RYAN FOOT AND ANKLE CLINIC
A division of InStride Foot & Ankle Specialists

Chart No: _____
(staff use only)

Patient Registration Form
Patient Demographics

Date: _____

First Name: _____M.I.: _____Last Name: _____Preferred Name: _____

Address: _____Apt/Unit #:_____City: _____State: _____ Zip: _____

Email address: _____

Primary Care Provider:_____

Date of birth (MM/DD/YYYY): _____/_____/_____

Pref. Language: ☐English ☐Spanish ☐ Other: _____

Phone: (_____) _____ ☐Home ☐Cell Secondary Phone: (_____) _____ ☐Home ☐Cell ☐Other: _____

Reminder preference: ☐ Email ☐ Text ☐ Phone Call

Gender: ☐Male ☐Female Race: ☐White/Caucasian ☐ Black/African American ☐ Hispanic ☐Asian ☐Other:_____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Who is responsible for patient's bills, if not the patient? ☐ Patient is responsible ☐ Other person(list below):

Name: _____ Phone: (_____) _____Relationship to patient:

Pharmacy:_____**City/Street**:_____

Authorization for Release of Information to Family and/or Friends (*Optional* Section)

I hereby authorize RFAC to discuss my medical care and release my confidential protected health information (PHI) to:

☐ Emergency Contact: _____ Phone: (_____) _____
Relationship to patient: _____ Information to be released: ☐ Any ☐ As follows:_____

☐ Primary Care Provider: _____ Phone: (_____) _____
Approximate date of last visit:_____ Information to be released: ☐ Any ☐ As follows:_____

☐ Other: _____ Phone: (_____) _____
Relationship to patient: _____ Information to be released: ☐ Any ☐ As follows:_____

Rights of the patient:
I understand that I have the right to revoke this authorization at any time and that I have the right to inspect a copy of the protected health information to be disclosed as described in this document by sending written notification to Ryan Foot and Ankle Clinic**, Attn: Security Officer; 492 Copperfield Blvd Concord, NC 28025**. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward from the date on the revocation.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization.

This authorization shall be in force and effect until revoked by the patient or representative signing the authorization on behalf of the patient.

_____ _____
Patient Signature, or Parent or Authorized Representative Signature Date
(Representative must provide proof of authority over patient)

I acknowledge that I was offered, or provided, a copy of the Notice of Privacy Practice and that I have read (or had the opportunity to read if I so chose) and understand this Notice.

_____ _____
Patient Signature, or Parent or Authorized Representative Signature Date

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Patient Name: _____**Height**: _____ **Weight**: _____**Shoe Size**: _____
Date of birth (MM/DD/YYYY):_____/_____/_____
How were you referred to our practice:_____
Name of PCP & date of last visit_____
Reason for Visit:_____
_____
How long have you had this problem?_____**List of previous treatments for your foot condition:**_____
_____
_____
What makes the problem worse?_____
_____
Check all that apply to your pain: ☐ Burning ☐ Shooting ☐ Sharp ☐ Aching ☐ Throbbing ☐ Numbness ☐ Tingling ☐ Dull

Home Health: Have you had any home health nurse treating you in your home in the last 90 days☐ Yes ☐ No
(physical therapy, administer oxygen, B12 injections, wound care)

Allergies: Please check any drug/medication allergies you may have: ☐ No known drug allergies
☐ Aspirin ☐ Codeine ☐ Latex ☐ Lidocaine ☐ Penicillin ☐ Sulfa ☐ Betadine ☐ Morphine ☐ Adhesive Tape ☐ Demerol
☐ Other: _____
_____

Medications : ☐ Please see attached sheet for Medications ☐ No Current Medications
(if you have a list, we can copy it)

Medical History: Please check box on any of your current/past conditions:
☐ None of the following apply
☐ Cancer (type:_____) ☐ Hypertension ☐ GI problems: (_____)
☐ Blood Clots ☐ Arthritis ☐ Diabetes Type: ☐ I ☐ II Last A1c:_____

☐ Stroke ☐ Renal (kidney) disease ☐ Gout
☐ Heart disease ☐ Liver disease ☐ Thyroid disease
☐ Periph. Vasc. Disease(PVD) ☐ Hepatitis ☐ HIV

Surgical History: Please check all that apply
☐ None of the following apply
☐ Heart surgery ☐ Stent placement ☐ Hip replacement ☐ Knee replacement
☐ Surgery of the Ankle/Foot: ☐ Bunion ☐ Hammertoe ☐ Joint fusion

Social History
Tobacco: ☐ Current smoker ☐ Former Smoker ☐ Never smoker Alcohol: ☐ Never ☐ Drinks alcohol ☐ Formerly

Review of Systems: Please mark any <u>current</u> symptoms you are experiencing: ☐ **None of the following apply**
<u>Const</u>: ☐ Fatigue ☐ Fever/Chills ☐ Night Sweats ☐ Recent weight gain or loss
<u>Skin</u>: ☐ Dry skin ☐ Itchy skin ☐ Rash ☐ Psoriasis ☐ Eczema
<u>Cardio</u>: ☐ Chest pain ☐ Palpitations ☐ Leg pain with exercise ☐ Varicose Veins
<u>MS</u>: ☐ Loss of muscle strength ☐ Muscle weakness ☐ Joint pain ☐ Back pain ☐ Joint stiffness ☐ Muscle aches

Provider/MA notes:_____
_____
_____
_____
_____
_____

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Financial Policy

- For patients with Insurance*:*
  - *I have provided correct* insurance information and understand I will be **responsible for payment at time of service** if I fail to disclose correct information to Ryan Foot and Ankle Clinic (RFAC).
  - I authorize RFAC to file a computerized claim form (paper or electronic) on my behalf.
  - I authorize benefits to be paid to me or on my behalf to the provider for the covered services. I authorize the release of any medical information to my carrier or its agents needed to determine benefits. I authorize RFAC to pursue a formal appeal or grievance on my behalf for any denied claim that they feel should not have been denied. If my insurance fails to respond to the claim within **60 days**, RFAC reserves the right to collect full payment from me.
  - I also agree to be responsible for any **co-payments, co-insurance, unmet deductibles, and non-covered services or supplies and understand that payment is due at the time of service**. Re-billing and collecting fees may apply for past due accounts.

    Note: **We recognize it is difficult to understand many of the points in today's insurance policies, with new plans and companies emerging constantly. Our office staff will make every attempt to follow the guidelines required by your insurance company. However, please understand that the contract is made between the insurance company and the patient. Therefore it is your responsibility to know and understand the details of your specific coverage.**

- **For patients with Medicare**
  - Medicare will only pay for services that they determine to be "reasonable and necessary" under Section 1862(a)(1) of the Medicare law. The following services are ones we know are not covered by Medicare:
    - Non qualifying Routine Foot Care (debridement, cutting, or trimming of corns, toenails, or calloused tissues)
    - Post-operative Surgical Shoes
    - Prescription Foot Orthotics
    - Laser treatments
    - Routine Pre-operative blood work/lab handling fees

- For patients with Medicare and that have changed to an HMO Insurance Policy (Medicare replacement plan):
  - I understand that if RFAC does not participate with my HMO plan, I may be responsible for **payment in full** if there are no out-of-network benefits.

- For patients without insurance, or on a plan that RFAC does not participate with:
  - I understand that RFAC's financial policy requires payment **in full at time of service**.

- Late Cancellation or No Show Fees:
  - There will be a $25.00 fee for any appointment cancelled with less than 24 hours prior to appointment time.
  - There is a **cancellation fee** for surgeries. Cancellation policy will be given when surgery is scheduled.

- **Payments**
  - RFAC accepts Discover, MasterCard, Visa, Debits, and Care Credit Cards, personal check, and cash.
  - If I am unable to pay my balance in full when due, I understand I need to contact RFAC's **billing supervisor immediately at 704-918-4607.** I understand that failure to make payment on my account as required every 30 days will require further action to collect the balance in full and my credit rating will be affected. I understand that if regular monthly payments are not received, and no payment arrangements are made, our clinic will no longer be able to extend credit to you for future visits and that an additional collection agency fee will also be added to the outstanding balance at the time of transfer to collections.

I have read the above financial policy in full and agree to comply with all of the listed policies.

_____ _____

Signature of Patient or Authorized Representative Date

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Medication List					
Drug	Frequency (example: 2x per day)	Strength/ Dose	How do you take it? (example: oral, sublingueal, injection, topical, etc.)	Provider Date Reviewed	Provider Initials