

Practice:

Today's Date:

Name: _____ DOB: _____ Chart Number: _____

Sex: M F Marital Status: Single Married Widowed Divorced SS#: _____

E-mail: _____ Spouse/Partner Name: _____

E-mail newsletters, reminders, statements, etc. Emergency Name: _____ Phone: _____

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

Home #: _____ Cell #: _____ Other #: _____

Employer: _____ Phone: _____

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

Primary Insurance: _____ Are you the insured? Yes No

Insured Information

Subscriber Name: _____ Relationship to insured: Spouse Child Self other

Phone #: _____ Sex: Male Female DOB: ___/___/___

Address: _____

Policy ID: _____ Group ID: _____ Employer: _____

Secondary Insurance: _____ Are you the insured? Yes No

Insured Information

Subscriber Name: _____ Relationship to insured: Spouse Child Self Other

Phone #: _____ Sex: Male Female DOB: ___/___/___

Address: _____

Policy ID: _____ Group ID: _____ Employer: _____

How did you find out about our practice? Physician Internet Telephone book Family member Friend
 Other: _____

What is the reason for your visit today? _____
Result of accident or work injury? Yes No

How long has this bothered you? 1 2 3 4 5 6 7 days weeks months years

What treatments have you tried & have they been effective? _____

On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain? ___/10

The pain quality is: burning constant dull sharp shooting throbbing tingling Other: _____

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____

Date: _____

History and Physical

Name: _____ DOB: _____ Chart Number: _____

- Medical History:**
- | | | | | | |
|---|--|--|---|---|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Circulation problems | <input type="checkbox"/> Musculoskeletal | <input type="checkbox"/> Breathing issues | |
| <input type="checkbox"/> Liver | <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Gout | <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Stomach/bowel | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety disorder | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Blood clot | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | |
| <input type="checkbox"/> Neuropathy (specify) _____ | <input type="checkbox"/> Thyroid disease (specify) _____ | <input type="checkbox"/> Diabetes (type I, type 2) | | | |
| <input type="checkbox"/> Arthritis (specify) _____ | <input type="checkbox"/> other (specify) _____ | <input type="checkbox"/> HIV | <input type="checkbox"/> CVA | | |
- Are you pregnant?** Yes No **Are you nursing?** Yes No Skin disorders Stroke

Surgical History None Appendectomy C-Section Angioplasty Bypass Cataracts Cholecystectomy

Have you ever had any surgical procedures on foot/ankle or anywhere else on your body? Yes No

If yes, please describe: _____

Do you have any artificial joints? Yes (where? _____) No Do you have an artificial heart valve? Yes No

Social History

Do you smoke? Yes No If yes how many packs per day? 1 2 3 4 5 For how long? _____

Do you drink alcohol? Yes, everyday (5-7 days/week) Yes, occasionally/socially No/Rarely

Substance abuse: Yes, I have a current substance abuse problem. Please specify: _____

Yes, I had a past substance abuse problem. Please specify: _____

No, I have never had a substance abuse problem

What is your occupation? _____ Does it involve mostly standing or sitting

Do you exercise regularly? No, I do not exercise regularly Yes, I do the following regular exercise: _____

Family History

 Is there any family history (blood relative) of: (Please indicate family member)

- | | |
|---|--|
| <input type="checkbox"/> Alzheimer's _____ | <input type="checkbox"/> Depression _____ |
| <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Bleeding disorders _____ | <input type="checkbox"/> Emphysema _____ |
| <input type="checkbox"/> Blood clot _____ | <input type="checkbox"/> Heart disease _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> High Blood Pressure _____ |
| <input type="checkbox"/> Cataracts _____ | <input type="checkbox"/> Neurological _____ |
| <input type="checkbox"/> Circulation problems _____ | <input type="checkbox"/> Strokes _____ |
| <input type="checkbox"/> Other (specify): _____ | |

Review of Systems

 (Please check the box if you currently have any of these symptoms or check "NONE")

