PATIENT NAME: _____

DATE OF BIRTH: ____/____/_____

PENSACOLA FOOT & ANKLE CENTER

850-477-9015

4850 N 9TH AVENUE
PENSACOLA FLORIDA 32503

AUTHORIZATION FOR RELEASE OF INFORMATION

I HEREBY AUTHORIZE PENSACOLA FOOT & ANKLE CENTER TO DISCLOSE MY PROTECTED HEALTH INFORMATION AS DESCRIBED BELOW. I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY. I UNDERSTAND THAT THE INFORMATION DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE SUBJECT TO DISCLOSURE BY THE RECIPIENT AND MAY NO LONGER BE PROTECTED BY FEDERAL OR STATE LAW. I UNDERSTAND THAT I MAY SEE AND COPY THE INFORMATION DESCRIBED ON THIS FORM IF I ASK FOR IT, AND THAT I WILL RECEIVE A COPY OF THIS FORM AFTER I SIGN IN. I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY GIVING NOTICE IN WRITING AT THE ADDRESS FOUND ABOVE, BUT IF I DO IT WILL NOT AFFECT ANY ACTIONS TAKEN BEFORE RECEIPT OF MY REVOCATION.

I UNDERSTAND THAT MY TREATMENT WILL NOT BE CONDITIONED ON WHETHER I PROVIDE AUTHORIZATION FOR THE REQUESTED USE OR DISCLOSURE EXCEPT (1) IF MY TREATMENT IS RELATED TO RESEARCH, OR (2) HEALTH CARE SERVICES ARE PROVIDED TO ME SOLELY FOR THE PURPOSE OF CREATING PROTECTED HEALTH INFORMATION FOR DISCLOSURE TO A THIRD PARTY.

PATIENT NAME:_____ DATE OF BIRTH_____
PERSONS/ORGANIZATIONS TO RECEIVE THE INFORMATION_____

THE SPECIFIC INFORMATION TO BE RELEASED/DISCLOSED IS SPECIFIED BELOW:
___COMPLETE MEDICAL RECORD ___OPERATIVE REPORTS ___X-RAYS ___PROGRESS NOTES
___BILLING AND CLAIM RECORDS___LABORATORY___OTHER-SPECIFY_____

THIS INFORMATION IS TO BE USED/DISCLOSED FOR THE FOLLOWING PURPOSES ONLY:

_____

(NO PURPOSE NEED TO BE STATED IF THE REQUEST IS MADE BY THE PATIENT AND THE PATIENT DOES NOT WISH TO STATE THE PURPOSE)

THIS AUTHORIZATION WITH EXPIRE ON _____(STATE DATE OR EVENT)

SPECIFIC AUTHORIZATION: I UNDERSTAND THAT MY HEALTH INFORMATION TO BE RELEASED MAY INCLUDE INFORMATION THAT IS RELATED TO SEXUALLY TRANSMITTED DISEASE, ACQUIRED IMMUNODEFICIENCY SYNDROME(AIDS), OR HUMAN IMMUNODEFICIENCY VIRUS(HIV), BEHAVIORAL OR MENTAL HEALTH SERVICES, AND/OR TREATMENT FOR ALCOHOL AND/OR DRUG ABUSE. MY SIGNATURE BELOW AUTHORIZES OF ALL SUCH INFORMATION UNLESS I HAVE SPECIFIED AND INITIALED IT.
_____YES _____NO INITIALS_____

I AUTHORIZE PENSACOLA FOOT AND ANKLE, TO RELEASE ANY OF MY MEDICAL INFORMATION, INCLUDING DRUG ALCOHOL AND HIV POSITIVE TEST RESULTS, TO MY INSURANCE COMPANY, AS NEEDED TO PROCESS MY INSURANCE CLAIM

_____ _____
SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE DATE

_____ _____
PRINTED NAME DATE

PATIENT NAME: _____

DATE OF BIRTH: ____/____/_____

PENSACOLA FOOT & ANKLE CENTER

850-477-9015

Patient Financial Agreement

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you with assignment of benefits to the doctor. You agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within 30 days of filing claim, we will have to look to you for payment.
- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. This means you agree to let your insurance company pay us directly when the claim is filed. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
  There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.
  There is a service fee of $25.00 for all returned checks/ $25.00 No Show fee for any missed appointments, not cancelled within 24 hours. Your insurance company does not cover this fee.
- Pensacola Foot and Ankle, Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing it.

