We would like to take a moment and welcome you to Tri-County Foot & Ankle! We realize that you have a choice for your foot care needs and we thank you for choosing us. We want you to know that we are committed to working with you to keep your feet healthy and moving. To assist us in providing you with the best foot care possible please take your time and completely and honestly fill out our welcome packet. The quality of our care and your outcome depends on us obtaining a complete history. We thank you in advance for your time.

IMPORTANT
AT THE TIME OF YOUR FIRST VISIT WE REQUIRE YOUR ORIGINAL INSURANCE CARDS AND A VALID GOVERNMENT ISSUED PHOTO ID WITH ADDRESS. PHOTO COPIES WILL NOT BE ACCEPTED.
THIS POLICY IS FOR YOUR PROTECTION AND IS STRICTLY ENFORCED, NO EXCEPTIONS! PLEASE UNDERSTAND YOUR PRIVACY, IDENTITY, AND SECURITY IS OUR PRIORITY.

Upon your arrival a photo will be taken of you for our records as an additional form of identification.

Sincerely,

Tri-County Foot & Ankle

Personal Information

Full Legal Name: _____ D.O. B: _____
Mailing Address/ PO Box: _____
City: _____ State: _____ Zip: _____
Social Security_____ Marital Status: _____
Home Phone: (_____) _____Cell Phone: (_____) _____
Work Phone: (_____) _____

Family Doctor (FIRST & LAST Name): _____
Phone Number: (_____) _____ Family Doctor City, State: _____

Emergency Contact: _____ Relationship: _____
Home Address: _____
City: _____ State: _____ Zip: _____ Home Phone: (_____) _____

Primary Insurance: _____ Insurance ID#: _____
Group #: _____ Effective Date: _____
Primary Insured's Name: _____ D.O.B: _____
Relationship: _____ Social Security #: _____

Secondary Insurance: _____ Insurance ID#: _____
Group #: _____ Effective Date: _____
Primary Insured's Name: _____ D.O.B: _____
Relationship: _____ Social Security #: _____

Secondary or Seasonal Address (if different from above): _____
City: _____ State: _____ Zip: _____

Email Address: _____
Would you like access to your records online through our secure patient portal? ☐ Y ☐ N

Preferred Language: _____ Ethnicity (Circle One): Hispanic or Latin/Not Hispanic or Latin
Race (Circle One): American Indian / Alaskan Native / White / Black / Hispanic / Hawaiian Native / Pacific Islands

Local Pharmacy Name: _____Pharmacy Phone Number: (_____) _____
Pharmacy Address: _____

Patient Acknowledgment: I understand that I have the right to accept and refuse medical treatment and to exercise my right and implement an Advance Directive. "Advance Directive" refers to any legal document that informs family members and medical personnel how you wish to be treated if you are hospitalized and cannot communicate your wishes. Please check the following statements that apply:

- ☐ I Have Not executed an Advanced Directive
- ☐ I Have executed an Advanced Directive (Location of Form): _____
  - ☐ Living Will
  - ☐ Durable Medical Power of Attorney
  - ☐ Do Not Resuscitate (DNR) order
  - ☐ Designation of health care surrogate form Designatee/Guardian: _____

Signature of Patient or Legal Guardian: _____

Print Name of Patient: _____Date: _____

Receipt of Privacy Practices

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement if you wish.

This Section for Office Use Only

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient, but it could not be obtained because:

- ☐ The patient refused to sign
- ☐ Due to an emergency it was not possible to obtain an acknowledgment
- ☐ We were not able to communicate with the patient
- ☐ Other (Please provide specific details): _____
  _____

_____ _____
Employee Signature Date

Authorization of Protected Health Information

Tri-County Foot & Ankle is concerned about the privacy of our patient's health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights.

