

PATIENT DEMOGRAPHICS

First Name _____ M.I. _____ Last Name _____ DOB ____/____/____
Street Address _____ Apt _____ City _____ State _____ Zip Code _____
Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____
E-Mail Address _____
Gender F M Marital Status Married Divorced Separated Single Widowed 1st Lang. Engl. Other _____
Race: (Choose all that apply)
 American Indian or Alaska Native Asian Hispanic White
 Black or African American Native Hawaiian or other Pacific Islander Other
Primary Care Physician _____ Phone (____) _____
Pharmacy _____ Pharmacy Phone (____) _____
Pharmacy Address _____ City, St _____ Pharmacy Zip Code _____
Are you diabetic? Yes No If yes, name of physician managing diabetes _____ Date last seen _____
Employed PT FT Retired None Employer _____
Emergency Contact _____ Relationship to Patient _____
Cell Phone Number (____) _____ Alternate Phone Number (____) _____

HOW DID YOU HEAR ABOUT US

Primary Care Physician Other Physician Name of Doctor _____ Practice Name _____
Practice Address _____ Practice Phone (____) _____
 Health Fair Internet (Source _____) Ad (Source _____)

INSURANCE INFORMATION

PRIMARY	SECONDARY
Insurance Company: _____	Insurance Company: _____
Insurance ID Number: _____	Insurance ID Number: _____
Group Number: _____	Group Number: _____
Primary Subscriber Name: _____	Primary Subscriber Name: _____
Primary Subscriber Birth Date: _____	Primary Subscriber Birth Date: _____
Relationship to Patient: _____	Relationship to Patient: _____

Financially Responsible Person if not Patient: First Name _____ Last Name _____
Gender F M Birth Date ____/____/____ Street Address _____
City _____ State _____ Zip _____
Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____

Patient's Authorization and Assignment of Benefits: I hereby authorize the processing of my medical insurance either by electronic or manual method by Foot & Ankle Specialists of the Mid-Atlantic, LLC (FASMA), and its management company U.S. Foot & Ankle Specialist, LLC (USFAS). My signature authorizes payment for all major medical and/or durable medical equipment supplies and/or surgical benefits to which I am entitled from the listed insurer(s) above and/or by providing my insurance cards to the office to pay for services rendered to FASMA. I certify that the information I have reported with regard to my insurance coverage is correct. I further authorize the release of any necessary information, including medical information, for this or any related claims. I grant permission to contact me via email/text as allowed by the FCC. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked, by me, at any time, in writing. I recognize my financial obligation of any balance, co-insurance, deductible, and non-covered services that may be required.

Signature of Responsible Party _____ Date _____
Relationship (if not Patient) _____

CONSENT FOR TREATMENT FORM

Consent for Treatment: I certify that the information above is true and correct to the best of my knowledge. I have been informed that if I am uncertain about any question on the form I should ask the doctor or a member of the office staff for assistance. By signing below, I hereby authorize Foot & Ankle Specialists of the Mid-Atlantic, LLC ("FASMA") to obtain medication history from community pharmacies and/or pharmacy benefit managers for the purpose of ongoing treatment. I give permission to FASMA to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet, ankles, and lower legs.

Consent to Photograph/Film/Video: I authorize the DPM and associates or assistants to photograph /film/video the site of treatment. Details of the photographing/filming/videotaping have been explained to me in terms I understand. I understand that the photos, films, or videos are the property of the above-mentioned doctor, and I may obtain a copy upon my written request. I agree and authorize the use of the photos, film or video for teaching purposes, which includes being shown to other patients, in the advertisements of the above-mentioned podiatrist, or to place my photo, film or video on his/her professional web site. *I am aware that my name and identity will not be disclosed.*

I deny consent to use my photo/video/film by initialing here: _____

Signature of Responsible Party _____ Date _____

Relationship (if not Patient) _____

PLEASE COMPLETE CONSENT FOR TREATMENT OF MINOR, IN ABSENCE OF PARENT/GUARDIAN

Consent for Treatment of Minor Patient in Absence of Parent/Guardian: I certify that I am the parent and/or legal guardian of _____. I authorize _____ to bring my child to office visits with Dr. _____ and to consent to the examination and/or treatment of my child. This authorization is effective until revoked by me in writing.

