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

*Please **PRINT** all information below. Thank you.*

Date: _____

Primary Care Physician: Name _____**Phone #** (____)_____

Patient Name (*full **Legal** name*)**:** _____
Last **First** **MI**

Patient Address: _____

City: _____ **State:** _____ **Zip:** _____ **E- mail:** _____

Date of Birth: _____ **Age:** _____ **Sex:** **M** ◯ **F** ◯

Best Phone #: (____)_____ **Second phone #:** _____

Employer/ Job Title: _____/_____

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

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

Parent/ Guardian Name: _____**Relationship:** _____

Phone # (if different than above): _____

Emergency Contact: _____

Relationship to patient: _____ **Phone #:** _____

Primary Insurance Information

Insurance Name: _____ **Policy ID#:** _____ **Group #:** _____

Subscriber Name: _____ **Subscriber DOB:** _____/_____/_____

Relationship to patient: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**

Who may we thank for referring you?

☐ **Relative/ Friend** ☐ **Dr.** _____

☐ **Google** ☐ **Facebook**

☐ **Insurance Website** ☐ **Health Fair**

PIEDMONT FOOT AND ANKLE CLINIC, P.A.

Medical History Form

ate: _____ Patient Name: _____ Sex: ☐ Male ☐ Female

rimary Care Physician: _____ Did your physician refer you to us? ☐ Yes ☐ No

riefly state the reason for your visit: _____

lease list all **previous surgeries** (i.e. tonsillectomy, appendectomy) you have had (include any other foot or ankle procedures) ıd the approximate dates of those surgeries: _____

_____

lease list any previous hospitalizations for any reason (childbirth, car accident) other than surgeries listed above:

_____

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

Significant weight change	○Y ○N	Heartburn	○Y ○N
Change in Wart/Mole	○Y ○N	Indigestion	○Y ○N
Dryness	○Y ○N	Joint Pain	○Y ○N
Nail Changes	○Y ○N	Joint Redness	○Y ○N
New Lesions	○Y ○N	Joint Stiffness	○Y ○N
Rash	○Y ○N	Joint Swelling	○Y ○N
Headache	○Y ○N	Decreased Memory	○Y ○N
Visual Disturbances	○Y ○N	Numbness	○Y ○N
Hearing Loss	○Y ○N	Stroke	○Y ○N
Neck Pain	○Y ○N	Trouble Walking	○Y ○N
Difficulty Breathing	○Y ○N	Weakness	○Y ○N
Calf Cramps	○Y ○N	Tingling	○Y ○N
Chest Pain	○Y ○N	Depression	○Y ○N
Edema	○Y ○N	Nervousness	○Y ○N
Elevated Blood Pressure	○Y ○N	Thyroid Disorder	○Y ○N
Night Cramps	○Y ○N	Anemia	○Y ○N
Shortness of Breath	○Y ○N	Blood Clots (Stroke, Phlebitis)	○Y ○N
Swelling of Extremities	○Y ○N	Excessive Bleeding	○Y ○N
Diarrhea	○Y ○N	Other/Not listed *(specify)*:_____	○Y ○N

Past Medical History: Do you have or have you ever had any of the medical diagnoses or conditions listed below? Please circle 'Y' for yes and 'N' for no.

AIDS/HIV	○Y ○N	Kidney Disorder	○Y ○N
Amputation (specify) _____	○Y ○N	Liver Disease	○Y ○N
Arthritis (type) _____	○Y ○N	Measles/Mumps/Rubella	○Y ○N
Artificial Heart valves/stent	○Y ○N	Meningitis	○Y ○N
Artificial Joints/Implants	○Y ○N	Nervous Disorder	○Y ○N
Asthma	○Y ○N	Neurological Disorder (type) _____	○Y ○N
Cancer (specify type) _____	○Y ○N	Psoriasis	○Y ○N
Chemical Dependency	○Y ○N	Psychiatric Care	○Y ○N
Chicken Pox/Shingles	○Y ○N	Radiation Treatment	○Y ○N
Circulatory Problems	○Y ○N	Reflux (GERD)	○Y ○N
Diabetes (specify type) _____	○Y ○N	Respiratory Disease	○Y ○N
Elevated Cholesterol	○Y ○N	Rheumatic/Scarlet Fever	○Y ○N
Epilepsy	○Y ○N	Tuberculosis	○Y ○N
Gout	○Y ○N	Ulcers	○Y ○N
Heart Disease	○Y ○N	Varicose veins	○Y ○N
Hepatitis/Jaundice	○Y ○N	Venereal Disease	○Y ○N
High Blood Pressure	○Y ○N	Other/Not Listed (specify) _____	○Y ○N

Female patients only: Is there a possibility you are pregnant? ◯ 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 their relationship to you and the condition(s): _____

_____

Do you 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
Do you currently use caffeine? Y N **If so, how much?** _____
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	☐	Novocain	☐	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 #:** (____) _____

Shoe Size: _____

_____

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.

