CAROLINA FOOT AND ANKLE ASSOCIATES

To Whom It May Concern,

In an effort to comply with Medicare requirements and guidelines, Carolina Foot & Ankle Associates created a policy for all new nursing home patients to facilitate the appointment process. Unfortunately, we continue to have problems with patients arriving without authorization to be treated, without adequate medical histories, or without an apparent reason for the referral.

Because of this concern, we are now requiring a family member or power of attorney to be with the patient at each visit.

Effective immediately, all patients from a facility will require the following:

1. For new patients, paperwork must be completed in full and returned to CFAA for our staff to review **prior to scheduling**. We are happy to send and receive the paperwork via fax for your convenience. If the patient is not responsible for his or her bills, the power of attorney must sign on the patient's behalf. Please provide the following information:
    a. Complete list of current medications & allergies
    b. Complete medical problem list (if the patient does have severe PVD, it must be noted to ensure coverage for palliative services)
    c. Copy of all insurance cards
    d. A written order stating the reason for the patient's appointment.
2. Any established patients receiving routine foot care must pay the $60 visit fee at the time of service. If the patient is not responsible for their bills and there is no power of attorney, please note that we will hold the facility responsible for any unpaid routine care charges.
3. Medicare patients who do not have secondary coverage must pay their coinsurance at the time of service.

If you have any questions regarding the above policy, please feel free to contact me directly. Thank you in advance for your cooperation.

Sincerely,
Laura D.
Practice Coordinator

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CAROLINA FOOT & ANKLE ASSOCIATES

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

MEDICAL HISTORY

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

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CAROLINA FOOT & ANKLE ASSOCIATES, PLLC
DEMOGRAPHICS

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

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

Gender: _____ Preferred Name: _____

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

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

Ethnicity: ☐ Hispanic ☐ Non-Hispanic Gender: _____ 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, PLLC
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 can 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, 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 agree that you have had the opportunity to read our notice of privacy practices.

Signature: X_____ **Date:** _____

Patient or Personal Representative

CAROLINA FOOT & ANKLE ASSOCIATES, PLLC
Office Policies

Patient Name: _____ Date of Birth: _____

YOUR INSURANCE

Please note that our primary relationship is with you as our patient, rather than your insurance company. If we participate with your insurance, we are pleased to file your claim on your behalf. However, we are unable to file third party payer claims for motor vehicles, workers' compensation, or other accidents.

In accordance with our insurance contracts, we are required to collect your portion of payment at the time services are provided. This includes any applicable co-pays, coinsurance, or deductible amounts, which should be paid at each visit. For high-deductible plans (including HRAs and HSAs), the contracted amount will be due at the time of service.

Should you require a procedure, a staff member will verify your insurance eligibility and obtain an estimate of your benefits. Prior to the procedure, payment of your estimated out-of-pocket expense is requested in full. Payment is also required in full for any services your insurance considers "non-covered" or "not reasonable or necessary."

IF YOU DO NOT HAVE INSURANCE

For self-pay patients, a minimum deposit of $250 is requested at check-in. Charges for follow-up visits are due at the time services are rendered.

PAYMENTS

We accept cash, checks, credit cards, and mobile payment options. With your signed authorization, we may securely retain your credit card information on file for your convenience.

RETURNED CHECKS

A $35 service fee applies to any checks returned for non-sufficient funds. A third-party service will attempt to process the check twice before it is returned to us as uncollectable. Patients with returned checks may be asked to pay for subsequent visits using cash or a credit card.

COLLECTIONS

If you are unable to pay your account in full as billed, we encourage you to contact our office to discuss alternative financial arrangements. Accounts with no activity after 90 days may be assigned to a collection agency for follow-up. Patients referred to collections may be dismissed from our practice.

PATIENT REFUNDS

Once all insurance balances have been resolved, refund checks for patient credit amounts over $10 will be issued. Refunds are processed once per month. Credit balances under $10 will be held on account and applied toward a future appointment.

NO SHOWS

For all scheduled appointments, we kindly request at least 24 hours' notice if you need to cancel. Repeated missed appointments without sufficient notice may result in dismissal from the practice. A rescheduling fee of $35 will be charged for cancellations with less than 24 hours' notice and for missed appointments.

MEDICAL RECORDS

To keep your information up to date, please inform us of any changes, including insurance, address, or phone number.

We are pleased to assist our patients by completing disability, FMLA, and similar forms. Please ensure that you have completed the patient portion of the form prior to submitting it to us. There is a $15 fee for the initial form and a $5 fee for each related follow-up form. Please allow up to five business days for processing. A signed release form is required before we can send completed forms.

Upon your request, copies of x-rays and medical records may be made available for pickup with 2 business days' notice. X-ray discs are $5 each. With your written authorization, we are happy to fax your medical records directly to another physician at no charge.

RETURN POLICY

In accordance with the North Carolina Board of Pharmacy (NCBOP) guidelines, to ensure the purity and safety of all prescription products, we are unable to accept returns once a product has left our office. This includes returns due to allergic reactions, irritation, or any other reason. We would like you to be informed of this policy at the time of purchase. A copy of this policy will be kept in your chart and is available for your review at any time. This policy applies to all products purchased at Carolina Foot & Ankle Associates facilities.

ZERO TOLERANCE POLICY

We are committed to maintaining a safe and respectful environment for our staff and patients. We ask that all patients and companions refrain from aggression, demanding behavior, verbal abuse, or sexual harassment. Such behavior will result in dismissal from our practice. By signing below, I acknowledge that I have read and understand the above policies and agree to follow them.

USE OF AI TOOLS AND EQUIPMENT

We may use secure audio recording and artificial intelligence (AI) tools during your visit to help your provider document your care more accurately and efficiently. Any recordings are protected under federal and state privacy laws, including HIPAA. You may choose not to be recorded at any time, and saying no will not affect your care in any way.

By signing below, I acknowledge that I have read and understand the above policies and agree to follow them.

Signature: X_____ **Date:** _____

Patient or Personal Representative