I have read Pensacola Foot and Ankle Patient Financial Agreement/Acknowledgement of Notice of Privacy Practices

_____ _____

Signature of Patient or Authorized Representative Date Signed

PATIENT NAME: _____

PENSACOLA FOOT & ANKLE CENTER

DATE OF BIRTH: ____/____/_____

850-477-9015

	PHYSICIAN'S NAME	PHONE #	CITY	DATE LAST SEEN
PRIMARY CARE DOCTOR				____/____/_____
DIABETES DOCTOR				____/____/_____
ORTHOPEDIC DOCTOR				____/____/_____
OTHER PODIATRIST				____/____/_____

PLEASE LIST ALL DRUGS YOU ARE CURRENTLY TAKING. DRUGS INCLUDE PRESCRIPTION AND OVER THE COUNTER MEDICATIONS, HERBAL PRODUCTS, NUTRITIONAL SUPPLEMENTS, AND RECREATIONAL DRUGS.

MEDICATIONS

DRUG NAME	STRENGTH	PER DAY	PURPOSE FOR MEDICATION

ALLERGIES:

☐ NONE KNOWN

☐ MEDICATIONS _____

_____

☐ ANESTHESIA _____ ☐ FOODS _____

☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER _____

VACCINATIONS

☐ ZOSTER/SHINGLES DATE OF VACCINE _____/_____/_____

☐ TETANUS DATE OF VACCINE _____/_____/_____

☐ PNEUMOCOCCAL DATE OF VACCINE _____/_____/_____

☐ INFLUENZA DATE OF VACCINE _____/_____/_____

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 OF PATIENT, PARENT OR GUARDIAN SIGNATURE OF DOCTOR

_____ _____

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT DATE

PATIENT NAME: _____

DATE OF BIRTH: ____/____/_____

PENSACOLA FOOT & ANKLE CENTER

850-477-9015

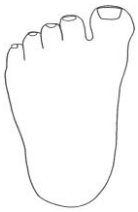
CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

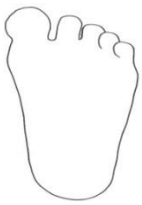
WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

LEFT FOOT

Top of foot



Bottom of foot

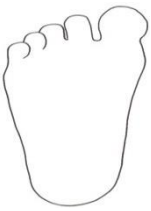


INSIDE OF FOOT

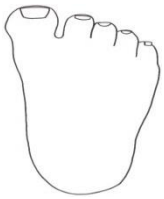
OUTSIDE OF FOOT

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 DEVELOPS OVER TIME
- HOW WOULD YOU DESCRIBE YOUR PAIN? ☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING ☐ RADIATING ☐ ITCHING ☐ STABBING ☐ OTHER _____
- HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%
- HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)
  (NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 *(WORST PAIN POSSIBLE)*
- SINCE YOUR PAIN OR PROBLEM BEGAN, 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? ☐ YES ☐ NO (DESCRIBE)_____

  IF YES, WAS IT A WORK-RELATED INJURY? ☐ YES ☐ NO

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 OF PATIENT, PARENT OR GUARDIAN SIGNATURE OF DOCTOR

_____ _____

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT DATE

PATIENT NAME: _____ **PENSACOLA FOOT & ANKLE CENTER**

DATE OF BIRTH: ____/____/_____ 850-477-9015

Shoe Size _____Height _____ Weight _____Pharmacy: _____ Location: _____

YOUR MEDICAL HISTORY

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N
OTHER CONDITIONS:											

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE
_____		_____	
_____		_____	
_____		_____	

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE
_____		_____	
_____		_____	
_____		_____	

SOCIAL HISTORY

- **MARITAL STATUS**: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED
- **USE OF ALCOHOL**: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE
  ☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY
- **USE OF TOBACCO**: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ ☐ SMOKE ____ PACKS/DAY FOR ____ YEARS
- **USE OF RECREATIONAL DRUGS**: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ TYPE _____
  ☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY
- **DO OTHERS DEPEND UPON YOU FOR THEIR CARE** ☐ CHILDREN–AGE(S) _____ ☐ PET(S)WHAT KIND? _____
  ☐ ELDERLY OR DISABLED FAMILY MEMBER ☐ OTHER _____
- **EXERCISE:** ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY

  TYPES OF EXERCISE: _____

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 OF PATIENT, PARENT OR GUARDIAN SIGNATURE OF DOCTOR

_____ _____

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT DATE

PATIENT NAME: _____ **PENSACOLA FOOT & ANKLE CENTER**

DATE OF BIRTH: ____/____/_____ 850-477-9015

PATIENT INFORMATION FORM

(PLEASE PRINT)

PATIENT NAME: _____ _____ ___ **TODAYS DATE: ___/____/____**
LAST FIRST MI

PATIENT DATE OF BIRTH: _____/_____/_____ AGE: _____ SEX: MALE / FEMALE

HOME ADDRESS: _____ CITY/STATE: _____ ZIP: _____

MAY WE LEAVE A MESSAGE?