Signature of Responsible Party _____ Date _____

Relationship (if not Patient) _____

FINANCIAL POLICY

Welcome to Foot & Ankle Specialists of the Mid-Atlantic, LLC (FASMA) and thank you for selecting our practice. We are committed to providing you with the best possible care. If you have medical insurance, we want to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our policy.

1. Your insurance is a contract between you and the insurance company. It is your responsibility to understand the benefits of your plan for any and all services. We cannot guarantee payment of your claims that we file. We file as a courtesy to you and your insurance company will not give us a guarantee of coverage. If your insurance company pays only a portion of your claim or rejects your claim, you and/or the policyholder should make an inquiry to your insurance company. Payment delays or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred. We may offer a payment plan for outstanding patient balances. Failure to adhere to an agreed upon, and executed payment plan may result in further collection activity. There will be a \$35.00 fee for all returned checks and credit payments.
2. We participate in a number of health insurance plans, including Medicare. All patients are required to pay their co-pay, co-insurance, deductibles, and any patient balances owed of all visits, at the time of their visit. In addition, HMO patients must present a valid referral/authorization from their primary physicians at check in. All health plans are not the same and do not cover the same services. In the event your health plan determines that you are not eligible for service, or determines that a service as "not covered" or you do not have an authorization, you will be responsible for all charges related to the services rendered. We will attempt to verify benefits for some specialized services; however benefits verification is not a guarantee of payment. You remain responsible for charges to any service rendered. Patients are encouraged to contact their insurance company for clarification of benefits prior to services rendered. In the event you do not satisfy your financial responsibilities, the practice may use a collection agency, and will provide protected health information to that agency. If such agency is used, you will be responsible for a 35% balance-based collection fee and any additional costs related to satisfying that debt, including, but not limited to, court costs, and/ or reasonable attorney fees that may be incurred in the collection of an outstanding balance affiliated with satisfying your financial responsibility. It is our standard procedure to send all pathology samples to a lab that is owned and operated by FASMA. We might also use other pathology labs, as necessary. **MEDICARE PATIENTS** If Medicare has provided reimbursement for services rendered, and if your supplemental insurance does not respond within 30 days, then you become responsible for the balance.
3. In order for us to service your account and/or to collect any amounts you may owe, we, FASMA, and our agents may contact you by telephone at any phone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide us to use. Methods of contact may include using pre-recorded or artificial voice messages and/or use of an automatic dialing device, as applicable.
4. Missed appointments: You may be billed a \$40.00 charge for missed appointments that are not cancelled within 24 hours' notice.
5. If you believe your insurance company has made an error or not adequately addressed your claims you may contact the insurance company and/or file a grievance or appeal with your state: for Maryland, contact the Maryland Insurance Administration at 410-468-2244 and/or The Health Advocacy Unit of the Maryland Attorney General at 410-528-1840; for Pennsylvania, contact the Bureau of Consumer Services, Pennsylvania Department of Insurance at 1-877-881-6388; for North Carolina, contact the Consumers Services Division, N.C. Department of Insurance at 1-855-408-1212; for Virginia, contact the State Corporation Commission, Virginia Bureau of Insurance at 1-877-310-6560; and for the District of Columbia contact the Department of Insurance, Securities and Banking at 202-727-8000.

