Patient Name: _____
Date: _____
DOB: _____

RYAN FOOT & ANKLE CLINIC
FOOT AND ANKLE SPECIALISTS

PATIENT INFORMATION SHEET

How did you hear about Ryan Foot and Ankle? ☐ Sign ☐ Internet ☐ Yellow Pages

Other: _____ ☐ Insurance ☐ Family/Friend ☐ Primary Care Doctor

If you were referred by your primary care doctor or a family/friend please provide their name so that we may properly thank them:

Family/Friend Name _____ Primary Care Doctor Name _____

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____ Work Phone: _____

Date of Birth: _____ SS No.: _____

Gender: _____ Marital Status: _____

Employer: _____

Employer Address: _____ City/State/Zip: _____

Emergency Contact: _____ Contact Phone: _____

Name of Pharmacy: _____ Pharmacy Location: _____

Primary Care Doctor: _____

PERSON RESPONSIBLE FOR THE BILL, IF OTHER THAN ABOVE PATIENT

Name: _____ Relationship: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

U S GOVERNMENT REPORTING

I WOULD PREFER NOT TO DISCLOSE THIS INFORMATION ☐

Language: ☐ English ☐ Chinese ☐ French ☐ Spanish ☐ Hindi
☐ Japanese ☐ Portuguese ☐ German ☐ Type Unknown ☐ _____

Race: ☐ Amer. Indian ☐ Asian ☐ Black ☐ Native Hawaiian
☐ White ☐ Other _____

Ethnicity: ☐ Hispanic ☐ Non Hispanic ☐ Other _____

SOCIAL HISTORY

Maritial Status: ☐ Single ☐ Married ☐ Other

Use of Tobacco: ☐ Current Everyday ☐ Never Smoker ☐ Former Smoker ☐ Current Someday Smoker
☐ Smoker, Status Unknown ☐ Unknown if ever Smoked

Alcohol Use: ☐ Yes ☐ No If Yes, how often: Drinks per day: _____ Drinks per week: _____

Drug Use: ☐ Yes ☐ No

Patient Name: _____

Date: _____

DOB:

RYAN FOOT & ANKLE CLINIC
FOOT AND ANKLE SPECIALISTS

CONSENT TO EXAMINATION AND TREATMENT, INSURANCE ASSIGNMENT, E-PRESCRIBE AND RECORDS AUTHORIZATION

I hereby consent to examination and treatment as deemed necessary by the Ryan Foot and Ankle Clinic (RFAC) and its physicians. I hereby authorize RFAC and its physicians to furnish patient health information concerning my relevant medical history to any of the following; other healthcare providers involved in my care, insurance carriers, attorneys and adustors. I hereby authorize RFAC to access and download my electronic prescription drug history. I hereby assign to the RFAC and its physicians all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

AUTHORIZATION FOR MEDICARE BILLING

I hereby certify that the information given to me in applying for payment under Title XVII and XIX of the Social Security Act is correct. I hereby authorize any holder of medical or other information about me to be released to the Social Security Administration or its agents, Centers for Medicare and Medicaid Services (CMS), or its intermediaries or carriers any information needed for this or a related Medicare claim. I hereby request that payment of authorized benefits be made on my behalf and hereby assign the benefits payable for physician services to the physician if he/she chooses to accept assignment. Medicare requires notification via an Acknowledgement of Benefit Notification (ABN) for non-covered services, including Durable Medical Equipment.

SPECIMEN / LABORATORY INSURANCE CONSENT

I authorize and give Ryan Foot and Ankle Clinic (RFAC) my consent to submit specimens (culture, skin tissue, etc.) to the laborator(ies) of choice for analyses and study. This authorization includes submission for payment to my insurance company, including Medicare and Medicaid, and/or me for charges incurred and agree to full responsibility and payment of any non-covered medical services.

