PREMIER FOOT & ANKLE

Patient Name: _____ **Date of Birth:** _____ **Sex:** ____M____F

Address: _____

Street Apt. No City State Zip

Home#: _____ **Work#**: _____ **Cell #:** _____

Email: _____ **Social Security No. _____**

Emergency Contact: _____**Emergency Phone:** _____

Primary Language: _____ Employed:___Y___N Occupation:_____

Ethnicity: _____ Marital Status (circle): Married Single Divorced Widowed Partner

PRIMARY CARE PHYSICIAN **Must be a doctor of Family Medicine, Primary Care, Internal Medicine, Endocrinology

Name: _____

Primary Physician Phone: _____ Date Last Seen: _____

PLEASE NOTE: Medicare related insurances require that a Primary Care Physician be listed for certain services to be paid

HOW DID YOU HEAR ABOUT US? (circle)

Physician Internet Insurance Friend Family Other _____

ARE YOU IN HOSPICE CARE? Yes No If yes, facility: _____.

ARE YOU IN SKILLED NURSING? Yes No If yes, facility: _____

INSURANCE INFORMATION

PRIMARY INSURANCE NAME: _____ Employer: _____

Policy Holders Name: _____ Social Security #: _____

Policy Holders Date of Birth: _____ Relationship to Patient: _____

SECONDARY INSURANCE NAME: _____ Employer: _____

Policy Holders Name: _____ Social Security #: _____

Policy Holders Date of Birth: _____ Relationship to Patient: _____

EXPLANATION OF PAYMENT POLICY & PRIVACY POLICY

I hereby authorize Premier Foot & Ankle to release medical information pertinent to the filing of insurance claims for me. I authorize my insurance carrier to pay benefits directly to Premier Foot & Ankle on any unpaid services filed on my behalf. I understand that I AM RESPONSIBLE for payment to Premier Foot & Ankle for charges for the above patient regardless of my insurance coverage. I also understand that Premier Foot & Ankle is not ultimately responsible for collecting my insurance or negotiating settlements of claims. I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have had the opportunity to read and understand the Notice. I also hereby give Premier Foot & Ankle permission to diagnose and administer treatment for my foot and/or ankle condition and authorize any release of information obtained during the course of my treatment.

Patient's Signature: _____ Date: _____

PREMIER FOOT & ANKLE

Patient Name: _____ **Shoe Size:** _____ **Height**: _____ **Weight**: _____

Reason for your visit: _____ **Pain Level (1-10):** _____
PREFERRED PHARMACY: _____ **Pharmacy Phone:** _____
Pharmacy Location and/or Address: _____

DRUG & OTHER ALLERGIES: Please list: _____
MEDICATIONS: List current medications & dosage:

_____ _____
_____ _____
_____ _____

Are you currently experiencing any of these symptoms? ☐ Nausea ☐ Vomiting ☐ Fever ☐ Chills ☐ Night Sweats
Date of Last Flu Vaccine: _____ **Pneumonia Vaccine:** _____ **COVID Vaccine:** _____

Past Medical History: If you have or have had any of the following conditions, please Check ALL that apply.

☐ Athlete's Foot	☐ Dementia	☐ HIV/AIDS	☐ Osteoarthritis
☐ Atrial Fibrillation	☐ Depression	☐ Heart Attack	☐ Osteopenia
☐ Bipolar Disorder	☐ Diabetes I	☐ Hepatitis B	☐ Osteoporosis
☐ Bleeding Disorder	☐ Diabetes II	☐ Hepatitis C	☐ Pacemaker
☐ Blood Clots	☐ Dialysis	☐ High Blood Pressure	☐ Peripheral Arterial Disease (PAD)
☐ Congestive Heart Failure	☐ Eczema	☐ High Cholesterol	☐ Peripheral Vascular Disease (PVD)
☐ COPD	☐ Endocrine Disorder	☐ Immune Disease	☐ Psoriasis
☐ Cancer	☐ Epilepsy	☐ Kidney Disease	☐ Rheumatoid Arthritis
☐ Coronary Artery Disease	☐ Fibroid Tumors	☐ Lupus	☐ Seizures
☐ Crohn's Disease	☐ GERD	☐ Lymphedema	☐ Stroke
☐ Currently Pregnant	☐ Glaucoma	☐ Nail Disease	☐ Thyroid Disease
☐ Deep Vein Thrombosis (DVT)	☐ Gout	☐ Neuropathy	☐ OTHER:

Family History: Please check any medical conditions that run in your family.