Signature of Responsible Party _____ **Date** _____

Relationship (if not Patient) _____

MEDICAL FORM

First Name _____ M.I. _____ Last Name _____ DOB ____/____/____

Reason for Visit _____ **RIGHT LEFT BILATERAL (PLEASE CHECK ONE)**
How long has this been a problem? _____ When does it occur? Morning Afternoon Evening Off & On All Day

TREATMENTS: Please list previous treatments (either prescribed or home remedies):

Age _____ Height _____ Weight _____ Shoe Size _____

Is this visit related to an accident/injury Y N If yes, date of injury _____

MEDICAL HISTORY: Please indicate: **S** (Self) or **F** (Family Member – Blood Relation) or **B** (if Both)

- | | | |
|--|---|--|
| ___ Alcohol/Drug Addiction/Dependency | ___ Gout | ___ <input type="checkbox"/> Osteoporosis / <input type="checkbox"/> Osteopenia |
| ___ Alzheimer's / Dementia | ___ GERD <input type="checkbox"/> Reflux / <input type="checkbox"/> GI Ulcers | ___ Phlebitis /DVT (blood clots in legs) |
| ___ Anemia – Type _____ | ___ Headaches/Migraines | ___ Pregnancy / <input type="checkbox"/> Currently Pregnant |
| ___ Arrhythmias – Type _____ | ___ Hearing Problems | Due Date _____ |
| ___ Arthritis – Type _____ | ___ Heart Disease | ___ Rheumatic Fever / Scarlet Fever |
| ___ Bleeding / Clotting Problems – Type _____ | ___ Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> Liver Disease | ___ Schizophrenia |
| ___ Cancer – Type _____ | ___ High Blood Pressure | ___ STD's (sexually transmitted dis.) |
| ___ Depression / Anxiety-disorder / Bipolar-depression / Other | ___ High Cholesterol | ___ Sickle Cell Trait / Disease |
| ___ Diabetes (how long) _____ | ___ HIV / Aids / ARC | ___ Thyroid Problem <input type="checkbox"/> Hyper <input type="checkbox"/> Hypo |
| ___ Emphysema / COPD | ___ Kidney / Renal Disease – Type _____ | ___ Tuberculosis |
| ___ Glaucoma | ___ Lung Disease / Pulmonary Embolism | ___ Other, Please Specify _____ |
| | ___ Lyme's Disease | |
| | ___ Nervous Condition – Type _____ | ___ None of the above |

SURGICAL HISTORY Y N If yes, please list the surgeries you have had:

HOSPITALIZATION Y N If yes, please list: _____

SMOKING Do you or have you ever smoked Y N If Yes, how many years _____ How long ago did you quit _____

ALCOHOL USE Do you or did you ever drink alcoholic beverages Y N
How many drinks do you consume a day? _____ week? _____ How long ago did you quit? _____

RECREATIONAL DRUG USE Do you or have you ever used illicit/recreational drugs? Y N
If yes, which ones? _____ How long ago did you quit? _____

MEDICATIONS Please list (or attach a list) of your current medications including over the counter medications and their dosages:

ALLERGIES Do you have a history of allergies/skin reaction/sickness following the administration of the following? If checked list reaction.

- | | | |
|--|--|--|
| <input type="checkbox"/> Adhesive Tape _____ | <input type="checkbox"/> Cortisone _____ | <input type="checkbox"/> Local Anesthetics _____ |
| <input type="checkbox"/> Anesthesia _____ | <input type="checkbox"/> Demerol _____ | <input type="checkbox"/> Penicillin _____ |
| <input type="checkbox"/> Aspirin _____ | <input type="checkbox"/> Food _____ | <input type="checkbox"/> Sulfa Drugs _____ |
| <input type="checkbox"/> Caffeine _____ | <input type="checkbox"/> Iodine _____ | Other Please List: _____ |
| <input type="checkbox"/> Codeine _____ | <input type="checkbox"/> Latex _____ | |

Signature of Responsible Party _____ Date _____

Relationship (if not Patient) _____

REVIEW OF SYSTEMS

First Name _____ M.I. _____ Last Name _____ DOB ____/____/____

Please check any of the following that you are currently experiencing or have recently experienced

