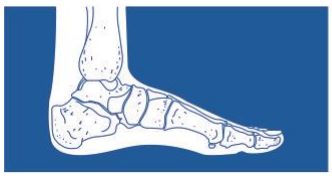

CERTIFIED FOOT & ANKLE SPECIALISTS, LLC.

Patient Name: _____ DOB: _____ SSN#: _____

Sex: Male / Female Status: Married / Single / Divorced / Separated / Widowed Age: _____

Address: _____ _____ City: _____ _____ State: _____ Zip: _____

Alternate Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell#: _____ Alternate#: _____

Email address: _____ Do you have a living will? _____

How did you hear about our practice? _____ Language (*English, Spanish, etc.*)? _____

Primary Care/ Family Doctor: _____ Phone#: _____

Preferred Pharmacy: _____ Phone#: _____

Employer Name: _____ Phone#: _____

Address: _____ City: _____ State: _____ Zip: _____

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

Guarantor Name: _____ DOB: ____/_____/_____ SSN#_____

Address: _____ City: _____ State: _____ Zip: _____

Phone#: _____ Relationship to patient: Spouse / Parent / Significant other

Employer Name: _____ Phone#: _____

Address: _____ City: _____ State: _____ Zip: _____

Who do we contact in the event of an emergency?

Name: _____ Relationship: Parent / Child / Spouse / Other: _____

Home #: _____ Cell#: _____ Alternate#: _____

IS YOUR VISIT DUE TO A WORK-RELATED INJURY PERSONAL INJURY OR CAR ACCIDENT? NO / YES

IF YES PLEASE NOTIFY RECEPTIONIST IMMEDIATLY. THE SECTION BELOW MUST BE COMPLETED AND SIGNED IN-FRONT OF THE RECEPTIONIST STAFF, AS THEY WILL NEED TO ACT AS A WITNESS FOR YOUR SIGNATURE.

Patient's signature _____ Witness Signature _____

Patient's Name _____ Witness' Name _____

I authorize the release of any medical information necessary to process this bill to my insurance company and request payment of benefits to Certified Foot & Ankle Specialists. I acknowledge that I am financially responsible for payment whether or not covered by insurance and there will be a fee for all FMLA or DISABILITY FORMS!

Patient's Signature: _____ Date: _____

CERTIFIED
FOOT & ANKLE
SPECIALISTS, LLC.

What brings you in today? (Please provide onset, course, duration, quality and location)

_____

_____

_____

REVIEW OF SYSTEMS
Please circle all that apply in each body system

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

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

Ears, Nose, Mouth, Throat: hearing loss ringing in ears ear pain nasal congestion/ 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 heartburn difficulty swallowing

Genitourinary: incontinence abnormal bleeding abnormal discharge urinary frequency/ hesitancy pain
Impotence/ sexual problem infection urinary retention other: _____

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

Neurological: headache weakness dizziness change in voice change in taste change in hearing
Loss/change sensation trouble walking balance problem coordination problem shaking speech problem

Do you have any loss of balance, instability while walking or history of falling? YES or NO

ALLERGIES: ASPIRIN CODEINE PENICILLIN SULFA LATEX MEDICAL TAPE OTHER: _____

MEDICATIONS: PLEASE LIST EACH OR ATTACH LIST:

_____ strength: _____ Frequency: _____ Problem: _____

_____ strength: _____ Frequency: _____ Problem: _____

_____ strength: _____ Frequency: _____ Problem: _____

_____ strength: _____ Frequency: _____ Problem: _____

CERTIFIED
FOOT & ANKLE
SPECIALISTS, LLC.

MEDICAL HISTORY

Do you have or have you ever been treated for? (*Please circle)*

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	AIDS/HIV	Other_____

Are you currently pregnant? Yes / No Are you planning on becoming pregnant? Yes / No

Do you smoke cigars, cigarettes, etc? Yes / No # of packs per day _____ for ____years Quit, when? _____

Do you drink beer, wine or liquor? Never Rarely Moderately Daily Quit

Do you use recreational drugs? Never Rarely Moderately Daily Quit

Have you ever had any of the following surgeries: (*Please circle)*

Tonsils	Year: _____	Appendectomy	Year: _____
Gallbladder	Year: _____	Hysterectomy	Year: _____
Hemorrhoids	Year: _____	Heart Surgery	Year: _____
Varicose Veins	Year: _____	Foot Surgery	Year: _____
Plastic Surgery	Year: _____	Ankle Surgery	Year: _____
Hip Surgery	Year: _____	Knee Surgery	Year: _____

Have you ever had any other operations? Yes / No Explain:

_____

_____

FAMILY MEDICAL HISTORY

List any family members who have had the following diseases:

Diabetes: _____ Foot Problems: _____

Arthritis: _____ Heart Attack: _____

Stroke: _____ High Blood Pressure: _____

Cancer: _____ Birth Defects: _____

(Please note if any of the above listed family members are deceased)

CERTIFIED
FOOT & ANKLE
SPECIALISTS, LLC.

HIPAA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provide 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. HIPAA 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 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 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 information 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. However, the practice may use photographs, videotaped images or other images. They may also be used for teaching purposes, which includes being shown to other patients, advertisements and placement on the practice's website.
7. From time to time our physicians will provide data from your records to help validate outcomes of already FDA cleared products that we routinely prescribe for our patients. The information that we provide remains confidential.
8. We agree to provide patients with access to their records in accordance with state and federal laws.
9. We may change, add, delete or modify any of these provisions to better serve the needs of both, the practice and patients.
10. 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.
11. The Physicians at CFAS take pride in training our next generation of physicians. Therefore, you may receive treatment from a Resident Physician. Please know they will always be under the supervision of one our CFAS doctors.

I, _____ date _____ do hereby

consent and acknowledge my agreement to the terms set forth in the HIPAA INORMATION FORM and

any subsequent changes in office policy. I understand that this consent shall remain from this time forward.

CERTIFIED
FOOT & ANKLE
SPECIALISTS, LLC.

Release of Medical Records/information and HIPAA compliance / confidentiality

The Certified Foot & Ankle Specialists, P.L. is HIPAA compliant. We make every effort t 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 Specialist, 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 Specialist, 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 (please 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 Specialist, 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 Specialist, 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 Specialist, 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 having 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-insurance 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 $35 for a non-sufficient fund fee. In the event that your account needs to be placed with an outside collection agency or attorney, you will be assessed an additional 30% of the balance to recover collection charges. If you 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 your read, agree with and understand the above statements.**

Print Name: _____ Signature: _____ Date: _____

CERTIFIED
FOOT & ANKLE
SPECIALISTS, LLC.

Appointment Cancellation/No Show Policy

1. Cancellation/ No Show Policy for Doctor Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment.

Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment schedule. If an appointment is not cancelled at least **24 hours in advance** for office visits **48 hours in advance for procedures and surgeries,** you will be charged a **fee**; this will not be covered by your insurance company.

2. Scheduled Appointments

We understand that delays can happen however we must try to keep the other patients and doctors on time. If a patient is **15 minutes** late, we may have to **reschedule** the appointment.

3. Office Visit Missed Appointment Fees

More than one **No show** within 12 months → **$25.00**.

4. Procedures and Surgeries Missed Appointment Fees

Missed ultrasound → **$75.00**
Missed RFA Scheduled consult/procedure fee → **$150.00**
Missed MRI fee → $**75.00**
Missed surgery fee → $**250.00**

This notice is effective as of January 1, 2021.

_____	_____	___/___/__
Print Name Patient	Signature Patient/Guardian	Date