Welcome to East Coast Podiatry, Inc.

PATIENT INFORMATION

Date _____

Name _____
Last First Initial

Social Security# _____ **Birthdate** _____ /_____ /_____ **Age** _____

Sex: ❑ **M** ❑ **F** **Marital Status:** ❑ SINGLE ❑ MARRIED ❑ WIDOWED ❑ DIVORCED **Race:** _____

Home Phone# _____ **Cellular#** _____

Home Address _____

City _____ **State** _____ **Zip Code** _____

Email address _____

Emergency Contact/Relationship _____ **Phone#** _____

Guarantor of Account/Relationship _____ **Phone#** _____

EMPLOYMENT INFORMATION

Employer _____ **Phone#** _____

Employer Address _____

❑ **Student** ❑ **Retired** ❑ **Unemployed** ❑ **Disabled**

VISIT INFORMATION

Doctor to be seen: ❑ **Dr. Donald C. Johnson** ❑ **Dr. Lisa A. Farrar** ❑ **Dr. Kristie L. Taddie**

Reason for visit today? _____

Is this related to a Worker's Compensation or Third Party Liability Claim? ❑ **Yes** ❑ **No**

Who can we thank for referring you to our office? _____

Have you seen a podiatrist before? ❑ **Yes** ❑ **No** If YES, please list: Name _____ Last Visit _____

Family Physician _____ **Phone#** _____

Pharmacy Name _____ **Phone#** _____

Address _____

INSURANCE INFORMATION

Primary Insurance _____

Policy or ID# _____ Group# _____ Copay $ _____

Subscriber Name _____ Subscriber Birthdate _____ /_____ /_____

Subscriber SS# _____ Relationship to Patient _____

Supplemental Insurance _____

Policy or ID# _____ Group# _____ Copay $ _____

Subscriber Name _____ Subscriber Birthdate _____ /_____ /_____

Subscriber SS# _____ Relationship to Patient _____

If you do not have any Insurance, and will be a Self-Pay Patient, please sign here to acknowledge that you understand that you are responsible for all costs associated with your visit and any treatment performed at East Coast Podiatry, Inc. in accordance with the Financial Agreement as outlined on the Patient Consent and Authorizations page attached here.

_____ _____

Patient or Authorized Representative Signature **Date**

MEDICAL HISTORY (check all that apply)

- ❑ Alzheimer's / Dementia
- ❑ Asthma
- ❑ Atrial Fibrillation
- ❑ Back Problems
- ❑ Cancer
- ❑ Chronic Pain
- ❑ Congestive Heart Failure
- ❑ COPD / Emphysema
- ❑ Depression
- ❑ Dizziness / Vertigo
- ❑ Fibromyalgia
- ❑ Eyesight Difficulties/Blind
- ❑ GERD
- ❑ Gout
- ❑ Hearing Difficulties/Deaf
- ❑ Heart Disease
- ❑ Hepatitis A / B / C
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ HIV Positive
- ❑ Liver Disease
- ❑ Mitral Valve Prolapse
- ❑ Myocardial Infarction
- ❑ Osteoarthritis
- ❑ Osteopenia or Osteoporosis
- ❑ Pacemaker
- ❑ Peripheral Neuropathy
- ❑ Peripheral Vascular Disease
- ❑ Psoriasis
- ❑ Renal Insufficiency/ESRD
- ❑ Seizures
- ❑ Stroke/TIA Date: _____
- ❑ Thyroid Disease
- ❑ Venous Insufficiency
- ❑ Other: _____
- ❑ Other: _____
- ❑ Hospice: Admit date: _____

Do you have **Diabetes**? ❑ **Yes** ❑ **No** If so, Year Diagnosed: _____ ❑ Type 1 ❑ Type 2 Current A1C _____

Have you had **DVT** or **Blood Clot** in your leg? ❑ **Yes** ❑ **No** If so, when? _____ Which leg? ❑ Right ❑ Left

Why did this occur? _____ What treatment was performed? _____

Do you have **Kidney Disease**? ❑ **Yes** ❑ **No** If so, are you on dialysis? ❑ **Yes** ❑ **No** ❑ Hemo ❑ Peritoneal