I acknowledge and agree that Tri-County Foot & Ankle may leave a message regarding billing questions, lab results, imaging studies, and medication request or refills on my home answering machine

☐ Brief Message ☐ Extended Message

I acknowledge and agree that Tri-County Foot & Ankle may disclose my protected health information and medical record information to the following individuals who are either, my family members, close personal friend, legal representatives, guardians, health care surrogates, or have power of attorney on my behalf:

Name	Relationship	Phone Number	Medical	Non-Medical
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Signature of Patient or Legal Guardian: _____

Print Name of Patient: _____Date: _____

The Patient Bill of Rights and Responsibilities

The goal of Tri-County Foot & Ankle is to provide all patients with high quality healthcare in a manner that clearly recognizes individuals' needs and rights. We also recognize that to accomplish this goal effectively, the patient and the health care provider must work together to develop and maintain optimum health. As a result, the following patient rights and responsibilities were written.

AS A PATIENT YOU HAVE THE RIGHT:

- ☐ To receive considerate care that is respectful of your personal beliefs and cultural and spiritual values
- ☐ To have all things explained to you in terms that you can understand and to have any questions answered concerning your diagnosis, prognosis, and treatment
- ☐ To appropriate assessment and management of your symptoms, including pain
- ☐ To know the contents of your medical records through interpretation by the provider
- ☐ To know who it is that is interviewing and examining you
- ☐ To have explained to you in a way that you can prevent your medical problem from recurring
- ☐ To refuse to be examined or treated by health providers and to be informed of the consequence of such decisions
- ☐ To be assured of the confidential treatment of disclosures and records and to have the opportunity to approve or refuse the release of such information except when the release of specific information is required by law or is necessary to safeguard you or the community
- ☐ To participate in the consideration of ethical issues that may arise in the provision of your care

AS A PATIENT YOU HAVE THE RESPONSIBILITY:

- ☐ To provide Tri-County Foot & Ankle with information about your current symptoms
- ☐ To provide Tri-County Foot & Ankle with information about past illnesses, hospitalizations, and medications
- ☐ To ask questions if you do not understand the directions or treatment being given by a provider
- ☐ To keep appointments or telephone the office at least 24 hours ahead if you need to cancel
- ☐ To be respectful of others and others' property while in our facility
- ☐ To keep an up to date list of all medications and to contact the office if there any changes
- ☐ To monitor prescription refill status and to initiate the refill process with a minimum of one week of medication remaining
- ☐ To treat all staff members with common courtesy whether in office or thru other means of communication

Signature of Patient or Legal Guardian: _____

Print Name of Patient: _____Date: _____

Office Financial Policy

1. We are required to make a copy of your original insurance cards for verification purposes. You may be billed for services rendered until the original insurance card is provided to our office. It is your responsibility to notify our office if there have been any changes to your insurance. As a courtesy, we will file to your primary and secondary insurance. It is your responsibility to make sure that your insurance company has the most recent address and contact information.

2. We will collect your deductible, coinsurance and/or copayment, and uncovered service fees at the time of service. Accepted payment methods are: Cash, Check, MasterCard, Visa, American Express, and Discover Card.

3. There may be a $25.00 charge on the following:
    a. All returned checks
    b. For any account(s) transferred to collections
    c. For the completion of short term disability paperwork, long term disability paperwork, and all FMLA paperwork prior to completion

4. There may be a charge for all missed appointments, or for failure to arrive within 15 minutes of your scheduled appointment.

5. Your insurance will send you an explanation of benefits that explains what they have paid to our office and what your responsibility is. This is a record that you MUST keep on file. If you do not agree with their payment, please contact your insurance company directly. If payment is not received within 30 days of the filing date with your insurance, you will be notified that payment is due.

6. Refusal to pay your balance with our office as designated by your insurance company including deductibles, co-payments, and coinsurances may be reported to your insurance company which may result in loss of coverage with your carrier.

7. If you are sent outside of the office for additional testing such as lab work or imaging, that facility will file to your insurance for you. If you have questions regarding billing or claim payment, call the facility directly. We do not have information regarding billing from outside of this office.