GENERAL / CONSTITUTIONAL	KIDNEY / URINARY / BLADDER	PSYCHIATRIC
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Frequent or painful urination	<input type="checkbox"/> Depression
<input type="checkbox"/> Weakness	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Stress
<input type="checkbox"/> Fever	MUSCULOSKELETAL	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Night sweats	<input type="checkbox"/> Low back pain	ENDOCRINE
<input type="checkbox"/> Malaise	<input type="checkbox"/> Pain in leg	<input type="checkbox"/> Thirsty
EYES	<input type="checkbox"/> Foot pain	<input type="checkbox"/> Night sweats
<input type="checkbox"/> Pain	<input type="checkbox"/> Joint pain	<input type="checkbox"/> Swollen glands
<input type="checkbox"/> Redness	<input type="checkbox"/> Bone pain	<input type="checkbox"/> Recent weight gain How much _____
<input type="checkbox"/> Loss of vision	<input type="checkbox"/> General muscle aches and pains	<input type="checkbox"/> Recent weight loss How much _____
<input type="checkbox"/> Double or blurred vision	<input type="checkbox"/> Swelling in the legs	HEMATOLOGIC / LYMPHATIC (BLOOD)
<input type="checkbox"/> Dryness	<input type="checkbox"/> Joint swelling	<input type="checkbox"/> Anemia
EARS, NOSE & THROAT	<input type="checkbox"/> Joint stiffness	<input type="checkbox"/> Clots
<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Change in gait	<input type="checkbox"/> Bleeding Problems
<input type="checkbox"/> Loss of hearing	<input type="checkbox"/> Difficulty climbing stairs	ALLERGIC / IMMUNOLOGIC
<input type="checkbox"/> Frequent sore throats	<input type="checkbox"/> Loss of leg strength	<input type="checkbox"/> Healing issues
<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Shoes wear out quickly	<input type="checkbox"/> Reactions to dyes
<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Shoes wear out unevenly	<input type="checkbox"/> Reactions to foods
<input type="checkbox"/> Pain in jaw	INTEGUMENTARY / SKIN	<input type="checkbox"/> Reactions to medicine
<input type="checkbox"/> Nose bleeds	<input type="checkbox"/> Sensitive skin with sun exposure	OTHER / NOTES
CARDIOVASCULAR	<input type="checkbox"/> Rashes	
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Warts on feet	
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Moles / lumps / bumps	
<input type="checkbox"/> Swollen legs or feet	<input type="checkbox"/> Extremely dry skin / cracking	
<input type="checkbox"/> Fainting	<input type="checkbox"/> Open skin sores	
RESPIRATORY	<input type="checkbox"/> Unusual areas of discoloration	
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Calluses	
<input type="checkbox"/> Cough	<input type="checkbox"/> Nail problems	
GASTROINTESTINAL / STOMACH	<input type="checkbox"/> Noticeable hair loss legs / feet	
<input type="checkbox"/> Black stools	NEUROLOGIC	
<input type="checkbox"/> Blood in stools	<input type="checkbox"/> Headaches	
<input type="checkbox"/> Increasing constipation	<input type="checkbox"/> Dizziness	
<input type="checkbox"/> Persistent diarrhea	<input type="checkbox"/> Fainting or loss of consciousness	
<input type="checkbox"/> Heartburn	<input type="checkbox"/> Numbness / tingling / burning	
<input type="checkbox"/> Nausea	Where _____	
<input type="checkbox"/> Vomiting	_____	
<input type="checkbox"/> Stomach pain		
<input type="checkbox"/> Yellow jaundice		

SUMMARY NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information according to the Health Information Portability and Accountability Act (HIPAA).

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To Government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law;
- To a collection agency and may provide protected health information to that agency in the event you do not satisfy your financial responsibilities.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please contact: our Privacy Officer, at 301-933-7133 or PrivacyOfficer@footandankle-usa.com.

I, _____ (Print Name of Patient or Legal Representative – **Patient DOB** ____/____/____)

Acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read or had the opportunity to read if I so chose and understood that notice. This authorization may be revoked by me at any time in writing.

In addition, I authorize the following people access to my personal health information upon request (including leaving a detailed message):

Name/Relationship: _____

Signature of Patient or Legal Representative

Date