- | | | | | | | |
|-------------------------|--|--|--|--|---|---------------------------------------|
| Cardiovascular | <input type="checkbox"/> leg pain when walking | <input type="checkbox"/> fever | <input type="checkbox"/> chest pain/pressure | <input type="checkbox"/> leg swelling | <input type="checkbox"/> cold hands/feet | |
| | <input type="checkbox"/> fainting | <input type="checkbox"/> palpitations | <input type="checkbox"/> vascular disease | <input type="checkbox"/> valve problems | <input type="checkbox"/> NONE | |
| Genitourinary | <input type="checkbox"/> blood in urine | <input type="checkbox"/> hesitancy | <input type="checkbox"/> incontinence | <input type="checkbox"/> increased urgency | | |
| | <input type="checkbox"/> decreased frequency | <input type="checkbox"/> excessive urination | <input type="checkbox"/> kidney disease | <input type="checkbox"/> kidney stones | <input type="checkbox"/> NONE | |
| Gastrointestinal | <input type="checkbox"/> abdominal pain | <input type="checkbox"/> heartburn | <input type="checkbox"/> blood in stool | <input type="checkbox"/> vomiting | <input type="checkbox"/> ulcers | <input type="checkbox"/> constipation |
| | <input type="checkbox"/> diarrhea | <input type="checkbox"/> trouble swallowing | <input type="checkbox"/> decrease appetite | <input type="checkbox"/> increase appetite | <input type="checkbox"/> NONE | |
| Integumentary | <input type="checkbox"/> athletes foot | <input type="checkbox"/> nail abnormalities | <input type="checkbox"/> keloids | <input type="checkbox"/> itchiness | <input type="checkbox"/> dry, scaly skin | <input type="checkbox"/> NONE |
| Hematologic | <input type="checkbox"/> lower leg ulcers | <input type="checkbox"/> sickle cell disease | <input type="checkbox"/> anemia | <input type="checkbox"/> blood thinners | <input type="checkbox"/> clotting disorders | <input type="checkbox"/> NONE |
| Neurological | <input type="checkbox"/> tingling | <input type="checkbox"/> weakness | <input type="checkbox"/> seizures | <input type="checkbox"/> numbness | <input type="checkbox"/> headaches | |
| | <input type="checkbox"/> tremors | <input type="checkbox"/> paralysis | | | <input type="checkbox"/> NONE | |
| Musculoskeletal | <input type="checkbox"/> back pain | <input type="checkbox"/> joint swelling | <input type="checkbox"/> muscle weakness | <input type="checkbox"/> muscle pain | <input type="checkbox"/> neck pain | |
| | <input type="checkbox"/> sciatica | <input type="checkbox"/> joint stiffness | <input type="checkbox"/> joint pain | <input type="checkbox"/> joint instability | <input type="checkbox"/> arthritis | <input type="checkbox"/> NONE |
| Respiratory | <input type="checkbox"/> chest pain | <input type="checkbox"/> wheezing | <input type="checkbox"/> COPD | <input type="checkbox"/> coughing | <input type="checkbox"/> snoring | |
| | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> emphysema | | | <input type="checkbox"/> NONE | |

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____

Date: _____

Practice:

Today's Date:

Name: _____ **Chart #:** _____ **Date of birth:** _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino Declined to specify

Race: Asian American Indian or Alaska Native Black or African American
 White Native Hawaiian or other Pacific Islander Declined to specify

Preferred Language: _____ Declined to specify

Pharmacy Name: _____ **Pharmacy Phone:** _____

Pharmacy Address: _____ City, State, Zip: _____

Primary Care Physician: _____ Phone: _____ Date Last Seen: _____

Address: _____

Referring Physician: _____ Phone: _____ Date Last Seen: _____

Address: _____

Privacy Information Preferences

Do you want to be exempt from public reporting? Yes No Can we send mail to the address on file? Yes No

Can we call the phone number on file? Yes No Can we leave voicemail on machine? Yes No

