PATIENT REGISTRATION FORM

Patient Name: _____ Social Security Number: _____-_____-_____

Date of Birth: ____/____/____ Age:_____ Sex: M / F (Circle one) Married/Single/Divorced/Widow

Address: _____
(Street) (City/State/Zip)

Alternate Address: _____
(Street) (City/State/Zip)

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

E-mail Address: _____

Employer Name: _____ Employer Phone Number: (_____) _____

Employer Address: _____
(Street) (City/State/Zip)

Primary Care/Family Doctor Name: _____ Phone: _____

Pharmacy Name: _____ Pharmacy Phone: _____

How did you hear about our Practice? _____

What is your primary language spoken? _____ Do you have a living will? _____

Person responsible for bill or parent (Complete only if different from patient)

Guarantor Name: _____ Social Security Number: _____ - _____ - _____

Relationship to Patient: (please check): ( ) self, ( ) spouse, or ( ) parent Date of Birth: ____/____/____

Address: _____ Phone Number: _____

Employer Name: _____ Employer Phone Number: (___) _____

Employer Address: _____
(Street) (City/Street)

Who to call for an emergency:

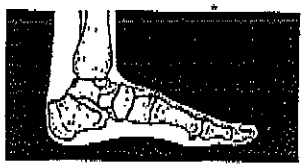
Name: _____ Address: _____

Home Phone: (__) _____ - _____ Work Phone: (___) _____-_____ Relationship: _____

IS YOUR VISIT DUE TO A JOB RELATED INJURY OR AUTOMOBILE ACCIDENT? Y_____ N_____
IF YES, PLEASE NOTIFY THE RECEPTIONIST

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Northeast Health. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Signature: _____ Date: _____



CERTIFIED FOOT & ANKLE SPECIALISTS, P.L.

Kyle I. Kinmon, MS, DPM
Fellow, *American College of Foot & Ankle Surgeons*
Diplomate, *American Board of Podiatric Surgery*
Board Certified, *Foot Surgery*
Board Certified, *Reconstructive Rearfoot & AnkleSurgery*

Shawn R. Norris, DPM
Associate, *American College of Foot & Ankle Surgeons*
Reconstructive Foot Surgery

Alan A. MacGill, DPM
Associate, *American College of Foot & Ankle Surgeons*
Reconstructive Foot & Ankle Surgery

Julio C. Ortiz, DPM
Fellow, *American College of Foot & Ankle Surgeons*
Board Certified, *Foot Surgery*
Board Certified, *Reconstructive Rearfoot & Ankle Surgery*

MEDICAL HISTORY

CHIEF COMPLAINT: (Onset, Course, Duration, Quality, Location)

_____

_____

_____

_____

REVIEW OF SYSTEMS

Please circle or list problems in each body system.

Constitutional: fever weight gain weight loss appetite change night sweats fatigue chills

Eyes: blurry double vision vision loss tearing redness pain sensitivity to light glaucoma

Ears, Nose, Mouth, Throat: hearing loss ringing in ears ear pain nasal congestion nasal drainage nosebleeds mouth/throat irritation tooth problem

Cardiovascular: chest pain/pressure heart racing palpitations sweating leg swelling high/low blood pressure

Pulmonary: cough yellow/green sputum blood in sputum shortness of breath wheezing

Gastrointestinal: nausea vomiting diarrhea constipation pain blood in stool or vomitus heartburn difficulty swallowing

Genitourinary: incontinence abnormal bleeding abnormal discharge urinary frequency urinary hesitancy pain impotence sexual problem infection urinary retention

Musculoskeletal: pain stiffness joint redness/warmth arthritis back pain weakness muscle wasting sprain/fracture

Neuro: headache weakness dizziness change in voice change in taste change in vision change in hearing loss/change sensation trouble walking balance problem coordination problem shaking speech problem

ALLERGIES: ASA Codeine Penicillin Other:_____

Medications I take or Attach List:	Strength?	Frequency?	For What Problem?

CERTIFIED FOOT & ANKLE SPECIALISTS, P.L.

Kyle J. Kinmon, MS, DPM
Fellow, *American College of Foot & Ankle Surgeons*
Diplomate, *American Board of Podiatric Surgery*
Board Certified, *Foot Surgery*
Board Certified, *Reconstructive Rearfoot & AnkleSurgery*

Shawn R. Norris, DPM
Associate, *American College of Foot & Ankle Surgeons*
Reconstructive Foot Surgery

Alan A. MacGill, DPM
Associate, *American College of Foot & Ankle Surgeons*
Reconstructive Foot & Ankle Surgery

Julio C. Ortiz, DPM
Fellow, *American College of Foot & Ankle Surgeons*
Board Certified, *Foot Surgery*
Board Certified, *Reconstructive Rearfoot & Ankle Surgery*

List family members *(son, daughter, father, mother, grandparents, brother, sister, etc.)* who have had:

Diabetes _____ Foot Problems _____
Arthritis _____ Heart Attack _____
Stroke _____ High Blood Pressure _____
Cancer _____ Birth Defects _____

Are any of the above family members deceased, If so who? _____

Do you have *or* have you ever been treated for:

☐ Epilepsy	☐ Nerve Disorder	☐ Cancer	☐ Depression	☐ Glaucoma
☐ Stomach Ulcer	☐ Psychiatric Disorder	☐ Rheumatoid Arthritis	☐ Scarlet Fever	☐ Stroke
☐ Heart Attack	☐ High Blood Pressure	☐ Heart Disease	☐ Phlebitis	☐ Trauma
☐ Diabetes	☐ Hepatitis	☐ Liver Disease	☐ Anemia	☐ Gout
☐ Kidney Disease	☐ Asthma	☐ Lung Disease	☐ Tumors	☐ Cataracts
☐ Arthritis	☐ Alzheimer's Disease	☐ Blood Clots	☐ _____	

