _____ When did it start? _____

What makes your problem better?_____ What makes it worse? _____

Was it a work-related injury? ☐ Yes ☐ No Do you plan on filing for workers compensation? ☐ Yes ☐ No

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CURRENT MEDICATIONS: Please list ALL medications ☐ NONE ☐ I will bring my list to my appointment

Medication Name	Dose	How often?	Medication Name	Dose	How often?
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

MEDICAL CONDITIONS ☐ NONE - I do not have ANY medical conditions

BLOOD DISORDERS ☐None ☐Blood Clots ☐Take Blood Thinners ☐Sickle Cell ☐_____

CANCER ☐None ☐Melanoma ☐Squamous Cell ☐Basal Cell ☐Bone Cancer ☐_____

DEVELOPMENTAL ☐None ☐Spina Bifida ☐Cerebral Palsy ☐Down Syndrome ☐ _____

ENDOCRINE ☐None ☐Diabetes Type 1 ☐ / Type 2 ☐ ☐Hypothyroid ☐_____

DIGESTIVE SYSTEM ☐None ☐IBD/Crohn's ☐Liver Dis ☐Stomach Ulcers ☐ Acid Reflux ☐_____

HEART & VASCULAR ☐None ☐Heart Attack ☐Arterial Disease ☐High Blood Pressure ☐Cholesterol
☐Heart Disease ☐Heart Failure ☐A-Fib ☐Valve Disorder ☐_____

INFECTIONS ☐None ☐MRSA ☐HIV/AIDS ☐Hepatitis ☐Bone Infection ☐_____

IMMUNE SYSTEM ☐None ☐Rheumatoid ☐Lupus ☐Fibromyalgia ☐ _____

KIDNEY ☐None ☐Kidney Disease Stage ___ ☐Dialysis ☐_____

LUNGS ☐None ☐COPD ☐Emphysema ☐_____

MUSCULO-SKELETAL ☐None ☐Arthritis ☐Osteoporosis ☐Fibromyalgia ☐_____

NERVOUS SYSTEM ☐None ☐Stroke ☐Multiple Sclerosis ☐Parkinsons ☐Neuropathy ☐_____

PSYCHOLOGICAL ☐None ☐Depression ☐Anxiety ☐_____

SKIN ☐None ☐Rashes_____ ☐Skin Cancer _____ ☐Ulcers ☐_____

***OTHER CONDITION*(S):** ☐_____ ☐_____ ☐_____

Patient Name: _____Date of Birth: _____

ALLERGIES: ☐ NONE ☐Latex ☐ Shellfish ☐ Iodine ☐ Food _____ ☐Anesthesia:_____☐ Other _____

☐Drug Allergies: _____ REACTION: _____

PREVIOUS SURGERIES: ☐ NONE

Type of Surgery	Date	Type of Surgery	Date
_____	_____	_____	_____
_____	_____	_____	_____

PREVIOUS HOSPITALIZATIONS: ☐ NONE

Reason for Hospitalization	Date	Reason for Hospitalization	Date
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY HISTORY: ☐ NONE ☐ Diabetes ☐ Cancer ☐ Heart Disease ☐ High Blood Pressure ☐ Stroke ☐Bleeding Disorder ☐ Rheumatoid Arthritis ☐Other _____

SOCIAL HISTORY: Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Did you drink any alcohol in past year: ☐ No ☐ Yes - If Yes, how often: ☐ Monthly ☐ Weekly ☐ 2-4 times/wk ☐ Daily

How many drinks in a typical day: ☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5+ How many *days per year* do you drink 6+/day: ___

Use of Tobacco: ☐ Never Smoked ☐ Quit – how long ago? _____ ☐ Currently Smoke ____ packs/day for ____ yrs

REVIEW OF SYSTEMS - Are you currently experiencing any of the following symptoms:

MUSCULOSKELETAL: ☐None ☐ Foot/Ankle Pain ☐ Back pain ☐ Muscle aches ☐_____

INTEGUMENTARY: ☐None ☐ Nail problem ☐ Dry Skin ☐ Callus ☐ Rash ☐_____

CONSTITUTIONAL: ☐None ☐Fever ☐Chills ☐Weight loss ☐_____

CARDIOVASCULAR: ☐None ☐ Chest pain ☐ Calf Pain ☐ Limb swelling ☐_____

RESPIRATORY: ☐None ☐ Difficulty breathing ☐ Cough ☐ Wheezing ☐_____

NEUROLOGICAL: ☐None ☐ Difficulty walking ☐ Numbness/Tingling ☐ Burning ☐_____

PSYCHIATRIC: ☐None ☐ Restless ☐ Anxiety ☐ Depression ☐ Hallucinations ☐_____

ENDOCRINE: ☐None ☐ Cold intolerance ☐ Excessive urination ☐_____

HEMATOLOGIC: ☐None ☐ Excessive bleeding ☐ Easy bruising ☐_____

ADDITIONAL INFORMATION

Height ___'____" Weight _____lbs Shoe Size _____

Have you had an *Influenza Vaccine* (Flu Shot) within the last year?: __Y / __N

Have you had a *Pneumonia Vaccine* ever in your lifetime? __Y / __N

Are you pregnant? __Y / __N Are you nursing? __Y / __N

Do you have diabetes? __Y / __N Recent A1c? ___ Name of doctor managing your diabetes: _____

OFFICE POLICIES & PROCEDURES: _____ (Initial)

These policies have been established to help us contain costs and provide the best possible care to all patients. Please acknowledge your understanding of these policies by initialing above.