Will you allow us to send internet based (e-mail) delivery of reminders and newsletters? Yes No

If yes, please provide your e-mail address: _____

Who can we leave messages with? Wife Husband Daughter Son Other:
Name(s): _____

Smoking Status

Current Every Day Smoker, Current Status Unknown

Current Some Day Heavy Tobacco Unknown If Ever

Former Never Light Tobacco I decline to answer

Vital Signs

Blood Pressure: _____ / _____

Height: _____ Weight: _____

Current Medications

No Known Medications I take the following medications:

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Use the back of this form if more room is needed

Allergies

No Known Allergies No Known Drug Allergies

Name: _____ Reaction _____

Name: _____ Reaction _____

Name: _____ Reaction _____

Name: _____ Reaction _____

Name: _____ Reaction _____

Name: _____ Reaction _____

Name: _____ Reaction _____

Use the back of this form if more room is needed

Last Flu Shot Date: _____ **Did you get a pneumococcal vaccination?** Yes No

PLEASE READ AND SIGN: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. (Assignment of Benefits): I authorize payment of medical benefits to the practice named above. (Release of Information): I authorize the release of any medical information necessary to process this claim. (HIPAA Privacy): I acknowledge that I received my HIPAA Privacy Practices Notice. (Medication History): I authorize the Doctor's office to retrieve my medication history.

Patient Signature: _____

Date: _____

❖ Office Financial Policy ❖
Gulfcoast Foot & Ankle Center, Inc.

- ❖ We are dedicated to providing the best possible care and service to you, while maintaining our patient's privacy and confidentiality. This requires your complete understanding of our financial policies as an essential element of your care and treatment. *If you have any questions, please discuss them with our front office staff.*
- ❖ We are Medicare participating providers. We will bill Medicare for you. You will be responsible for your annual deductible, co-payment and charges for non-covered services. You will be asked to sign an Advanced Beneficiary Notice form for services that we know are not covered by Medicare. Medicare does cover surgery, X-rays and some other types of foot care. Medicare **does not** cover routine foot care such as trimming of corns, calluses or cutting of toenails. You will need to pay for these services at the time they are provided.
- ❖ Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check.
- ❖ Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period (60 days), you are responsible for payment. Please assist us in settling your claim by periodically calling your insurance carrier and requesting they pay us in a timely manner.
- ❖ We have made prior arrangements with some insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service. We will do our best to inform you of whether we accept or participate with your insurance company. This list changes frequently, *so please check your benefits with your insurance company.* We handle these claims in accordance with our agreement, if one exists. We file your insurance as a **courtesy**. In the event that we are not aware of a charge or service that is not covered by your plan, you will be billed after we receive a denial from your insurance company.
- ❖ There are certain elective surgical procedures that we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.
- ❖ You must inform the office of all insurance changes and authorization and referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- ❖ Past due accounts are subject to collection proceedings, including the filing of a Medical Lien. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due this office.
- ❖ If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis as a **courtesy**. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service. If the charges exceed \$1,000 you will be asked to pay 40% of the entire bill with remaining balance payable in 45 days. This gives you time to file with your insurance company. Please understand that since we do not have a contract with your plan, we are not obligated to adjust our charges based on your plan's coverage or benefit schedule.
- ❖ All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services; however, you remain responsible for charges for all services rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered. We will not become involved in a dispute between you and your company regarding deductibles, co-payments, secondary insurances, usual and customary charges or medical necessity. We will supply factual information as necessary.
- ❖ There is a service fee of \$35.00 for all returned checks. Your insurance company does not cover this fee.
- ❖ Your signature below signifies that you understand and agree to our financial policy and your responsibility regarding charges incurred in this office.

Signature of Patient / Responsible

Party: _____

Printed Name: _____ Date: _____

Patient Name (if different) _____

Witness: _____ Date: _____

Printed Name: _____

_____ Patient initials to indicate copy received

Gulfcoast Foot and Ankle Center, Inc.

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