LIFETIME AUTHORIZATION FOR INSURANCE ASSIGNMENT AND AUTHORIZATION TO RELEASE INFORMATION

I. RELEASE OF INFORMATION – I, the below named patient, do hereby authorize any physician examining and/or treating me to release to any third payor (such as an insurance company or governmental agency, example: Blue Shield of Florida or Medicare) any medical condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

II. PHYSICIAN INSURANCE ASSIGNMENT - I, the below named subscriber, hereby authorize payment directly to any physician examining me of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for their services.

III. MEDICARE/MEDICAID - Patient's certification authorization to release information and payment request, I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration/Division of Family Services or its intermediaries or carriers any information needed for this of a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

IV. I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIANS OFFICE. This assignment will remain in effect until revoked by me in writing.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand it's my responsibility to pay the deductible amount, co-insurance, or any other balance not paid for by insurance or third payor within a reasonable period of time not to exceed 60 days.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

Signature of Patient or Legal Guardian: _____

Print Name of Patient: _____Date: _____

Name: _____ DOB: _____

Medication List

Please complete the following list with your current medications as prescribed to you by your other physician(s). Be sure to include dosage and frequency. You may attach a list as an alternative.

Date Prescribed	Medication	Dose	Quantity	Frequency

Name: _____ DOB: _____

Medical History

Please indicate with a (✓) any of the medical conditions below that pertain to you

- ☐ Abdominal Aortic Aneurysm
- ☐ Alzheimer's/ Dementia
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arthritis
- ☐ Atrial Fibrillation
- ☐ Back Pain
- ☐ Benign Prostatic Hypertrophy
- ☐ Bipolar Disorder
- ☐ Bleeding Disorders
- ☐ Blood Transfusion
- ☐ Bronchitis
- ☐ Cancer (type): _____
- ☐ Cardiomyopathy
- ☐ Chemical Dependency
- ☐ Circulatory Problems
- ☐ Congestive Heart Failure
- ☐ CVA (Stroke)
- ☐ Deep Venous Thrombosis (DVT)
- ☐ Depression
- ☐ Diabetes, Type II
- ☐ Diverticulitis
- ☐ DNR
- ☐ Edema
- ☐ Emphysema
- ☐ Fracture
- ☐ GERD
- ☐ Gout
- ☐ Headache
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Hypothyroidism
- ☐ Insomnia
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Macular Degeneration
- ☐ Mental Disorder: _____
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Palpitations
- ☐ Parkinson's Disease
- ☐ Phlebitis
- ☐ Pneumonia
- ☐ Polio
- ☐ Pulmonary Embolus
- ☐ Pulmonary Nodule
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Thyroid Nodule
- ☐ TIA (Transient Ischemic Attack)
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Other: _____

Allergies

Please indicate with a (✓) if you have any allergies to medications? ☐ No ☐ Yes, if yes, list below

_____

_____

Surgical History

Please indicate with a (✓) any of the surgical conditions below that pertain to you, and circle which anatomical side

- ☐ Amputation of Foot or Toes Right /Left
- ☐ Ankle Surgery Right /Left
- ☐ Bunion Surgery Right /Left
- ☐ Colon Surgery
- ☐ Foot Surgery Right /Left
- ☐ Fracture Repair, where: _____
- ☐ Hammertoe Surgery Right /Left
- ☐ Hip Replacement Right /Left
- ☐ Knee Replacement Right /Left
- ☐ Open Heart Surgery
- ☐ Organ Transplant
- ☐ Pacemaker/Defibrillator
- ☐ Vein Surgery/Artery Surgery
- ☐ Other _____

Name: _____ DOB: _____

Family History

Please indicate with a (✓) for family members who have had any of the following conditions

	Diabetes	Hypertension	Heart Disease	Cancer	Stroke	Unknown
Father						
Mother						
Siblings						
Children						