PATIENT DISCLOSURE

Please indicate any additional parties you authorize Ryan Foot and Ankle Clinic (RFAC) to speak with regarding your care, medical information and account. This authorizaton may be revoked at any time in writing.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Can we leave a message regarding your health information on your answering machine or voicemail? **YES** **NO**

PARENT / GUARDIAN ACKNOWLEDGEMENT

I certifiy that I am the parent or legal guardian of _____, and adult, and as such am authorized to sign on his/her behalf.

RECEIPT OF NOTICE OF USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

I hereby acknowledge that I have been given the opportunity to read and receive a copy of Ryan Foot and Ankle Clinic's Notice of Privacy Policy as required by the Health Information and Portability Accountability Act (HIPAA).

_____ _____

Signature of Patient or Guardian Date

_____ _____

Please Print Guardian Name Relationship to Patient

Patient Name: _____
Date: _____
DOB: _____

RYAN FOOT & ANKLE CLINIC
FOOT AND ANKLE SPECIALISTS

FINANCIAL POLICY

Our objective is to provide you with the highest quality healthcare in the most cost effective manner. However the ability of Ryan Foot and Ankle Clinic to achieve this objective depends greatly on your understanding of our financial policy. If you have medical insurance we will file insurance claims on your behalf. We do this as a courtesy to our patients and are eager to help you receive the maximum allowable benefits from your insurer.

MEDICARE PATIENTS: As a participating provider of Medicare Plan B (Physician Services), Ryan Foot and Ankle Clinic will only bill you for your Medicare coinsurance, deductible and any services rendered but not covered by Medicare. All other services will be billed directly to Medicare. **You will be required to pay the co-insurance, co-pay and deductibles for authorized services at the time of service.**

NOTE: You will be informed of services not covered by Medicare prior to these services being rendered. Your signature upon the appropriate Medicare Waiver form represents your authorization for the physician to perform these services and your acceptance of the financial responsibility for these services.

If you have Medicare Part A only, then the services you will receive from our practice will not be covered by Medicare.

COMMERCIAL INSURANCE PATIENTS: Your insurance policy is a contract between you and your insurance company. If your insurance company pays only part of your bill or rejects your claim, you are financially responsible for the balance and are to pay it upon receipt of your statement. **You will be required to pay the co-insurance, co-pay and deductibles for authorized services at the time of service.**

HMO/MANAGED CARE INSURANCE PATIENTS: Many HMO/Managed Care plans require that you obtain a referral in order to receive care from a specialist. It is your responsibility for obtaining this referral if needed. Unauthorized services will be the financial responsibility of the patient. **You will be required to pay the co-insurance, co-pay and any deductibles for authorized services at the time of service.**

PATIENT WITH NO INSURANCE: Patients with no insurance are required to pay for all services related to their visit in full at the time of service.

CANCELLATION/NO SHOW POLICY: A $25 fee will be charged if you fail to cancel your appointment without a 24 hour notice or if you fail to come to your scheduled appointment (no show).

We accept VISA, MasterCard, Discover or cash.

_____ _____

Patient/Guardian Signature Date

Patient Name: _____
Date: _____
DOB: _____

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FOOT AND ANKLE SPECIALISTS

New Patient: YES NO
Referring Dr: _____
PCP: _____
Family/Friend: _____

Purpose of Today's Visit (Patient to complete this section)

1. Are You Diabetic? ☐ **Yes** ☐ **No** **If yes, how long have you been diabetic** _____
2. Please describe the nature of your foot problem and the cause (if you know)_____
3. When did your problem start _____
4. Circle all that applies to your pain: **burning** **shooting** **sharp** **aching** **throbbing** **numbness** **tingling** **dull**
5. What makes the problem worse? _____
6. List previous treatments for you foot condition: _____
7. List anything else you think we should know: _____

