TALLAHASSEE PODIATRY ASSOCIATES FOOT & ANKLE CENTER

Dr. George N. Merritt
Dr. Russell W. Rowan
Dr. Bryan A. Spooner
Dr. Joshua A. Nichols
Dr. Marc A. Alvarez

Patient Information

Name (Last, First, M.I.):_____ *If Minor*, (Parent/Guardian): _____

Address:_____ City:_____ State:_____ Zip:_____

Phone (Home):_____ (Cell):_____ (Work):_____ Contact Preference:_____

Age:_____ DOB:_____ Gender:_____ Marital Status:_____ SSN:_____

Race:_____ Ethnicity:_____ Language:_____ Email:_____

Employer:_____ Occupation:_____ Student Status:_____

Emergency Contact:_____ Relationship:_____ Phone:_____

Insurance Information

Primary Insurance:_____ Policy Number:_____ Group Number:_____

Subscriber's Name/Relationship:_____ DOB:_____ SSN:_____

Secondary Insurance:_____ Policy Number:_____ Group Number:_____

Subscriber's Name/Relationship:_____ DOB:_____ SSN:_____

Who may we thank for referring you to our office?:_____

Please note: *Payment for services is required at the time services are rendered. Regardless of insurance, ultimately, the patient or guarantor is responsible for all charges incurred. Also, some insurance may require a prior authorization at for services. Please verify with our front office personnel to ensure this approval has been obtained before being seen by one of our physicians.*

Insurance Authorization: *This is to relates to both primary and secondary insurances which may include Capital Health Plan, Medicare, Blue Cross Blue Shield, United Health Care, Humana, Wellcare, Aetna, as well as any other medical insurances not listed. SIGNATURE ON FILE—I authorize use of this form on all my insurance submissions; I authorize release of information to all my insurance carriers; I understand I am responsible for my bill; I authorize payment directly to my physician; I permit a copy of this authorization to be used in place of the original.*

Patient's Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____

Medical & Podiatric Information

Primary Care Physician:_____ City:_____ State:____ Last Visit:_____

Previous Podiatrist:_____ City:_____ State:____ Last Visit:_____

Current Cardiologist:_____ City:_____ State:____ Last Visit:_____

Health History (Please Check Yes or No)

Patient Condition	***Yes***	***No***	***If Yes, Specify Type***	***Other Details***
Acid Reflux				
Anemia				
Arthritis				
Asthma				
Back Trouble				
Bladder Infections				
Bleeding (Abnormal)				
Blood Clots				
Blood Transfusion				
Bronchitis/Emphysema				
Cancer				
Diabetes				
Fibromyalgia				
Gout				
Heart Attack				
Heart Disease/Failure				Pacemaker:_____ Defibrillator:_____
Hepatitis				
HIV+/AIDS				
High Blood Pressure				
Kidney Disease				Dialysis Patient:_____
Liver Disease				
Low Blood Pressure				

Health History (Please Check Yes or No)

Patient Condition	***Yes***	***No***	***If Yes, Specify Type***	***Other Details***
Lung Disease				On Oxygen:_____ CPAP/BiPAP:_____
Mental Disorder				
Migraine Headaches				
Mitral Valve Prolapse				
Neuropathy				
Open Sores				
Peripheral Vascular Disease				Arterial Insufficiency:_____ Varicose Veins:_____
Pneumonia				
Polio				
Rheumatic Fever				
Sickle Cell				
Skin Disorder				
Sleep Apnea				
Stomach Ulcers				
Stroke				
Thyroid Disease				
Tuberculosis				
Other Conditions				

Have any of your relatives had any of the conditions listed above? ☐ Yes ☐ No

Describe:_____

_____

_____

Medical History

Description	***Yes***	***No***	***N/A***	***Other Details***
Tobacco Use?				How much & duration _____
Alcohol Use?				How much: _____
Recreational Drug Use?				Type, amount, & duration _____
Are you pregnant?				Due date: _____
Are you breastfeeding?				
Have you been hospitalized in the past year?				List reason(s):

Medication Name and Dosage	Dosing Frequency	Medication Name and Dosage	Dosing Frequency

**Please initial consenting to retrieve electronically , if available. Initial:_____ Date:_____

Allergy	Reaction	Severity

Previous Surgeries	Date	Details

Preferred Pharmacy:_____

Current Problem

Reason For Visit: _____

_____

Where is the pain/problem located? Please mark on the pictures below.

