PIEDMONT FOOT & ANKLE CLINIC, P.A. – PATIENT REGISTRATION SHEET

Date: ______________ Primary Care Physician Name & Phone # : ______________________ (____)_____________

Patient Name*: ____ Sex: M F (circle)
Last First MI

Full LEGAL name-- no nicknames please. ***Please PRINT all information above and below. Thank you.***

Patient Address: ____

City: ____________________________ State:________ Zip:______________ E-mail:__________________________

Date of Birth: ____(mm) ____ (dd) _______ (yyyy) Age: ______ Social Security #: __________________________
(not required unless used as insurance ID)

Home Ph#: (____)________________Work Ph#: (____)____________________Other#: (____)______________

Employer / Job Title:___________________________/_____________________________ Status: ☐ F/T ☐ P/T ☐ PRN

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Other

If patient is under 18 years of age, please complete the following:

Parent or Guardian Name: ____Relationship *(if other than parent)*: ____________

Phone# *(if different from above)*: __________________________(day) ______________________________(evening)

Emergency Contact *(other than parent or guardian)*: ____

Relationship to patient: ____________________________ Emergency Phone#: __(_____)_______________________

***Whom may we thank for referring you?* __Yellow Pages __Relative/Friend __Web/Internet __Dr.____________________**
(doctor name)

INSURANCE COVERAGE INFORMATION – Primary

Insurance Name: _____________________________ Policy ID#: ___________________________ Group#: _____________

Subscriber Name: _____________________________ DOB: ____/____/_____ Relationship: ☐self ☐spouse ☐ child ☐other

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INSURANCE COVERAGE INFORMATION – Secondary

Insurance Name: _____________________________ Policy ID#: ___________________________ Group#: _____________

Subscriber Name: _____________________________ DOB: ____/____/_____ Relationship: ☐self ☐spouse ☐ child ☐other

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INSURANCE COVERAGE INFORMATION – Tertiary

Insurance Name: _____________________________ Policy ID#: ___________________________ Group#: _____________

Subscriber Name: _____________________________ DOB: ____/____/_____ Relationship: ☐self ☐spouse ☐ child ☐other

PRIVACY PRACTICES ACKNOWLEDGEMENT

A copy of our privacy practices is located in our patient lobby. If you would like a copy, please ask the receptionist.
COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, please contact the Office Manager by phone or in writing at 875 Walnut Street, Suite 100, Cary, NC 27511. All complaints must be filed within 180 days of the alleged violation. You will not be penalized for filing a complaint.

If you have questions regarding this notice or our health information privacy policies, please contact the Office Manager at the address noted above. By signing below, I (the patient, guarantor or legal guardian) hereby acknowledge that Piedmont Foot & Ankle Clinic has notified me of their Privacy Practices.

APPOINTMENT CANCELLATION POLICY

Piedmont Foot & Ankle Clinic will make every effort to remind patients of their appointments at least one day in advance. **This is done as a courtesy only.** Patients are ultimately responsible for remembering to keep their appointments. Our office requires at least 24 hours notice prior to canceling an appointment. If less than 24 hours notice is given (this includes appointments missed without any notice or appointments cancelled on the same day as they are made), our office reserves the right to charge a cancellation or no-show fee to the patient's account. ***Exceptions to this policy are at the sole discretion of the management of Piedmont Foot & Ankle Clinic.***

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

In accordance with HIPAA/Privacy guidelines, I authorize Piedmont Foot & Ankle Clinic to release any medical information necessary to process my insurance claims. I authorize Piedmont Foot & Ankle Clinic to release any pertinent medical information to my primary care physician or other continuing care physician or provider for the continuation of my medical care. I understand that patient medical records are the property of Piedmont Foot & Ankle Clinic, and in order to obtain a copy of the patients' medical record or any information contained therein, a signed medical release form is required and I understand there will be a charge for the copying of said records. I understand that if I want to transfer my records to another physician, a signed medical release form will be required. There is no fee charged to transfer records to another physician, medical office or hospital. I understand that this release is good for one year from the date of signature below. This authorization for release of records may be revoked at any time by requesting it in writing. ****IF YOU WISH TO AUTHORIZE RELEASE OF YOUR MEDICAL INFORMATION TO ANYONE OTHER THAN YOURSELF PLEASE INDICATE BELOW (If the patient is under the age of 18, the parent/guardian can designate someone other than themselves):***

*Name of authorized person(s): ____Relationship: __________________

I have read and understand the above policies concerning PRIVACY PRACTICES ACKNOWLEDGEMENT, APPOINTMENT CANCELLATION POLICY and AUTHORIZATION TO RELEASE MEDICAL INFORMATION. I agree to the terms and conditions as set forth above.