To be completed by the Medical Assistant

Height: _____ **Weight:** _____ **Blood Pressure:** _____

Protective Sensation: ☐ Intact ☐ Loss **Shoe Size:** _____

Describe Sensation Loss: _____

Chief Complaint: _____

Nursing Home / Home Healthcare

Have you received home healthcare in the last 60 days? ☐ Yes ☐ No

Do you currently reside in a nursing care facility? ☐ Yes ☐ No

Facility Name: _____ Skilled? ☐ Yes ☐ No

Routine Care

Purple Form: ☐ **YES** ☐ **NO** **Date Shoes were last dispensed:** _____

ABN Required: ☐ **YES** ☐ **NO** **Date of Last PCP Visit:** _____

Doctors Notes

Pedal Pulses:	Left				Right			
	DP	P / NP	PT	P / NP	DP	P / NP	PT	P / NP

Patient Name: _____
Date: _____
DOB: _____

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FOOT AND ANKLE SPECIALISTS

RISK ASSESSMENT - PERIPHERAL VASCULAR DISEASE

When you walk or exercise do you experience aching, cramping or pain in your arms, legs, thighs or buttocks?
☐ Yes ☐ No

If you answered YES above, does the pain subside with rest?
☐ Yes ☐ No

Do you have any painful sores or ulcers on your legs or feet that are not healing?
☐ Yes ☐ No

PATIENT - PAST MEDICAL HISTORY

☐ Diabetes	☐ Phlebitis	☐ Asthma	☐ High Blood Pressure	☐ Gout
☐ Stomach Problems	☐ Circulation	☐ Cancer	☐ Liver	☐ Osteoarthritis
☐ Kidney Disease	☐ Alcoholism	☐ _____	☐ _____	☐ _____

FAMILY - PAST MEDICAL HISTORY

☐ Diabetes	☐ Tuberculosis	☐ Heart Attack	☐ Epilepsy	☐ Gout
☐ Kidney Disease	☐ Spinal Disorder	☐ Cancer	☐ Mental Illness	☐ Hypertension
☐ Allergies	☐ Arthritis	☐ Alcoholism	☐ Migranes	☐ _____

SURGICAL HISTORY

Have you ever had general anesthesia? ☐ **Yes** ☐ **No** If yes, please explain below:

Complications from Anesthesia:

Please list surgeries below:

Surgery:	Year:		Surgery:	Year:	

ALLERGIES

	Yes	Severity of Reaction: Mild	Moderate	Severe	Unknown
Penicillin	☐	☐	☐	☐	☐
Betadine	☐	☐	☐	☐	☐
Morphine	☐	☐	☐	☐	☐
Sulfa Drugs	☐	☐	☐	☐	☐
Latex	☐	☐	☐	☐	☐
Adhesive Tapes	☐	☐	☐	☐	☐
Aspirin	☐	☐	☐	☐	☐

RYAN FOOT & ANKLE CLINIC
FOOT AND ANKLE SPECIALISTS

Michael J. Ryan DPM – David J. Garchar DPM – Jeffrey J. Glaser DPM – Scott E. Whitman DPM

Thank you for choosing Ryan Foot and Ankle Clinic.

For over 23 years the doctors of Ryan Foot and Ankle Clinic have been providing the Charlotte area with the best possible medical and surgical podiatric care for adults and children. Our knowledgeable, sensitive and well trained staff welcomes you to our practice and ensures a pleasant experience. It is the goal of Ryan Foot and Ankle Clinic to offer the best quality care in a comfortable and professional manner. We look forward to getting to know you, providing the care you need and getting you back on your feet.

To expedite your check in process, please complete the enclosed paperwork. It is important that you bring the following information with you:

1. **Completed enclosed paperwork.**
2. **A current list of your medications both prescription and over the counter.**
3. **Your current insurance card(s).**
4. **You primary care physicians name, phone number and/or written referral.**
5. **Name and address of your preferred pharmacy.**
6. **Payment for services not covered under you insurance plan. Including co-pays, co-insurance and / or deductible amounts.**

Please be aware that it is our policy to collect any co-payments, co-insurance and/or deductible amounts at the time of your appointment. The complete financial policy is attached. If you have any questions or concerns regarding your billing issues you may contact our billing office at 704-721-0900 or your insurance carrier.

For more information about our doctors or directions to our offices please feel free to visit our website at www.ryanfootandankleclinic.com or contact one of our offices below.

We look forward to your visit. Once again, thank you for choosing Ryan Foot and Ankle Clinic.