Social History

Please indicate with a (✓) any of the responses that pertain to you

Marital/Living Status:

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Employment:

☐ Currently Employed ☐ Retired ☐ Self Employed ☐ Unemployed

Exercise:

Do you exercise regularly? ☐ No ☐ Yes

Substances:

Alcohol:

Do you drink alcohol? ☐ No ☐ Yes: _____ Drinks Per Day

Drug Use:

Do you use any recreational drugs? ☐ No ☐ Yes

Tobacco Use

Cigarettes:

☐ Never

☐ Former Smoker: _____ Number of Years Quit Date _____

☐ Current Smoker: _____ Packs per day _____ Number of Years

Other Tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Are you interested in quitting? ☐ Not ready to quit

☐ Thinking about quitting

☐ Ready to quit

Name: _____ DOB: _____

Review of Systems

Please indicate with a (✓) any of the medical conditions below that pertain to you, if none of the below apply, (✓) Not Applicable

Cardiovascular
- □ Leg cramping
- □ Leg weaknes
- □ Clots in leg
- □ Feet cold
- □ Varicose Veins
- □ Not Applicable

Hematology/Lymph:
- ☐ Ease of bruising
- ☐ Ease of bleeding
- ☐ Swollen glands
- ☐ Not Applicable

Integumentary:
- ☐ Itching
- ☐ Rash
- ☐ Deformed nails
- ☐ Psoriasis
- ☐ Skin cancer
- ☐ Eczema
- ☐ Not Applicable

Constitutional:
- ☐ Fever
- ☐ Chills
- ☐ Fatigue
- ☐ Weight loss
- ☐ Weight gain
- ☐ Insomnia
- ☐ Weakness
- ☐ Not Applicable

Musculoskeletal:
- ☐ Muscle or joint pain
- ☐ Stiffness
- ☐ Back pain
- ☐ Redness of joints
- ☐ Swelling of joints
- ☐ Trauma
- ☐ Not Applicable

ENT:
- ☐ Hearing loss
- ☐ Ringing in ears
- ☐ Earache
- ☐ Nosebleeds
- ☐ Nasal discharge
- ☐ Sinus pain
- ☐ Dry mouth
- ☐ Sore throat
- ☐ Cold
- ☐ Cough
- ☐ Not Applicable

Ophthalmology:
- ☐ Diminished vision
- ☐ Red eyes
- ☐ Blurring of vision
- ☐ Dry eyes
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Not Applicable

Respiratory:
- ☐ Shortness of breath
- ☐ Chest pain
- ☐ Cough
- ☐ Wheezing
- ☐ Not Applicable
- ☐

Gastroenterology:
- ☐ Swallowing difficulties
- ☐ Heartburn
- ☐ Change in appetite
- ☐ Nausea
- ☐ Change in bowel habits
- ☐ Rectal bleeding
- ☐ Constipation
- ☐ Diarrhea
- ☐ Yellow eyes or skin
- ☐ Not Applicable

Neurology:
- ☐ Dizziness
- ☐ Fainting
- ☐ Seizures
- ☐ Weakness
- ☐ Numbness
- ☐ Tingling
- ☐ Tremors
- ☐ Not Applicable

Urology:
- ☐ Frequency
- ☐ Urgency
- ☐ Burning or pain
- ☐ Blood in urine
- ☐ Incontinence
- ☐ Change in urinary strength
- ☐ Not Applicable

Endocrinology:
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Sweating
- ☐ Frequent urination
- ☐ Thirst
- ☐ Change in appetite
- ☐ Not Applicable

Psychology:
- ☐ Nervousness
- ☐ Stress
- ☐ Depression
- ☐ Memory Loss
- ☐ Eating disorder
- ☐ Panic attacks
- ☐ Not Applicable

Allergy:
- □ Runny nose
- □ Scratchy throat
- □ Itchy eyes
- □ Ear fullness
- □ Sinus congestion
- □ Not Applicable