Father	☐	Diabetes	☐	Gout	☐	High Blood Pressure	☐	Circulation Problems	☐	Cancer
	☐	Heart Disease	☐	Seizures	☐	High Cholesterol	☐	Other		
Mother	☐	Diabetes	☐	Gout	☐	High Blood Pressure	☐	Circulation Problems	☐	Cancer
	☐	Heart Disease	☐	Seizures	☐	High Cholesterol	☐	Other		
Siblings	☐	Diabetes	☐	Gout	☐	High Blood Pressure	☐	Circulation Problems	☐	Cancer
	☐	Heart Disease	☐	Seizures	☐	High Cholesterol	☐	Other		

Caffeine Consumption ☐ Never ☐ Occassional ☐ Moderate ☐ Heavy
Alcohol Consumption ☐ Never ☐ Occassional ☐ Moderate ☐ Heavy

Tobacco use? ☐ Never
☐ Current Smoker Packs/day _____ Years Active _____
☐ Former Smoker Packs/day _____ Years Active _____ Year Quit _____

Other nicotine use? ☐ No ☐ Yes
Electronic cigarettes? ☐ No ☐ Yes Vaping? ☐ No ☐ Yes

Surgeries: List all surgeries you have had. Begin with the most recent. Please give the year.

_____
_____

If **diabetic**, who handles your diabetes? _____ Phone #: _____
Last A1C? _____ Date Performed: _____Performed by: _____

PREMIER FOOT & ANKLE

Your understanding of our financial policies is an essential element of your care and treatment.
If you have any questions, please ask to discuss them with our supervisor.

**** PLEASE INITIAL that you have read each of the practice policies below regarding patient financial responsibility ****

☐ As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.

☐ 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 doctors. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within 60 days, you will receive a bill.

☐ 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 services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

☐ You must inform the office of all insurance changes and authorization/ referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

☐ There are certain elective surgical procedures for which 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 or at the time of your Pre-op appointment.

☐ Patients who are 90 days past due on their balance will be sent to collections unless a payment plan has been put into place. Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due to the office.

☐ There is a fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

☐ We understand that emergencies occur but repeated no shows or cancellations with less than 24 hours' notice will result in a fee of $25.00. You might be asked to pay before you are seen by the doctor. Patients who come to office fifteen minutes later than scheduled appointment might be asked to reschedule.

Signature of Patient/ Responsible Party: _____ Date: _____

Printed Name of Patient/ Responsible Party: _____ Date: _____

StrideCare

Name: _____

Date of Birth: _____/_____/_____

Date: _____

Your podiatrist is part of Stride Care, a multi-specialty network of practices with a focus on improving the overall vascular health of patients. Below you will find important question that will help us determine whether you are at risk for vascular disease and need evaluation by one of our vascular specialists.

Please take a moment to answer the questions below.