Are you currently pregnant?..... ☐ Yes ☐ No Are you planning on becoming pregnant?... ☐ Yes ☐ No

Do you smoke Cigars, Cigarettes etc? ☐ Yes ☐ No Number of packs per day _____ for _____ years

Did you ever smoke?..... ☐ Yes ☐ No Number of packs per day _____ for _____ years
If you quit, when did you do so? _____

Do you drink Beer, Wine or Liquor? *(circle one)* Never Rarely Moderately Daily Quit

Do you use recreational drugs? *(circle one)* Never Rarely Moderately Daily Quit

Have you ever had any of the following operations:

Tonsils.....	☐ Yes ☐ No	Year_____	Appendectomy.....	☐ Yes ☐ No	Year_____
Gallbladder.....	☐ Yes ☐ No	Year_____	Hysterectomy.....	☐ Yes ☐ No	Year_____
Hemorrhoids.....	☐ Yes ☐ No	Year_____	Heart Surgery.....	☐ Yes ☐ No	Year_____
Varicose Veins....	☐ Yes ☐ No	Year_____	Foot Surgery.....	☐ Yes ☐ No	Year_____
Plastic Surgery....	☐ Yes ☐ No	Year _____	Ankle Surgery.....	☐ Yes ☐ No	Year_____
Hip Surgery.....	☐ Yes ☐ No	Year _____	Knee Surgery.....	☐ Yes ☐ No	Year _____

Have you had any other operations?....☐ Yes ☐ No *explain:* _____

Signature: _____ Date: _____

Release of Medical Records/information and HIPAA compliance/confidentiality

The Certified Foot & Ankle Specialists, P.L. is HIPAA compliant. We make every effort to protect your privacy. We feel it is important that you understand your patient rights to confidentiality. Any concerns please see the manager.
I understand that the Certified Foot & Ankle Specialists, P.L. complies with HIPAA regulations. All medical records are confidential and cannot be disclosed without the written consent of the person to whom they pertain. I further understand that under Florida law I have the right to my medical records. I further understand that I may request that my records be released to a physician and/or facility; however, this request must be made in writing. I understand that by law this office may only release medical records that were generated by The Certified Foot & Ankle Specialists, P.L.; they cannot release medical records from any other physician, hospital or facility. I agree to accept responsibility for any copying fees as provided by Florida statues. I understand that employees have no responsibility or liability regarding any aspect of this authorization. Furthermore, I have the right to complain to this practice or to the secretary of HHS if I feel that my privacy rights have been violated. It is the policy of this office that no retaliation of any type will be taken against any patient that files a complaint. **Initials** _____. I understand that by signing this form I am also authorizing that any holder of my medical information be able to release my medical information to the insurance carrier(s), the social security administration, the health care financing administration, it's intermediaries, carriers for this or any medical related claim. I, the undersigned, authorize the release of my medical records to other physicians, hospitals and/or healthcare facilities as needed to provide me with medical care. I understand that Certified Foot & Ankle Specialists, P.L. may have to fax my records to hospitals and/or physicians in whom they will make all reasonable efforts to maintain confidentiality. **Initials** _____.
I, the undersigned, give Certified Foot & Ankle Specialists, P.L. authorization to release any information pertaining to my illness and or treatment to (pleases list name) _____. **Initials** _____.
I **authorize** Certified Foot & Ankle Specialists, P.L. to leave medical information on my answering machine and/or give my spouse my medical information. **Initials** _____.
If you do not authorize Certified Foot & Ankle Specialists, P.L. to release any part of your medical records to anyone in your family or leave any medical information on your answering machine please let the receptionist know.
By signing below you acknowledge that you read, agree with and understand the above statements.

Print name: _____ **Signature:** _____ **Date:** _____

Method of Payment and Financial Policy

I, the undersigned, understand that Certified Foot & Ankle Specialists, P.L. has agreed to accept Medicare and/or Health Insurance for payment of my medical bills. By my signature below, I acknowledge that I am fully responsible for any balances after Medicare and/or my health insurance has paid Certified Foot & Ankle Specialists, P.L. which may be a result of my yearly deductible, co-insurance, and/or co-payment. I also understand that any benefits given to Certified Foot & Ankle Specialists, P.L. by my insurance carrier is not a guarantee of my benefits as it may be subject to change. I also understand that it is my responsibility as the patient to get a referral if my policy requires a referral. I also understand that if I do not present a referral and it is necessary that my insurance company may deny the claim as a result of not have the referral. **Initials:** _____. Payment is required at the time that services are rendered. Certified Foot & Ankle Specialists, P.L. is a participating provider with Medicare, BCBS and most PPO and HMO plans. Please check with the receptionist to see if we are participating with your insurance plan. Our offices will file the Insurance claims automatically. I understand that I am responsible for any co-pays, co-insurances or deductible amounts at the time of service. **Initials:** _____. We accept MasterCard, Visa, American Express, Discover as well as cash and checks. Please note that if you write a check and it is returned that we will charge your account $25 for a non-sufficient fund fee. In the event that your account need to be placed with an outside collection agency or attorney, you will be assessed an additional 30% of the balance to recover the collection charges. If your claim is not paid within 90 days, the claim will be transferred to patient responsibility and if timely payment is not received, the account may be referred to a collection agency or attorney.
By signing below you acknowledge that you read, agree with and understand that above statements.

Print name: _____ **Signature:** _____ **Date:** _____

HIPAA INFORMATION AND CONSENT FORM

The health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPPA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedure utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of both, the practice and patient

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ date _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in from this time forward.