Do you have any **Open Wounds**? ❑ **Yes** ❑ **No** If so, where? _____

Have you ever had an Arterial Doppler Scan? **Yes** **No** If so, when? _____

Have you ever had a Venous Doppler Scan? **Yes** **No** If so, when? _____

Shoe Size: Length _____ Width _____ ❑ Men's ❑ Women's

Gait Assistance: ❑ None ❑ Cane ❑ Walker ❑ Scooter ❑ Wheelchair ❑ Bed-ridden

SURGICAL HISTORY

Please Include Pertinent Surgeries or Treatments Including Vascular, Lower Extremity, etc. and Dates:

_____

_____

_____

FAMILY HISTORY

	Mother	Father	Other		Mother	Father	Other
Cancer	❑	❑	_____	High Blood Pressure	❑	❑	_____
Diabetes	❑	❑	_____	Kidney Disease	❑	❑	_____
Heart Disease	❑	❑	_____	Other _____	❑	❑	_____

SOCIAL HISTORY

Exercise: ❑ NONE ❑ OCCASIONALLY ❑ ROUTINELY TYPE OF ACTIVITY _____

Tobacco Use: ❑ NEVER ❑ FORMER DATE QUIT _____ ❑ CURRENT PPD _____ / YEARS _____

Alcohol Use: ❑ NONE ❑ RARELY ❑ MODERATELY ❑ DAILY ❑ QUIT

Immunizations: Last Flu Vaccine Date: _____ Pneumonia Vaccine Date: _____

MEDICATIONS

PLEASE LIST YOUR CURRENT PRESCRIPTION AND OVER THE COUNTER MEDICATIONS WITH DOSAGE:

❑ Aspirin Dosage _____ Start Date _____

❑ Prednisone Dosage _____ Start Date _____

❑ Blood Thinner: Name _____ Dosage _____ Start Date _____

❑ Antibiotic: Name _____ Dosage _____ Start Date _____

_____

_____

_____

_____

ALLERGIES (List type and severity of reaction)

❑ **No Known Drug Allergies**

❑ Adhesive Tape/Band-aids _____

❑ Aspirin _____

❑ Betadine/Iodine _____

❑ Codeine _____

❑ Latex _____

❑ Local Anesthetics _____

❑ Penicillin _____

❑ Quinolones (ie. Cipro, Levaquin) _____

❑ Stainless Steel/Metal _____

❑ Sulfa (ie.Bactrim) _____

❑ Suture Material _____

❑ Tetracycline _____

❑ Other: _____

HIPAA DESIGNATION DISCLOSURE FORM

Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain pieces of my health information to a Personal Representative of my choosing, since such person is involved with my healthcare or payment relating to my healthcare. In that case, East Coast Podiatry, Inc. (ECP) will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my healthcare. These Personal Representatives are:

Name_____ Phone_____ Relationship _____

Name_____ Phone_____ Relationship _____

Request to Receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby request ECP communicate with me as listed below:

Home Telephone #: _____

❑ May Leave Message with Detailed Information

❑ Leave Message with Call Back Request Only

Work Telephone #: _____

❑ May Leave Message with Detailed Information

❑ Leave Message with Call Back Request Only

Written Communication:

❑ May Fax written information to me at _____

❑ May Write to me at my Home Address or at _____

The Following Persons <u>are not authorized</u> to receive my Patient Health Information:

Name _____ Name _____

The above authorizations are voluntary and I may refuse to agree to their terms without affecting any of my rights to receive healthcare at ECP. These authorizations may be revoked at any time by notifying ECP in writing at the mailing address of ECP. The revocation of this authorization will not have any effect on disclosures occurring prior to the execution of my revocation. The authorization is valid as of the date I have signed below and shall remain valid until changed or revoked.

_____ _____

Patient or Authorized Representative Signature **Date**

EAST COAST PODIATRY, INC.
233 Osceola Avenue, Ormond Beach, Florida 32176

PATIENT CONSENT AND AUTHORIZATIONS

CONSENT FOR TREATMENT: I, the undersigned patient, parent or legal guardian, do hereby present myself (or the patient) for care or treatment at East Coast Podiatry and voluntarily consent to the rendering of such care or treatment, including performance of diagnostic and/or surgical procedures. I understand that I am under the same care and supervision of my physician and it is the responsibility of the practice and its staff to carry out at the instructions of such physician. I understand that the physician furnishing services to me is an employee of East Coast Podiatry, however, other services such as radiology, laboratory, and pathology may be provided by independent practitioners. All physicians expect payment in full upon receipt of a bill and I will assist in billing appropriate insurance companies if insurance or other benefits are involved. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments or examination in the office. I understand that I am responsible for the outcomes of care or treatment if I do not follow the care, service, or treatment plan.