1. Our office will work to determine your insurance benefits prior to your visit. Please note that payment in full is expected at the time of your visit based on the benefits provided by your insurance carrier.
2. The patient is responsible for all insurance coverage, co-insurance, deductible, and copays.
3. The patient is responsible for any required referral prior to his/her visit.
4. If your check is dishonored/returned for any reason, we will electronically debit your account for the amount of the check + $35 processing fee.
5. There is a $25.00 fee charged for all paperwork completed by doctors. (i.e. Disability forms, FMLA paperwork, etc.) Please allow at least 3 business days for these requests.
6. Requests for copies of medical records: Pursuant to North Carolina code § 90.411 the fee is $10.00 plus 50 cents per page for the first 50 pages; then 25 cents per page thereafter. Any applicable postage fees will also be assessed. There is a $10 fee to copy x-rays to disc. Please allow at least 3 business days for these requests.
7. All medical devices and durable medical equipment (custom orthotic, insoles, walking cast boots, night splints, surgical shoes, orthotics, etc.) are non-refundable.
8. There is a $7 per month billing fee for accounts unpaid after thirty days
9. Billing questions pertaining to lab fees should be directed to the lab from which the bill was received.
10. There is a $45 no show fee or failure to reschedule at least 24 hours in advance of the appointment.

CONSENTS, AUTHORIZATIONS, AND ASSIGNMENT OF BENEFITS : _____ (Initial)

1. **CONSENT TO TREAT**: The undersigned consents to INSTRIDE FOOT & ANKLE SPECIALISTS, PLLC and its providers performing any initial or subsequent evaluations, examinations, x-rays, laboratory procedures, other tests, medications, medical treatment, surgery, physical therapy, home instructions, orthotics, or other durable medical equipment. The undersigned acknowledges that it is their duty to schedule the patient's follow-up appointments, other services, prescriptions, and ordered items. An ownership stake in pathology services may provide financial benefits to some INSTRIDE FOOT & ANKLE SPECIALISTS, PLLC physicians. You have the right to choose a different pathology provider because of this ownership interest, and we will make arrangements for you to do so upon your request. The undersigned also acknowledges that while providers exercise reasonable skill and diligence in providing care, they do not guarantee outcomes or treatment.

2. **DIGITAL E-PRESCRIBING**: I authorize INSTRIDE FOOT & ANKLE SPECIALISTS, PLLC and its associates to view my external prescription history via electronic e-prescribing services. I understand that prescription history from multiple, other unaffiliated, providers, insurance companies, pharmacies and pharmacy benefit managers may be viewable by the providers and staff of INSTRIDE FOOT & ANKLE SPECIALISTS, PLLC and it may include prescriptions back in time for several years and may include prescriptions to treat HIV, substance abuse and psychiatric conditions. If applicable, I understand that my prescription history will become part of my record at this practice. I understand all of the above, I hereby provide informed consent to INSTRIDE FOOT & ANKLE SPECIALISTS, PLLC to enroll me in the e-prescribe program. This consent will remain enforced until revoked or changed.

3. **ASSIGNMENT OF BENEFITS**: I hereby irrevocably assign, transfer and convey to INSTRIDE FOOT & ANKLE SPECIALISTS, PLLC and any practitioner providing care and treatment to me/my dependent, any and all benefits and all interest and rights (including causes of action, the right to enforce payment and the right to appeal an adverse benefit determination) to which I am entitled under an employee benefit plan sponsored by my employer, all insurance policies, benefits, any third-party reimbursement, or prepaid health care plan for services rendered or products I received from INSTRIDE FOOT & ANKLE SPECIALISTS, PLLC.

4. **MEDICARE ASSIGNMENT**: I agree to complete the Medicare screening form annually and certify that the information I provided when applying for payment under Section XVIII of the Social Security Act is accurate. I grant permission for the Social Security Administration or its intermediaries to obtain information about me, as well as any information required to submit a Medicare claim on my behalf. I request that payment and authorized benefits be made on my behalf. I assign benefits payable for services to INSTRIDE FOOT & ANKLE SPECIALISTS, PLLC.

