



TALLAHASSEE  
**PODIATRY**  
ASSOCIATES  
FOOT & ANKLE CENTER

Name (Last, First, M.I.): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender:  Male  Female Social Security #: \_\_\_\_\_

Reason For Visit: \_\_\_\_\_

Select your preferred method of contact

Email: \_\_\_\_\_  Cell: \_\_\_\_\_

Home Phone: \_\_\_\_\_  Work: \_\_\_\_\_

Address: \_\_\_\_\_ Apt #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Insurance Company: \_\_\_\_\_

Insurance #: \_\_\_\_\_ Group #: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_

Insurance #: \_\_\_\_\_ Group #: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_

Pharmacy Phone: \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Ethnicity

Non-Hispanic

Hispanic

Language

English

Spanish

Other: \_\_\_\_\_

Race

African American/Black

Asian

Caucasian/White

Native American

Pacific Islander

Other: \_\_\_\_\_

Primary Care Physician

\_\_\_\_\_

Date Last Seen: \_\_\_\_\_

Referred By (How you found us)

\_\_\_\_\_

Surgeries: \_\_\_\_\_ Hospitalizations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Injuries/Trauma: \_\_\_\_\_

\_\_\_\_\_

Family History  Diabetes  High Blood Pressure  Heart Disease  Cancer

Other: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



TALLAHASSEE  
**PODIATRY**  
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Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Shoe Size: \_\_\_\_\_ Are You Pregnant?:  Yes  No

Marital Status:  Married  Single  Divorced  Separated  Widowed

Living Situation:  Alone  With Family/Friends  Nursing Facility/Rehab

Do You Use:  Alcohol  Tobacco  Illicit Drugs Occupation: \_\_\_\_\_

Do you currently smoke?:  Yes  No Packs per day?: \_\_\_\_\_ Years?: \_\_\_\_\_

If no, have you ever smoked?:  Yes  No Quit Date: \_\_\_\_\_

PAST MEDICAL CONDITIONS

- No known medical problems
- Diabetes  Occupation: \_\_\_\_\_
- High Blood Pressure \_\_\_\_\_
- Poor Circulation \_\_\_\_\_
- Heart Disease \_\_\_\_\_
- Kidney Disease \_\_\_\_\_
- Liver Disease \_\_\_\_\_
- Gout \_\_\_\_\_
- Heart Attack \_\_\_\_\_
- Stroke \_\_\_\_\_
- HIV/AIDS \_\_\_\_\_
- Hepatitis \_\_\_\_\_
- Stomach Ulcers \_\_\_\_\_

MEDICATIONS

Dosage/How Often

I don't take any medications

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ALLERGIES TO MEDICATIONS

- I have no allergies that I am aware of
- Iodine  Penicillin  Aspirin  Anesthesia / Novacaine
- Codeine  Sulfa  Cortisone  Adhesive / Tape on the skin
- Other: \_\_\_\_\_

Explain in detail what happens when you are exposed to the above

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Date this first occurred: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**REVIEW OF SYSTEMS**  
Mark Y for Yes and N for No



<u>General</u>	<u>Y</u> <u>N</u>
Weight change	<input type="checkbox"/> <input type="checkbox"/>
Tired	<input type="checkbox"/> <input type="checkbox"/>
Fever	<input type="checkbox"/> <input type="checkbox"/>
Loss of appetite	<input type="checkbox"/> <input type="checkbox"/>
<u>Eyes</u>	<u>Y</u> <u>N</u>
Headaches	<input type="checkbox"/> <input type="checkbox"/>
Vision problems	<input type="checkbox"/> <input type="checkbox"/>
<u>Ear/Nose/Throat</u>	<u>Y</u> <u>N</u>
Ringing in ears	<input type="checkbox"/> <input type="checkbox"/>
Trouble swallowing	<input type="checkbox"/> <input type="checkbox"/>
Nosebleeds	<input type="checkbox"/> <input type="checkbox"/>
Sore throat	<input type="checkbox"/> <input type="checkbox"/>
Bleeding gums	<input type="checkbox"/> <input type="checkbox"/>
<u>Cardiovascular</u>	<u>Y</u> <u>N</u>
Chest pain	<input type="checkbox"/> <input type="checkbox"/>
Irregular heart beat	<input type="checkbox"/> <input type="checkbox"/>
Fainting	<input type="checkbox"/> <input type="checkbox"/>
<u>Respiratory</u>	<u>Y</u> <u>N</u>
Shortness of breath	<input type="checkbox"/> <input type="checkbox"/>
Cough	<input type="checkbox"/> <input type="checkbox"/>
<u>Gastrointestinal</u>	<u>Y</u> <u>N</u>
Nausea/vomiting	<input type="checkbox"/> <input type="checkbox"/>
Diarrhea	<input type="checkbox"/> <input type="checkbox"/>
Constipation	<input type="checkbox"/> <input type="checkbox"/>
Abdominal pain	<input type="checkbox"/> <input type="checkbox"/>
Stomach ulcers	<input type="checkbox"/> <input type="checkbox"/>

<u>Genital/Urinary</u>	<u>Y</u> <u>N</u>
Incontinence	<input type="checkbox"/> <input type="checkbox"/>
<u>Musculoskeletal</u>	<u>Y</u> <u>N</u>
Joint pain	<input type="checkbox"/> <input type="checkbox"/>
Weakness	<input type="checkbox"/> <input type="checkbox"/>
Leg cramps	<input type="checkbox"/> <input type="checkbox"/>
<u>Integument</u>	<u>Y</u> <u>N</u>
Rashes	<input type="checkbox"/> <input type="checkbox"/>
Open wounds	<input type="checkbox"/> <input type="checkbox"/>
<u>Neurologic</u>	<u>Y</u> <u>N</u>
Balance problems	<input type="checkbox"/> <input type="checkbox"/>
Numbness/Tingling	<input type="checkbox"/> <input type="checkbox"/>
<u>Psychiatric</u>	<u>Y</u> <u>N</u>
Depression	<input type="checkbox"/> <input type="checkbox"/>
Anxiety	<input type="checkbox"/> <input type="checkbox"/>
<u>Endocrine</u>	<u>Y</u> <u>N</u>
Excessive sweating	<input type="checkbox"/> <input type="checkbox"/>
Frequent urination	<input type="checkbox"/> <input type="checkbox"/>
Excessive thirst	<input type="checkbox"/> <input type="checkbox"/>
<u>Hematologic</u>	<u>Y</u> <u>N</u>
Easy bruising	<input type="checkbox"/> <input type="checkbox"/>
Anemia	<input type="checkbox"/> <input type="checkbox"/>
Blood thinner use	<input type="checkbox"/> <input type="checkbox"/>
<u>Immunologic</u>	<u>Y</u> <u>N</u>
Swollen glands	<input type="checkbox"/> <input type="checkbox"/>
Itching	<input type="checkbox"/> <input type="checkbox"/>

PATIENT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

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## 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

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date

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## 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 you, 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: \_\_\_\_\_