CAROLINA FOOT & ANKLE ASSOCIATES
MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____ Appointment Date: _____

Name of Primary Care Physician: _____ Last seen (Month/Year) _____

Preferred Pharmacy: _____ City: _____ Phone Number: _____

Describe the reason for your visit today: _____

Duration of symptoms_____ Are you experiencing pain? ___No ___Yes (if yes, please answer the following)

Pain severity 0 = none, 10 = very severe (please circle) 0 1 2 3 4 5 6 7 8 9 10

Have you ever been diagnosed and /or treated for any of the follow? Please check below

___ Diabetes (Last A1C and Date _____)		___ Heart Problems	___ Circulation Trouble
___ Cancer/ Tumors (Specify_____)		___ Gout	___ Mental Illness
___ Stroke	___ High Blood Pressure	___ Nerve Problems	___ Kidney/ Bladder Disease
___ Arthritis	___ Thyroid Disease	___ Breathing Problems	___ Asthma
___ Anemia	___ HIV/ AIDS	___ Back Pain/ Injury	___ Bleeding Tendencies
___ Seizures	___ Stomach Problems	___ High Cholesterol	___ History of MRSA
___ Blood Clots	___ Liver Problems (Specify_____)		___ Hepatitis

List any medications you take:	Dosage/Frequency	What is it for? ___ **See Attached list**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any allergies? Please list: _____

Have you had any surgeries?

Year	Type of Surgery
_____	_____
_____	_____
_____	_____

Shoe Size_____

Have you had a Flu Vaccine? Yes No If Yes, approximately when? _____

Have you had a Pneumonia Vaccine? Yes No If Yes, approximately when? _____

Have you had a COVID-19 Vaccine? 1st dose 2nd dose

Social History

Do you smoke cigarettes? ___ No ___Yes If so, for how many years? ____ How many packs per day? _____

Are you a former smoker? ___ No ___Yes If so, for how many years? ____ How many packs per day _____

Do you drink alcoholic beverages? ___ No ___ Yes What kind & approximately how many each week? _____

Are you employed? ___ Yes ___ No ___ Retired Are you pregnant? ___ Yes ___ No

What would resolving your condition mean to you? _____

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

Signature: X_____ **Date:** _____

Patient or Personal Representative

To be used by Carolina Foot & Ankle Staff:

BP (sitting): _____/_____ Pulse _____/min (Reg. Irreg.) Resp. _____/min Temp: _____°F Height _____
Weight_____ If over 65, Falls? _____

CAROLINA FOOT & ANKLE ASSOCIATES
DEMOGRAPHICS

Patient's Last Name: _____First: _____ Middle Int: _____

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

Gender: _____ Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated ☐

Race: ☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ Native American ☐ Other: _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic Preferred language: _____

Social Security: _____ Date of Birth: _____

Home Phone: _____ Work Phone: _____Cell Phone: _____

Primary Care Doctor's Practice Name: _____

Email Address: _____

Primary Insurance: _____Secondary Insurance: _____

Who carries the insurance? ☐ The patient ☐ Other (Name): _____ DOB: _____

How did you hear about our practice? _____

Is the patient in a facility (ex: nursing home)? Name: _____ Phone: _____

Responsible Party
If someone (other than the patient) is responsible for the patient's bill, please complete the following:

Responsible Party's Name: _____Relationship to patient: _____

Mailing Address: _____City: _____ State: _____ Zip: _____

Emergency Contact: _____**Relationship to Patient**_____

Home: _____ Cell: _____ Work: _____

I authorize the release of any medical information necessary to process my Insurance Claim and request payment of benefits to the doctor. I hereby give permission to the doctor to administer treatment and to perform any minor procedures as may be needed in the diagnosis and/or treatment of my foot and ankle condition. I understand that services rendered should be paid for at the time of service unless other arrangements have been made.

I authorize payment of insurance benefits to the doctor. This authorization applies to all dates of service until revoked.

Signature: _X_____ **Date:** _____
Patient or Personal Representative

CAROLINA FOOT & ANKLE ASSOCIATES

FINANCIAL POLICY

Patient Name: _____ **Date of Birth:** _____

YOUR INSURANCE

Our relationship is with you, not your insurance company. If we are a participating provider with your insurance, we will file your claim for you. We do not; however, file third party payer claims for motor vehicle, worker's compensation, or other accidents. If you do not have your insurance card at the time of service, it may be necessary for you to pay for your visit in full.