5. **AUTHORIZATION TO RELEASE INFORMATION**: I give INSTRIDE FOOT & ANKLE SPECIALISTS, PLLC and its agents permission to share my health information with any of the following entities for payment, treatment, or healthcare operations: any practitioner, support staff, or facility involved in my care plan or care transfer, as well as my insurance company and its affiliates. I am aware that the Privacy Notice outlines the potential uses and disclosures of my Health Information. On our website, you can find the HIPAA Notice of Privacy Practices. Individual copies are available in the lobby and in the office. I have read my HIPAA rights, which include paying for records, and I have had the opportunity to read them.

6. **DESIGNATION OF AUTHORIZED REPRESENTATIVE**: I authorize INSTRIDE FOOT & ANKLE SPECIALISTS, PLLC (and its agents) to act on my behalf to recover benefits from my employee benefit plan, insurance policy, and any third-party reimbursement or prepaid health care plan by: 1) requesting and receiving a copy of the summary plan description; 2) pursuing a benefit claim; 3) appealing any adverse benefit determination; and/or 4) filing a legal/equitable action. I acknowledge and agree that my designated representative shall have full authority to act and receive notices on my behalf with regard to an initial determination of the claim for health benefits relating to treatment and health care services received by me or my dependent at INSTRIDE FOOT & ANKLE SPECIALISTS, PLLC, any requests for documents relating to this claim, and an appeal of an adverse claim determination.

7. **FINANCIAL AGREEMENT**: To the extent I am legally obligated to do so, I hereby promise to pay for any and all goods or services received or provided to me or my dependent. I am aware that I am responsible for any and all copayments, deductibles, coinsurances, OTC (over-the-counter) convenience items, non-covered services, and other charges incurred during the service or during the pre-operative appointment. I, as the designated responsible party, am liable for all funds owed to INSTRIDE FOOT & ANKLE SPECIALISTS, PLLC in the event that the insurance company misrepresents their coverage or delays payment of a claim for more than 60 days. This applies regardless of the assignment of benefits. Additionally, I am aware that the insurance contract is between me and the company; As a result, if a policyholder has questions about benefits, they should first get in touch with the insurance company.

8. **CONSENT FOR PHOTOGRAPHY**: I authorize INSTRIDE FOOT & ANKLE SPECIALISTS, PLLC to take photographs during the course of my treatment. I understand that the media is the property of INSTRIDE FOOT & ANKLE SPECIALISTS, PLLC, and I may obtain a copy upon my written request. I agree and authorize the use of the media in my medical record and for teaching purposes, which includes being shown to other patients. I am aware that my name and identity will not be disclosed.

9. **CONSENT FOR COMMUNICATION:** I give INSTRIDE FOOT & ANKLE SPECIALISTS, PLLC and its associates permission to call or text me me at any account-associated phone number, including wireless phone numbers, that could result in charges to me. INSTRIDE FOOT & ANKLE SPECIALISTS, PLLC, and its partners may likewise reach me by sending instant messages or messages, utilizing any email address or phone number you give us to utilize. Pre-recorded or artificial voice messages, automated text messages, and/or an automatic dialing device may be used as methods of communication.

10. **PRIVACY NOTICE**: I understand that INSTRIDE FOOT & ANKLE SPECIALISTS, PLLC may use and disclose my protected health information for purposes of treatment, payment, and health care operations. We may use your protected health information for our own health care operations and for those of the Organized Health Care Arrangements in which we participate. I also acknowledge that I have received, have been offered to read the notice at www.instridefoot.com, or have received in the past a copy of the **Practice's Notice of Privacy Practices**, which provides information about how the practice, and individuals involved in my care in the practice, may use and disclose my protected health information. As provided in the notice, the terms of the notice may change. To obtain a copy of any current notice, contact the privacy office at INSTRIDE FOOT & ANKLE SPECIALISTS, PLLC.

    I understand that I have the right to request that the practice restrict how my protected health information is used or disclosed for treatment, payment or health care operations, but I also understand that the practice is not required to agree to a requested restriction. However, if the practice does agree, it is bound by that agreement. I understand that I have the right to revoke this consent in writing at any time, except to the extent that the practice, or individuals involved in my care in the practice, have already used or disclosed protected health information in reliance on my prior consent.

AFFIRMATION:

I certify, to the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

I give permission to the practitioners at InStride Foot and Ankle Specialists to administer and perform any diagnostic, therapeutic and/or operative procedures as may be deemed medically necessary in diagnosis and/or treatment of my condition.

Patients/minors under the age of 18, will not be treated without a parent or legal guardian present. If another family member, caretaker or friend, over the age of 18 will be present; written consent from the parent/legal guardian stating as such must be presented at the time of the appointment. Thank you.

_____ _____

Patient Name (PRINT) Legal Guardian (PRINT)

_____ _____

Patient Signature Legal Guardian Signature