ASSIGNMENT OF BENEFITS: I hereby assign payment directly to East Coast Podiatry, and the physician accepting this assignment, of all medical benefits applicable and otherwise payable to me. I understand that I am financially responsible to East Coast Podiatry and their physician for charges not covered by this assignment or for any and all charges which the insurance carrier declines to pay.

RELEASE OF MEDICAL INFORMATION: I, the undersigned patient, parent, or legal guardian, do hereby authorize East Coast Podiatry, its offices and employees, to release any third party payer (such as an insurance company or government agency; Example: Blue Cross/Blue Shield of Florida or Medicare) any medical, psychiatric, alcohol, drug abuse, and/or HIV (AIDS and AIDS related complex) treatment information and records, in accordance with the policy of East Coast Podiatry and any applicable State or Federal Statutes, concerning diagnosis and treatment for the above admission when requested by such third party payor for its use in connection with determining a claim for payment for such care, treatment, and/or diagnosis. I authorize the release of any and all medical information to all physicians involved in my care and treatment. I do hereby release East Coast Podiatry from all liability that may arise from the release of the information requested.

FLORIDA LAW: Section 817.234 Florida Statutes, stipulates that any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

FOR MEDICARE AND MEDICAID PATIENTS ONLY – CERTIFICATION AND AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII and/or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary-carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to East Coast Podiatry physician(s). I understand that I am responsible for any health insurance deductibles and coinsurance.

_____ **(initials)**

MEDICARE BENEFICIARY NOTICE OF NON-COVERED SERVICES: Medicare does not cover some inpatient, outpatient, and emergency services. Items not covered include, but are not limited to, medications typically self-administered, annual testing, and physicals.

ACKNOWLEDGEMENT OF RECEIPT OF AN IMPORTANT MESSAGE FROM MEDICARE (FOR MEDICARE PATIENTS ONLY): My signature only acknowledges my receipt of this message from East Coast Podiatry as dated below and does not waive my right to request a review or make me liable for any payment.

FINANCIAL AGREEMENT: The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she individually hereby obligates himself/herself to pay the account of East Coast Podiatry physician(s) in accordance with the regular rates and terms of the physician(s). The undersigned will pay all costs and expenses including reasonable collection fees (which may include agency, attorney, interest or court fees) incurred or paid by East Coast Podiatry in collection of this obligation by suit or otherwise. Furthermore, I hereby authorize and appoint the administrator of East Coast Podiatry and/or its physician(s) or his successor/designee as my attorney-in-fact to take measures in my behalf as may be necessary to collect such claims or insurance proceeds and to endorse any checks made payable to me for such claims or insurance proceeds by signing my name as attorney-in-fact for me to any such checks and/or insurance claim forms.

ELECTRONIC PRESCRIPTION HISTORY AND BENEFITS AUTHORIZATION: My signature acknowledges my permission for East Coast Podiatry to electronically download my prescription history from SureScripts and my prescription benefits from my insurance company.

CANCELLATIONS: For future appointments there will be a $25.00 cancellation/no show fee charged unless 24 hour notice is given to the office prior to the appointment. If your appointment is not cancelled and you do not show to your scheduled appointment, $25.00 will be charged to your account. Of course, we realize emergencies occur, so please notify us of any emergency as soon as possible.

_____ **(initials)**

DME RETURN POLICY: All sales are final. Returns will not be permitted on any and all Durable Medical Equipment purchased from East Coast Podiatry, Inc.

I permit a copy of these authorizations and assignments to be used in place of the original which may be on file at East Coast Podiatry.

_____ **Print Name**

_____ / _____ / _____ **Patient Date of Birth**

_____ **Patient's Signature**

_____ **Patient's Representative (Indicate relationship)**

_____ **Witness**

_____ / _____ / _____ **Date**

Patient unable to sign due to: _____