According to our insurance contracts, we are obligated to collect the patient's responsibility at the time we provide services. Therefore, any applicable co-pays, coinsurance, or deductible amounts must be paid at each visit. In the case of high deductible plans (including HRAs and HSAs), the contracted amount will be due from the patient at the time of service. If you require a procedure, a member of our staff will contact your insurance company to confirm eligibility and gain an estimate of your benefits. Prior to the procedure, you are required to pay in full for your estimated out-of-pocket expense related to the procedure. Patients with a history of not paying these fees may be discharged from our practice and their insurance carrier will be notified. Payment must be made in full for any services considered by your insurance as "non-covered" or "not reasonable or necessary".

Some insurance companies may require a pre-certification or pre-authorization for certain services. While we will gladly assist you with this process, the final responsibility to ensure that any such requirements are completed prior to treatment is yours. Denied charges due to lack of proper pre-certification/pre-authorization will be billed to you.

IF YOU DO NOT HAVE INSURANCE

A minimum deposit of $250 is due at check in for all self-pay patients. Charges for follow up visits will be due at the time of service.

NO SHOWS

Please try to give our office 24 hours advance notice of cancellation so we may offer the appointment to another patient. Repeatedly missing appointments without adequate notice may lead to dismissal from the practice.

PAYMENTS

We accept cash, check, credit cards, apple pay and CareCredit. We are able to keep your credit card on file with a signed authorization form.

RETURNED CHECKS

There is a $35 service fee for all checks returned for non-sufficient funds. A third-party service will attempt to have the check clear your account twice before returning it to us as uncollectable. Patients who have written returned checks will be required to pay for subsequent visits using cash or a credit card.

COLLECTIONS

If you are unable to pay your account in full as billed, please contact our office to make other financial arrangements. Overdue accounts with inactivity after 90 days may be assigned to a collection agency for follow up. Regrettably, patients referred to collections will be dismissed from our practice.

PATIENT REFUNDS

After all insurance balances have been settled, we will issue patient refund checks for credit amounts over $10. Checks are written once per month. Due to administrative costs, credit balances under $10 will be held on account for a return appointment.

MEDICAL RECORDS

In order that we may keep your information up to date, please inform us of any changes, including insurance, address, or phone number.

We are happy to complete disability, FMLA etc. forms for our patients. Before leaving the form with us, please make sure you have filled in the patient portion. There will be a $15 fee for your first form and a $5 fee for any related follow up form. Please allow five business days for processing. A signed release form is required before we are able to send completed forms.

Upon your request, copies of x-rays and medical records may be made available for your pick up by giving us a 48-hour notice. As a courtesy, the first two x-ray films are free. Each film thereafter is $10. X-ray discs are $5 each. There will be a minimum charge of $10 for medical record copying; however, with your written authorization we are happy to fax your medical records directly to another physician at no charge.

By signing below, I acknowledge that I have read the above financial information and agree to adhere to the policies outlined.

Signature: _X_____ **Date:** _____

Patient or Personal Representative

AUTHORIZATION TO RELEASE INFORMATION TO FAMILY/FRIENDS

Patient Name: _____ **Date of Birth:** _____

Carolina Foot and Ankle is authorized to release protected health information about the above-named patient to the entities named below:

Check each person/entity approved to receive information.	Check type of information that can be given to person/entity on the left in the same section.
☐ Are we able to leave a voice mail for you? Please indicate the type of information we are able to leave in the voice mail in the section to the right.	☐ Results of lab tests/x-rays ☐ Appointment reminders ☐ Other_____
☐ Other person (s) we may speak to about you. (Provide name and **phone number**) What type of information may we discuss? 1._____ 2._____ 3._____	☐ Financial ☐ Medical ☐ Able to pick up supplies ☐ Permission to bring minor/dependent and to consent for treatment
☐ Email Communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Medical ☐ Breach notification
☐ Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Other: _____
☐ For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	

Patient Rights:

- I have the right to revoke this authorization at any time by contacting our office.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

Please note that we we participate in NC HealthConnex (North Carolina's state-operated Health Information Exchange). More information about the exchange, including details about how to opt out can be found at hiea.nc.gov/patients

Notice of Privacy Practices: Our notice of privacy practices provides information about how we may use and disclose protected health information about you. It also provides information about your rights as a patient of our practice and whom you may contact at our office to ask questions about our privacy practices. By signing below, you are agreeing that you have had the opportunity to read our notice of privacy practices.

Signature: X_____ **Date:** _____

Patient or Personal Representative