____ ____________________________________

Signature of patient *(if under age 18, parent/guardian must sign)* Date

____ ____________________________________

Signature of parent/guardian/responsible party Date

PIEDMONT FOOT AND ANKLE CLINIC, P.A.

Medical History Form

Date:________________ Patient Name:____ Sex: ☐ Male ☐ Female

Primary Care Physician:__________________________________ Did your physician refer you to us? ☐Yes ☐ No

Briefly state the reason for your visit: ____
____

Please list any previous surgeries you have had (include any other foot or ankle procedures) and the approximate dates of those surgeries: ____
____
____

Please list any previous hospitalizations for any reason other than surgeries listed above: _______________________
____

Do you have or have you ever had any of the medical conditions or treatments listed below? Please circle 'Y' for yes or 'N' for no.

Condition			Condition		
AIDS/HIV	Y	N	High Blood Pressure	Y	N
Amputation *(specify)*:________________	Y	N	Kidney Disorder	Y	N
Anemia	Y	N	Liver Disease	Y	N
Angina	Y	N	Low Blood Pressure	Y	N
Arthritis	Y	N	Measles/Mumps/Rubella	Y	N
Artificial Heart Valves	Y	N	Meningitis	Y	N
Artificial Joints/Implants	Y	N	Nervous Problems	Y	N
Asthma	Y	N	Neurological Disorders	Y	N
Back problems	Y	N	Phlebitis/Blood Clot	Y	N
Bleeding Disorders	Y	N	Psoriasis	Y	N
Cancer *(specify type)*:__________________	Y	N	Psychiatric Care	Y	N
Chemical Dependency	Y	N	Radiation Treatment	Y	N
Chest Pain	Y	N	Rash	Y	N
Chicken Pox	Y	N	Respiratory Disease	Y	N
Chronic Diarrhea	Y	N	Rheumatic/Scarlet Fever	Y	N
Circulatory Problems	Y	N	Shortness of Breath	Y	N
Diabetes *(specify type)*:_________________	Y	N	Sinus problems	Y	N
Ear problems	Y	N	Special Diet	Y	N
Edema	Y	N	Stroke (CVA)	Y	N
Elevated cholesterol	Y	N	Swelling in Legs/Feet	Y	N
Epilepsy	Y	N	Swollen Neck Glands	Y	N
Eye problems	Y	N	Thyroid Disorder	Y	N
Fainting	Y	N	Tuberculosis	Y	N
Foot/Leg cramps	Y	N	Ulcers	Y	N
Gout	Y	N	Varicose Veins	Y	N
Headaches	Y	N	Venereal Disease	Y	N
Heart Disease	Y	N	Weight loss (unexplained)	Y	N
Hepatitis/Jaundice	Y	N	Other/Not listed *(specify)*:_________________	Y	N

Do you have any relatives who have or have had any of the following: angina, arthritis, cancer, peripheral artery disease, peripheral vascular disease, heart disease, hypertension, diabetes or liver disease? **Yes** **No** *(circle one)*
If **yes**, please list the their relationship to you and the condition(s):____
____

Do currently use cigarettes or tobacco? Y N **If yes, how long have you smoked?** ______ years
How many packs per day? _________ **For previous users--how long ago did you quit?** ________ mths _____yrs

Alcohol use: Yes No **Quantity:** ______________ daily weekly ***(circle one)***

Do you have any allergies? Yes No **If you answered yes, please specify *(see below-check all that apply)*:**

Adhesive tape	☐	Iodine	☐	Penicillin	☐
Anticoagulant therapy	☐	Latex	☐	Seafood/Shellfish	☐
Aspirin	☐	Local anesthetics	☐	Sulfa	☐
Codeine	☐	Novocaine	☐	Other *(please specify)*: ___________	
Demerol	☐	Peanuts	☐	______________________________	

Please list below the names of any prescription medications, over-the-counter (OTC) medications, vitamins or supplements you are currently taking. Please include the strength and the frequency if known.