Signature of parent/guardian/responsible party _____ Date _____

Welcome to our New Patients

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 2015 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	Robert van Brederode, William Broyles, Thomas Verla
	Ankle & Foot Center of Charlotte **(Resigned from group 7/1/2017)**	Scott Basinger
	Brunswick Foot & Ankle Surgery, PA	Joseph Kibler
	Carmel Foot Specialists	Barbara Kaiser, Richard Lind, Richard Miller, Kevin Molan, Tori Simmons-Lewis
	Carolina Foot & Ankle Health Center	Millicent Brown
	Carolina Foot Care Associates, PLLC	Ashma Davidson, Terry Donovan (ret), William O'Neill
	Carolina Podiatry Group	Brandon Percival, Julie Percival, William Harris
	Central Carolina Foot & Ankle Associates	Melissa Hill, Gary Liao, Alan Sotelo, Phil Ward (ret.), John Iredale (ret.)
	Chapel Hill Foot & Ankle Associates, P.A.	Jane Andersen, Alan Bocko, Katherine Williams
	Charlotte Foot & Ankle Specialists, PLLC **(resigned from group 8/1/2017)**	Kristine Strauss
	Coastal Carolina Foot & Ankle	Thomas Hagan, Tyler Hagan
	Comprehensive Foot & Ankle Center, P.A.	Zack Nellas
	Crystal Coast Podiatry	Thomas Bobrowski
	Eastover Foot & Ankle, P.A. **(Resigned from Group 1/1/17)**	Chris Fuesy, Ron Futerman, Kent Picklesimer
	Family Foot & Ankle Center, P.A.	Patrick Dougherty, Doug Smith
	Family Foot Care	Kevin McDonald
	Foot & Ankle Center of Durham	Eric Simmons
	Foot & Ankle of the Carolinas, PLLC	Eric Ward, Blaise Woeste
	Gaston Foot & Ankle Associates, P.A.	David Kirlin, Ryan Meredith, Wagner Santiago, Randell Contento
	Greensboro Podiatry Associates, P.A.	Martha Ajlouny, N'Tuma Jah (resigned 12/21/17), Jonathan Simpson (eff: 1/1/18)
	Hendersonville Podiatry	Russ Barone(ret), Pam Stover
	James Mazur, D.P.M., P.A.	James Mazur
	Kinston Podiatry	Dale Delaney
	Matthews Foot Care	Brian Killian, Kevin Killian, David Ellenbogen
	Mt. Airy Foot & Ankle Center, PLLC	Jim Shipley, David Collard, Thurmond Siceloff
	Myers Podiatric Clinic	William Myers
	Piedmont Foot & Ankle Clinic	Rick Hauser, Rob Lenfestey (ret.), Jason Nolan, Joel Kelly, Elizabeth Bass Daughtry, Jacob Panici, Brian Futrell (eff:3/1/18)
	Piedmont Podiatry Associates	Subodh Choudhary, Nicholas Canoutas, Cassandra Pike, Sarah Fitzgerald, Smitha Joseph (ret.)
	Queen City Foot & Ankle Specialists, P.C.	Roxanne Burgess, Alison Garten
	Raleigh Foot & Ankle **(Resigned from Group 1/1/2018)**	Alan Boehm, Robert Hatcher, Jordan Meyers, Kirk Woelffer
	Ryan Foot & Ankle Clinic	David Garchar, Jeff Glaser, Michael Ryan, Scott Whitman, Matthew Borns
	Salem Foot Care	Walter Falardeau, Scott Matthews
	Summit Podiatry	Derek Pantiel
	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**1/01/2015.**

☐ I attest that to my best recollection, I have not been seen by any of the above divisions/physicians since **01/01/2015.**

Signature of patient: _____ Date: _____

Printed 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, or 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 increased risk for stroke and heart attack. Answers to these questions will determine if you are at risk for PAD and if a vascular exam will help us better assess your vascular health status.

Name:_____ Date:_____

Circle "Yes" or "No":

			Test for PAD
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?	○Yes ○No	☐
2.	Do you experience any pain at rest in your lower leg(s) or feet?	○Yes ○No	☐
3.	Do you experience foot or toe pain that often disturbs your sleep?	○Yes ○No	☐
4.	Are your toes or feet pale, discolored, or bluish?	○Yes ○No	☐
5.	Do you have skin wounds or ulcers on your feet or toes that are slow to heal (8-12 weeks)?	○Yes ○No	☐
6.	Has your doctor ever told you that you have diminished or absent pedal (foot) pulses?	○Yes ○No	☐
7.	Have you suffered a severe injury to the leg(s) or feet?	○Yes ○No	☐
8.	Do you have an infection of the leg(s) or feet that may be gangrenous (black skin tissue)?	○Yes ○No	☐

Patient Signature:_____

Physician Signature:_____ Date :_____

ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was offered or provided with a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the notice.