HOME PHONE #: (____) ____-_____ YES NO CELL PHONE #: (____) ____-_____ YES NO
WORK PHONE #: (____) ____-_____ YES NO E-MAIL: _____ YES NO

PRIMARY LANGUAGE: _____ RACE_____

SOCIAL SECURITY NUMBER_____ -_____-_____

EMPLOYER: _____ OCCUPATION: _____

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO

IF YES, NAME: _____ RELATIONSHIP: _____ PHONE #: (____) ____-_____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE #: (____) ____-_____

NAME OF FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION

_____NO_____ YES NAME(S) _____

GUARANTOR NAME _____ RELATIONSHIP TO PATIENT _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____-____

WHO REFERRED YOU TO US?_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____-_____

INSURED NAME: _____ DATE OF BIRTH _____ EMPLOYER _____

CONTRACT # _____ GROUP # _____

SECONDARY INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____-_____

INSURED NAME: _____ DATE OF BIRTH _____ EMPLOYER _____

CONTRACT # _____ GROUP # _____

PATIENT NAME: _____

DATE OF BIRTH: ____/____/_____

PENSACOLA FOOT & ANKLE CENTER

850-477-9015

FAMILY HISTORY

CONDITION	MOTHER	FATHER	SISTER	BROTHER	GRANDMOTHER (M)	GRANDMOTHER (P)	GRANDFATHER (M)	GRANDFATHER (P)
ALZHEIMER'S								
ASTHMA								
BREAST CANCER								
CANCER								
DEMENTIA								
DIABETIC								
EMPHYSEMA								
HIGH BLOOD PRESSURE								
KIDNEY DISEASE								
PARKINSON'S								
STROKE								
ANEMIA								
BLEEDING DISORDER								
HEMOPHILIA								
SICKLE CELL ANEMIA								
ABNORMAL GAIT								
ACUTE ARTHRITIS								
BACK PAIN								
CLUB FOOT								
DEFORMITY								
FIBROMYALGIA								
OSTEOPOROSIS								
RHEUMATISM								
ALS								
ACOUSTIC NEUROMA								
MENINGITIS								
MENKES SYNDROME								
MIGRAINE								
SEIZURES								
TIA								
TREMOR								
AUTISM								
ANXIETY								
DEPRESSION								
SCHIZOPHRENIA								
CELIAC DISEASE								
CYSTIC FIBROSIS								
HEART DISEASE								
MUSCULAR DYSTROPHY								
NEUROFIBROMATOSIS								
TOBACCO USER								
SUBSTANCE USER								
ALCOHOL USER								

PATIENT NAME: _____

DATE OF BIRTH: ____/____/_____

PENSACOLA FOOT & ANKLE CENTER

850-477-9015

Pensacola Foot & Ankle Center

COMPLETE PODIATRIC MEDICAL AND SURGICAL CARE

4850 N. 9th Avenue, Pensacola Florida 32503 PH:850-477-9015 FX:850-478-5227

ADVANCE BENEFICIARY NOTICE (ABN)

- YOU ARE RECEIVING THIS NOTICE BECAUSE YOUR INSURANCE COMPANY MAY NOT PAY FOR ALL THE SERVICES THAT YOU RECEIVE DURING YOUR VISIT TO OUR OFFICE.

WHAT YOU NEED TO DO NOW:

- READ THIS NOTICE, SO YOU CAN MAKE AN INFORMED DECISION ABOUT YOUR CARE
- ASK QUESTIONS

Patient Name_____Date_____Insurance_____

SUPPLIES AND SERVICES	**REASON INSURANCE MAY NOT PAY**	**ESTIMATED COST**
In Office procedures, injections, imaging studies, x-rays	Non Covered Expense, copay, co-insurance, and / or deductible.	$0-$1500.00
Medical supplies/ Custom brace/ orthotics/ shoes/ Custom inserts		$0-1500.00

____YES I want to receive these services. If my commercial insurance carrier denies payment, I am completely responsible for payment in full. I understand that I can appeal this decision for nonpayment by my insurance carrier.

____NO I have decided not to receive these services

____OTHER should I decide to request these services in the future, I understand I will be charged and am responsible for payment in full.

BY SIGNING THIS NOTICE YOU AGREE TO TAKE FINANCIAL RESPONSIBILITY FOR THE COST OF THE SUPPLIES AND SERVICES LISTED ABOVE SHOULD YOUR INSURANCE COMPANY DENY COVERAGE FOR THE LISTED ITEMS.

Guarantor	Date: