Michael J. Ryan, DPM
David J. Garchar, DPM
Jeffrey J. Glaser, DPM
Scott E. Whitman, DPM
Matthew A. Borns, 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. Your 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 your insurance plan. Including co-pays, co-insurance and /or deductible amounts.

Please be aware, it is our policy to collect any co-payments 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.

8310 Medical Plaza Drive Ste E
Charlotte, NC 28262
Phone: 704.548.0222
Fax: 704.548.1157

492 Copperfield Blvd
Concord, NC 28025
Phone: 704.788.9797
Fax: 704.788.6830

6831 Fairview Rd
Charlotte, NC 28210
Phone: 704.376.3947
Fax: 704.376.9487

8912 Blakeney Professional Dr
Charlotte, NC 28277
Phone: 704.544.6517
Fax: 704.544.2988

3800 Highway 49 S
Harrisburg, NC 28075
Phone: 704.455.2999
Fax: 704.455.1624

www.ryanfootandankleclinic.com

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Welcome to our New Patients

Welcome to our practice! We appreciate the opportunity to be of service to you and hope that you will be pleased with our services. We strive to not only meet, but exceed your expectations on every level.

Our practice is a division of the NC Podiatric Physicians and Surgeons Group, PLLC. We have divisions across the state, and we operate under one tax id number. As such, if you have seen any of the following physicians in the past three years, we need to know so that we will not file a new patient code for your visit today. Since the insurance carriers look at the NCPPSG as one large practice, if you have been seen at any of the following divisions, you will not be considered a new patient in our practice. Visits prior to 2013 do not need to be disclosed.

Please review the names of the divisions and podiatrists below and indicate if you have been seen at any of these divisions by putting a ✓ on the line to the left of the practice name. Thank you for disclosing this information to us – it will allow us to be in compliance with nationally mandated correct coding initiatives.

	Division	Podiatrist
___	Alta Ridge Foot Specialists	Robert van Brederode, William Broyles
___	Ankle & Foot Center of Charlotte	Scott Basinger
___	Brunswick Foot & Ankle Surgery, PA	Joseph Kibler
___	Carmel Foot Specialists	Barbara Kaiser, Richard Lind, Richard Miller, Kevin Molan
___	Carolina Foot Care Associates, PLLC	Ashma Davidson, Terry Donovan, William O'Neill
___	Central Carolina Foot & Ankle Associates	Melissa Hill, John Iredale, Gary Liao, Phil Ward
___	Chapel Hill Foot & Ankle Associates, P.A.	Nicholas Adams, Jane Andersen, Alan Bocko
___	Charlotte Foot & Ankle Specialists, PLLC	Kristine Strauss
___	Comprehensive Foot & Ankle Center, P.A.	Zack Nellas
___	Crystal Coast Podiatry	Thomas Bobrowski
___	Eastern Carolina Medical Center	Scott Matthews
___	Eastover Foot & Ankle, P.A.	Chris Fuesy, Ron Futerman, Kent Picklesimer
___	Edgewater Medical Center	Scott Matthews
___	Family Foot & Ankle Center, P.A.	Patrick Dougherty, Doug Smith
___	Family Foot Care	Kevin McDonald, Tori Simmons-Lewis
___	Foot & Ankle Ctr of Durham	Eric Simmons
___	Foot & Ankle of the Carolinas, PLLC	Eric Ward, Blaise Woeste
___	Gaston Foot & Ankle Associates, P.A.	David Kirlin, Ryan Meredith, Wagner Santiago
___	Greensboro Podiatry Associates, P.A.	Martha Ajlouny, N'Tuma Jah
___	Hendersonville Podiatry	Russ Barone, Pam Stover
___	James Mazur, D.P.M., P.A.	James Mazur
___	Matthews Foot Care	Brian Killian, Kevin Killian
___	Mt. Airy Foot & Ankle Center, PLLC	Jim Shipley
___	Piedmont Foot & Ankle Clinic	Rick Hauser, Rob Lenfestey, Jason Nolan, Joel Kelly, Scott Matthews
___	Queen City Foot & Ankle Specialists, P.C.	Roxanne Burgess
___	Raleigh Foot & Ankle	Alan Boehm, Robert Hatcher, Jordan Meyers, Kirk Woelffer
___	Ryan Foot & Ankle Clinic	David Garchar, Jeff Glaser, Michael Ryan, Scott Whitman
___	Salem Foot Care	Walter Falardeau
___	Wake Foot & Ankle Center	Mike Hodos, Jim Judge
___	Wilson Podiatry Associates, PA	Kendall Blackwell

__ I attest that I have been seen in the above indicated division of the NCPPSG since 01/01/2013.

__ I attest that to my best recollection, I have not been seen by any of the above divisions/physicians since 01/01/2013.