_____

Patient Name (print)

_____

Parent/ Authorized Representative/Parent (if applicable)

Authorization for release of information

I hereby authorize Instride Piedmont Foot and Ankle Specialists to disclose my individual medical information to the person listed below. I understand that this authorization is voluntary and will not expire, however it may be revoked at any time by notifying Instride Piedmont Foot and Ankle Specialists in writing.

Person(s) allowed to receive my medical information	***Relationship to Patient***	***Phone Number***

Signature: _____ Date: _____

InStride Foot & Ankle Specialists℠

Notice of Privacy Practices
for InStride Piedmont Foot & Ankle Clinic

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act (HIPAA; "Act") of 1996, revised in 2013, requires us as your health care provider to maintain the privacy of your protected health information, to provide you with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We are required to maintain these records of your health care and to maintain confidentiality of these records.

The Act also allows us to use your information for treatment, payment, and certain health operations unless otherwise prohibited by law and without your authorization.

- Treatment: We may disclose your protected health information to you and to our staff or to other health care providers in order to get you the care you need. This includes information that may go to the pharmacy to get your prescription filled, to a diagnostic center to assist with your diagnosis, or to the hospital should you need to be admitted. If necessary to ensure that you get this care, we may also discuss the minimum necessary with friends or family members involved in your care unless you request otherwise.
- Payment: We may send information to you or to your health plan in order to receive payment for the service or item we delivered. We may discuss the minimum necessary with friends or family members involved in your payment unless you request otherwise.
- Health operations: We are allowed to use or disclose your protected health information to train new health care workers, to evaluate the health care delivered, to improve our business development, or for other internal needs.
- We are required to disclose information as required by law, such as public health regulations, health care oversight activities, certain law suits and law enforcement.

Certain ways that your protected health information could be used or disclosed require an authorization from you: disclosure of psychotherapy notes, use or disclosure of your information for marketing, disclosures or uses that constitute a sale of protected health information, and any uses or disclosures not described in this NPP. We cannot disclose your protected health information to your employer or to your school without your authorization unless required by law. You will receive a copy of your authorization and may revoke the authorization in writing. We will honor that revocation beginning the date we receive the written signed revocation.

You have several rights concerning your protected health information. When you wish to use one of these rights, please inform our office so that we may give you the correct form for documenting your request.

- You have the right to access your records and/or to receive a copy of your records, with the exception of psychotherapy notes. Your request must be in writing, and we must verify your identity before allowing the requested access. We are required to allow the access or provide the copy within 30 days of your request. We may provide the copy to you or to your designee in an electronic format acceptable to you or as a hard copy. We may charge you our cost for making and providing the copy. If your request is denied, you may request a review of this denial by a licensed health care provider.

- You have the right to request restrictions on how your protected health information is used for treatment, payment, and health operations. For example, you may request that a certain friend or family member not have access to this information. We are not required to agree to this request, but if we agree to your request, we are obligated to fulfill the request, except in an emergency where this restriction might interfere with your care. We may terminate these restrictions if necessary to fulfill treatment and payment.
- We are required to grant your request for restriction if the requested restriction applies only to information that would be submitted to a health plan for payment for a health care service or item for which you have paid in full out-of-pocket, and if the restriction is not otherwise forbidden by law. For example, we are required to submit information to federal health plans and managed care organizations even if you request a restriction. We must have your restriction documented prior to initiating the service. Some exceptions may apply, so ask for a form to request the restriction and to get additional information. We are not required to inform other covered entities of this request, but we are not allowed to use or disclose information that has been restricted to business associates that may disclose the information to the health plan.
- You have the right to request confidential communications. For example, you may prefer that we call your cell phone number rather than your home phone. These requests must be in writing, may be revoked in writing, and must give us an effective means of communication for us to comply. If the alternate means of communication incurs additional cost, that cost will be passed on to you.
- Your medical records are legal documents that provide crucial information regarding your care. You have the right to request an amendment to your medical records, but you must make this request in writing and understand that we are not required to grant this request.
- You have the right to an accounting of disclosures. This will tell you how we have used or disclosed your protected health information. We are required to inform you of a breach that may have affected your protected health information.
- You have the right to receive a copy of this notice, either electronic or paper or both.
- You have the right to opt out of fund raising communications.

If you have any questions about our privacy practices, please contact our Privacy Officer at the number below.

You have the right to file a complaint with us or with the Office for Civil Rights. We will not discriminate or retaliate in any way for this action. To file a complaint, please contact the applicable party:

InStride Foot & Ankle Specialists Compliance Specialist / Central Office

Phone number: (704) 886-1918

Fax number: (704) 257-2049

Office for Civil Rights
http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

We are required to abide by the policies stated in this Notice of Privacy Practices, which became effective on 01/01/2017.