Left Foot

Top of Foot

Bottom of Foot

Inside of Foot

Outside of Foot

Right Foot

Bottom of Foot

Top of Foot

Inside of Foot

Outside of Foot

How long ago did this problem first start? _____ Days / Weeks / Months / Years

Did your pain or problem: ☐ Begin all of a sudden ☐ Gradually developed over time

How would you describe the pain: ☐ No pain ☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Radiating ☐ Itching

☐ Stabbing ☐ Other_____

How would you rate the pain (0-10 scale): (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain Possible)

Since the pain/problem begin, has it: ☐ Stayed the same ☐ Become Worse ☐ Improved

What makes your pain or problem feel worse: ☐ Walking ☐ Standing ☐ Daily Activities ☐ Resting ☐ Dress Shoes

☐ High Heels ☐ Flat Shoes ☐ Any Closed Toe Shoe ☐ Running ☐ Other_____

What makes your pain or problem feel better:_____

What treatments have you had for this problem:_____

How has this problem affected your lifestyle or ability to work:_____

Was this problem caused by an injury: ☐ No ☐ Yes (Describe) _____

_____

Date of injury:_____ Type of Injury: ☐ Work ☐ Accident

Privacy Practice & HIPAA Release Information

Tallahassee Podiatry Associates (TPA) has provided me with the opportunity to review the practice's Privacy Notice prior to my signing this consent. The privacy notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) that is necessary for this practice to provide medical treatment, obtain payment, and carry out its health care operations. A copy of this privacy notice is available to me now and in the future upon my request.

TPA reserves the right to change its privacy practices in accordance to applicable federal and state laws.

I understand and consent to the following appointment reminders which may be used by TPA: a telephone call to the telephone number(s) provided by me whether it is home, work, or mobile. A message may be left on an answering machine, with a person answering the given number, or text message to the mobile number provided. The person calling will give the name of the practice or doctor's name, time, and date of the appointment.

I understand TPA uses a fax/efax machine to transmit certain information pertinent to my care to HIPAA compliant entities, such as a doctor's office, insurance company, etc. If I request a fax be sent to a personal or business fax, I will sign a release.

I understand anyone picking up any information for me must have photo identification and authorization.

I understand TPA uses a sign in sheets for patients. It may be seen by others seeking treatment on the same day. There is no PHI required on the sign in sheet.

I understand I have the right to request TPA restricts how my PHI is used and disclosed to carry out treatment, payment, and healthcare operations. However, TPA is not required to agree to any restrictions I have requested. If TPA does agree to a requested restriction, then the restriction is binding on TPA.

I understand there are instances where no consent is required for TPA to disclose my PHI. Those are in accordance with federal and state regulations and are listed in the privacy notice.

This consent is valid for seven (7) years. I further understand I have the right to revoke this consent, in writing, any time for all future transactions, with the understanding any such revocation shall not apply to the extent TPA has already taken action in reliance to consent.

I understand if I revoke this consent at any time, TPA has the right to refuse to treat me.

I understand if I refuse to sign this consent evidencing my consent to the uses and disclosures described to me above and pertaining to the privacy, then TPA will NOT treat me.

I understand I have the right to complain to TPA's administrator if I feel my rights have been violated. All complaints must be in writing.

I have read and fully understand the forgoing notice and have had all my questions answered.

Initial:_____ Date:_____

Privacy regulations require our practice to have a signed release which allows family members and/or friends regarding your medical treatment(s) and financial information. Each person you wish to grant contact must be listed individually by name (Including spouse or significant other).

Please print name, relationship, and telephone number for each person you are authorizing release of your PHI and/or financial information. This authorization will remain in effect until at such time changes are made in writing by the patient or authorized legal representative.

Name	Relationship	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

Billing Information

We are committed to providing you with the best possible podiatric care. If you have medical insurance, we want to help you receive the maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policies.

Payment for services are due at the time services are rendered. We accept cash, credit cards, personal checks, and money orders. If we are providers for your insurance company, we will file your claim(s) for your, however, you are responsible at the time of services for all copay and deductibles. It is your responsibility to know what those amounts are according to your contract with your insurance company. If we are not providers, we expect payment in full and will give you all the information needed to file your claim(s) for reimbursement.

However, you must realize that:

1. Your insurance is between you and your insurance company. We are not a party to that contract unless we have entered into a written agreement with your insurance company as a provider. An example:

    A. Medicare-

        I. The patient is responsible for all co-insurances and deductible amounts as outlined in the Medicare laws. Supplementary insurance will be accepted ONLY if it crosses over under the Medigap program. If not, the patient is responsible for all deductibles and 20% of Medicare's allowed amount.

2. Our fees are generally considered to fall within the acceptable range of most insurance companies and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage of Usual, Customary and Reasonable Fees (UCR) for a specific reason. This does not apply to companies who reimburse on fee schedules.

3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Therefore, the patient is responsible for these services. We also carry several items that are not paid for by your insurance company and are listed as non-covered supplies. These must be paid for at the time of purchase.

4. Returned checks are subject to additional collection fees.

5. Charges may also be incurred for appointments and surgical reservations not cancelled 24 hours in advance. TPA reserves the right to refuse services to any patient who "no show" appointments three (3) times within a 12 month period.

We must emphasize as podiatry care providers, our relationship is with YOU, not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility for the date services are rendered.

I UNDERSTAND AND AGREE, REGARDLESS OF MY INSURANCE STATUS, I AM ULTIMATELY RESPONSIBLE FOR ALL CHARGES AND BALANCES DUE ON MY ACCOUNT FOR PROFESSIONAL SERVICES INCURRED AT TALLAHASSEE PODIATRY ASSOCIATES, PA. I HAVE READ AND UNDERSTAND THE INFORMATION PROVIDED TO ME.

Patient's Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____

Witness Signature:_____ Date:_____