Have you ever had any testing done to your legs for poor circulation?	☐ YES	☐NO
RISK FACTORS		
Have you ever been told you have diabetes?	☐ YES	☐NO
Do you have high blood pressure or are you on blood pressure medication?	☐ YES	☐NO
Do you have high cholesterol or are you on a medication to lower your cholesterol?	☐ YES	☐NO
Do you smoke or have you ever smoked?	☐ YES	☐NO
Have you ever been told that you have had a heart attack or stroke?	☐ YES	☐NO
Has anyone ever told you that you have poor circulation in your legs, intermittent claudication or peripheral arterial disease?	☐ YES	☐NO
Have you ever had an angioplasty or stent placed in the heart or leg?	☐ YES	☐NO
SYMPTOMS OF PAD		
Do you have any infections or sores that are not healing on your legs, feet or toes?	☐ YES	☐NO
Has your walking pace slowed enough to significantly alter your daily activities?	☐ YES	☐NO
Do your legs ever feel tired or heavy causing you to stop and rest? Do they get better with rest?	☐ YES	☐NO
When you walk, do you ever have to stop because you have pain or cramping in your calves, thighs, or buttocks? Does the pain go away with rest?	☐ YES	☐NO
Do you ever experience cramping, tightness, "Charlie horses" or pain in the legs or feet when lying down that improves when you stand up?	☐ YES	☐NO
Have you given up things you once enjoyed doing over the last year due to leg fatigue, weakness, or discomfort?	☐ YES	☐NO
Have you ever had trauma to either of your legs?	☐ YES	☐NO
Do you have any infections or sores that are not healing on your legs, feet or toes?	☐ YES	☐NO
SYMPTOMS OF CVI		
Do you have aching/pain in your legs?	☐ YES	☐NO
Do you get cramps in your legs?	☐ YES	☐NO
Do your legs feel heavy?	☐ YES	☐NO
Do you get itching or burning in your legs?	☐ YES	☐NO
Do you have restless legs?	☐ YES	☐NO
Discoloration/darkening of the skin below your knee?	☐ YES	☐NO
Episodes of redness or inflammation below the knee?	☐ YES	☐NO
Do you have swelling in your legs, ankles, or feet?	☐ YES	☐NO
Throbbing in your legs?	☐ YES	☐NO
Do your legs feel tired/fatigued?	☐ YES	☐NO
Do you have varicose veins or spider veins?	☐ YES	☐NO
Sores, ulcers, wounds that are difficult to heal?	☐ YES	☐NO
At StrideCare we deeply value our patients and want to provide you excellent service. Given the severity of vascular conditions that we often see do you give us permission to call and discuss your vascular health and options for lower extremity care?	☐ YES	☐NO

HIPAA COMPLIANCE PATIENT CONSENT FORM

The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. The terms of this notice may change. If so, you will be notified at your next visit to update your signature and date.

By signing this form, you consent to our use and disclosure of your protected healthcare information according to the indications below.

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- This privacy policy may be changed by the practice, when necessary, as required or allowed by law.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- This privacy policy will stay in effect until the time that it is revoked by the patient or changed as required by law.

PLEASE INDICATE YOUR PREFERENCES REGARDING YOUR PERSONAL HEALTHCARE INFORMATION:

Health notifications:	____ E-mail	____ Phone	____ Text message
Prescription Notifications:			____ Text message only
Auto Appointment Reminders:	____ E-mail	____ Phone	____ Text message
Practice Announcements:	____ E-mail	____ Phone	____ Text message
Billing information:	____ E-mail	____ Phone	____ Text message

I consent to have my medical records shared with other Premier Foot & Ankle/ Stridecare providers. ____ Yes ____ No
I consent to have my medical records shared with my care providers outside the Stridecare network. ____ Yes ____ No

May we discuss your medical condition with a family member? ____ Yes ____ No
If YES, please list the name of the members allowed:
_____ Relationship to patient _____
_____ Relationship to patient _____

AUTHORIZATION TO RELEASE DETAILED BILLING DOCUMENTS AND/OR PERSONAL MEDICAL RECORDS VIA EMAIL

Premier Foot & Ankle is dedicated to keeping your medical record information confidential. Due to the nature of email and texting, despite our best efforts, third parties may have access to these messages. Please be aware that some companies consider email and text messages corporate property, and messages sent via work emails may be monitored. Even when emailing to/from your home or mobile phone, access to email may be unsecure or may be uncontrolled.

I understand that Premier Foot & Ankle/ Stridecare will NOT be responsible for information loss, delay, or breach of confidentiality due to technical issues beyond our control. By selecting AUTHORIZE below, you are agreeing that we may send medical related correspondence to you via email, and that we may respond in the same way to your emails.

☐ **I DECLINE** this option. I have read and understand the risks in sending my personal information via email and decline.

☐ **I AUTHORIZE** to have my personal information sent via email. I have read and understand the risks in sending personal information via email, however, upon my request, **I AUTHORIZE** that my personal MEDICAL RECORDS or DETAILED BILLING DOCUMENTS may be sent via email. **My Preferred Email Address**: _____

PRINTED NAME OF PATIENT: _____ DATE OF BIRTH: _____
Patient or Guardian Signature: _____ DATE: _____