Name of Medication/Vitamin/Supplement	Strength (*mg*)	Frequency *(# doses/day)*
________________________________	__________	________________
________________________________	__________	________________
________________________________	__________	________________
________________________________	__________	________________
________________________________	__________	________________
________________________________	__________	________________
________________________________	__________	________________
________________________________	__________	________________
________________________________	__________	________________

Please provide the name and phone number of the pharmacy that you use most often:

Pharmacy Name:_________________________________ Phone #: (_____)_________________________

PATIENT/GUARDIAN CONSENT:

I certify that the above information is true and correct to the best of my knowledge. I hereby authorize the physician to administer and perform such procedures that may be deemed necessary in the diagnosis and treatment of my feet and/or ankles.

Patient Signature: ____ Date: _______________

Parent/Guardian: ____ Date: _______________

(if patient is under the age of 18, parent or guardian MUST sign form)

Medical history reviewed by: ______________ ***(initials)*** **Date reviewed:** _________________

PIEDMONT FOOT & ANKLE CLINIC, P. A.

PATIENT PAYMENT POLICY

Thank you for choosing our practice! It is our belief that establishing a written financial policy is mutually beneficial to all parties. It is our goal to avoid any miscommunication or concerns regarding financial matters in order to focus our energies on providing excellent healthcare services to our patients.

We participate with many insurance plans. If you would like a list of these plans, please ask the receptionist. Each insurance plan has different benefits for you as well as different financial obligations. Not all insurance policies cover all services. It is ultimately your responsibility to check with your insurance company to determine covered benefits. We do not file claims to any insurance in which we do not participate.

The following are our guidelines/policies relative to financial responsibility:

- **Payment is expected at the time services are rendered.** This includes co-pays, deductibles and co-insurance, as well as payment for any non-covered or over the counter items.
- Please present your insurance card(s) at each visit to our office.
- You may be charged a no-show fee of $35.00 for any appointments missed, not cancelled or rescheduled with at least 24 hours notice.
- Prior balances on your account must be paid in full within 60 days unless other arrangements are made **in advance and in writing** with the office manager.
- Accounts may be turned over to a collection agency for any balances past due 60 days or more.
- A service charge of $35.00 will be assessed for returned checks, refiling of insurance due to incomplete or incorrect information given at the time of the appointment or for accounts turned over to collection agencies.
- I understand that I will be legally responsible for all collection costs associated with the collection of this account including court costs, reasonable attorney fees, and all other expenses incurred with collection if I default on any unpaid balance.
- A fee of $20.00 will be assessed for the completion of any disability, Family Medical Leave Act (FMLA), attending physician statements (APS) or any other miscellaneous forms.
- Interest in the amount of 1.5% monthly (18% annually) may be added to any balances older than 60 days.
- In the case of services provided to patients under the age of 18, the parent, guardian or legal representative who initiates the services for the minor will be responsible for payment. We do not bill another individual or estranged spouse for payment.

I hereby authorize Piedmont Foot & Ankle Clinic, hereafter known as PFAC, to file all medical claims with any and all insurances in which PFAC participates. I hereby authorize payment of insurance benefits to be made to PFAC. I further understand that if my insurance company denies any or all medical services as “non-covered”, “coverage terminated”, “pre-existing” or “not a covered member”, I will be responsible for full payment within 30 days of said denial(s), or within 30 days of the first billing statement sent by PFAC following the receipt of said denial(s). I understand that PFAC will not file any claims for non-covered or over the counter items. I further understand that PFAC does NOT file supplemental, secondary or tertiary claims EXCEPT for the following: 1) Medigap (Medicare supplement) coverages in which PFAC participates, OR 2) where PFAC participates with BOTH the primary and secondary coverages.

I fully understand the above policies and agree to be financially responsible for any and all incurred charges resulting from medical services rendered.

UPON ARRIVAL AT OUR OFFICE, YOU WILL BE ASKED TO READ AND SIGN THIS FORM PRIOR TO RECEIVING ANY SERVICES. A COPY OF THE SIGNED FORM WILL BE PROVIDED TO YOU.