Signature of patient: ______________________________ Date: ______________

Printed Name: ______________________________ DOB: ______________

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

Marital 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

BC1

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

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 adjustors. 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 authorization 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 certify 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

BC2

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 ____________

BC3

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

DP	P / NP	PT	P / NP

Right

DP	P / NP	PT	P / NP

BC4

InStride Ryan Foot & Ankle Clinic

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 ☐ Migraines

SURGICAL HISTORY

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

Complications from Anesthesia:

Please list surgeries below:

Surgery:	Date:	Surgery:	Date:

ALLERGIES

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

Please describe the allergic reactions that you have to any of the above:

BC5

InStride Ryan Foot & Ankle Clinic

REVIEW OF SYSTEMS

	Yes	No		Yes	No		Yes	No
Musculoskeletal/Injuries			**Respiratory**			**Genitourinary**		
Fractured/Broken Bone	☐	☐	Emphysema	☐	☐	Frequent Urination	☐	☐
Sprains	☐	☐	Lung Problems	☐	☐	Painful Urination	☐	☐
Back Injury	☐	☐	Cough	☐	☐	Bladder Trouble	☐	☐
Arthritis	☐	☐	Shortness of Breath	☐	☐	Kidney Disease	☐	☐
Constitutional			Asthma	☐	☐	**Hematologic**		
Night Sweats	☐	☐	Bronchitis	☐	☐	Anemia	☐	☐
Abnormal Thirst	☐	☐	**Gastrointestinal**			Take Coumadin	☐	☐
Weight Loss	☐	☐	Spitting Up Blood	☐	☐	Take Aspirin	☐	☐
Immunological/Lymphatic			Constipation	☐	☐	Bleeding Disorder	☐	☐
Frequent Infections	☐	☐	Diarrhea	☐	☐	**Neurological**		
Swelling of Feet	☐	☐	Heartburn	☐	☐	Stroke	☐	☐
HIV	☐	☐	Reflux	☐	☐	Seizures	☐	☐
Hepatitis	☐	☐	Black Stools	☐	☐	Weakness	☐	☐
Psychiatric			Rectal Bleeding	☐	☐	Temp Loss of Sight	☐	☐
Depression	☐	☐	**Eyes, Ears, Nose, Throat**			Numbness	☐	☐
Anxiety	☐	☐	Impaired Eyesight	☐	☐	**Cardiovascular**		
Schizophrenia	☐	☐	Headache	☐	☐	Heart Problems	☐	☐
Bi-Polar	☐	☐	Migraines	☐	☐	Chest Pain	☐	☐
Drug/Alcohol Abuse	☐	☐	Ear Pain	☐	☐	Varicosities	☐	☐
OB_GYN			Ear Infections	☐	☐	Swelling	☐	☐
Currently Pregnant	☐	☐	Sore Throat	☐	☐	Leg Pain when Walking	☐	☐
Abnormal Menstrual Cycle	☐	☐	Difficulty Hearing	☐	☐	Dizziness	☐	☐
Menopause	☐	☐	**Skin**			Fainting	☐	☐
Hysterectomy	☐	☐	Frequent Rashes	☐	☐		☐	☐
Taking Estrogen	☐	☐	Psoriasis	☐	☐		☐	☐
	☐	☐	Eczema	☐	☐		☐	☐

BC6

Name:
DOB:
Chart:
Age:
Date:

RYAN FOOT & ANKLE CLINIC
FOOT AND ANKLE SPECIALISTS

Medication List

Drug	Form	Strength	Drug	Form	Strength

BC7