FOOT AND ANKLE CENTER OF DURHAM

A division of InStride Foot & Ankle Specialists

Date:_____

Patient Demographics

First Name:_____M.I.:____ Last Name:_____Preferred Name:_____

Address:_____Apt/Unit#:____ City:_____State: _____Zip:_____

Email address: _____ **SSN**_____

Date of Birth **(MM/DD/YYYY):**_____ Living in Nursing Home or Facility? ☐ Yes ☐No

Phone: (H) _____ (M) _____ (O) _____

Reminder preference: ☐Email ☐ Text ☐ Phone Referred by: ☐PCP ☐Website ☐ Other: _____

Gender: ☐Male ☐Female Race: ☐White/Caucasian ☐Black/African American ☐Hispanic ☐Asian ☐Other:_____

Marital Status: ☐Single ☐Married ☐ Divorced ☐ Widowed Ethnicity: ☐ Hispanic/Latino ☐Not Hispanic/Latino

Primary Care Physician (PCP): _____ Last office visit (MM/YYYY):_____

Insurance card holder: _____ Date of Birth: _____

Who is responsible for patient's bills, if not the patient? ☐ Patient is responsible ☐ Other person (list below):
Name:_____Phone: (___) _____ Relationship to patient:_____

Authorization for Release of Information to Family and/or Friends *(Optional* Section)

I hereby authorize FAD to discuss my medical care and release my confidential protected health information (PHI) to:

☐Emergency Contact:_____ Phone:_____
Relationship to patient: Information to be released: ☐Any or ☐ As follows:_____

☐Primary Care Provider:_____ Phone: _____
Approximate date of last visit: Information to be released: ☐Any or ☐As follows:_____

☐Other: _____ Phone:_____
Relationship to patient: Information to be released: ☐Any or ☐As follows:_____

Rights of the patient:

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect a copy of the protected health information to be disclosed as described in this document by sending written notification to **Foot and Ankle Center of Durham, 3811 N. Roxboro St, Durham, NC 27704.** I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward from the date on the revocation.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization.

This authorization shall be in force and effect until revoked by the patient or representative signing the authorization on behalf of the patient.

_____ _____

Patient Signature, or Parent or Authorized Representative Signature (Representative must provide proof of authority over patient) Date

I acknowledge that I was offered, or provided, a copy of the Notice of Privacy Practice and that I have read (or had the opportunity to read if I so chose) and understand this Notice.

_____ _____

Patient Signature, or Parent or Authorized Representative Signature Date

FOOT AND ANKLE CENTER OF DURHAM
A division of InStride Foot & Ankle Specialists

Patient's Name: _____ Height: _____ Weight: _____ Shoe Size: _____ Date:_____

Chief foot complaint:_____How long have you had this problem?_____

Is the problem injury related? ☐ Yes ☐ No If yes, date of injury:_____Was the injury at work? ☐ Yes ☐ No
If so, is there a Worker's Comp claim? ☐ Yes ☐ No Worker's Comp Contact:_____ Phone: _____

Briefly describe the problem: _____

Have you received prior treatment from a physician or treated it yourself? (Check all that apply): ☐ No prior treatment

☐ Treatment:_____Surgery:_____When?_____ ☐ Antibiotic ☐ Anti-inflammatory
☐ Change in shoe gear ☐ Orthotics or insoles ☐ OTC products ☐ Trimming or cutting of lesions

Allergies: (Please check any drug/medication allergies you may have) ☐ No known drug allergies
☐Aspirin ☐Codeine ☐Latex ☐Lidocaine ☐Penicillin ☐Sulfa ☐ Other:_____

Medications
List all current medications (if you have a list, we can copy it): ☐No current medications ☐ See attached list

Drug Name	Strength (mg)	Frequency (how often?)	Prescribed by:

Pharmacy_____City/Street:_____

Medical History: (Check all you have or have had in the past)

☐ Alzheimer's	☐ Blood Clots	☐ Gout	☐ Kidney disease	☐ Stroke
☐ Anemia	☐ Cancer:_____	☐ Heart Disease	☐ Osteoporosis	☐ Thyroid disease
☐ Arthritis	☐ Diabetes Type I II	☐ HIV	☐ PVD	☐ Tuberculosis
☐ Asthma	☐ GI _____	☐ Hypertension	☐ Liver disease/hepatitis	☐ Other:_____

Surgical History: (Please check all that apply) ☐None apply
☐Angioplasty ☐Stent placement ☐Back surgery ☐Hip replacement ☐Knee replacement ☐Pacemaker
☐Surgery of the Ankle/Foot: ☐Bunion ☐Hammertoe ☐Joint fusion ☐Fracture

Social History
Tobacco: ☐Current smoker ☐Former Smoker ☐Never smoker Alcohol: ☐Never ☐Sometimes ☐Formerly

Family History

Alcoholism	Father	Mother	Brother	Sister	Heart Disease	F	M	B	S	Peripheral Vascular Disease	F M B S
Diabetes	F	M	B	S	Hypertension	F	M	B	S	Renal (kidney) disease	F M B S
Gout	F	M	B	S	Osteoarthritis	F	M	B	S	Stroke	F M B S
Cancer	F	M	B	S	Osteoporosis	F	M	B	S	Other:_____	F M B S

Review of Systems: (Please mark any current symptoms you are experiencing) ☐None of the following apply
Const: ☐Fatigue ☐Fever/Chills ☐Night Sweats ☐Recent weight loss/gain Skin: ☐Dry ☐Itchy ☐Rash
GU: ☐Frequent urination ☐Urinary incontinence Hem: ☐Easy bleeding ☐Easy bruising
Endo: ☐Heat/cold intolerance ☐Excessive sweating ☐Loss of body hair Resp: ☐Cough ☐Shortness of breath
Neuro: ☐Headaches ☐ Memory loss ☐Numbness/tingling Psych: ☐Anxiety ☐Depression
EENT: ☐Vision impairment/loss ☐Blurry vision ☐Hearing loss ☐Ringing in ears
Cardio: ☐Chest pain ☐Palpitations ☐Leg pain with exercise ☐Varicose Veins
GI: ☐Difficulty swallowing ☐Heartburn ☐Nausea ☐Vomiting ☐ Abdominal pain ☐Diarrhea ☐Constipation
MS: ☐Loss of muscle strength ☐Muscle weakness ☐Joint pain ☐ Back pain ☐Joint stiffness ☐Muscle aches

_____ _____
Signature of Patient or Person Completing Medical History Date

FOOT AND ANKLE CENTER OF DURHAM

A division of InStride Foot & Ankle Specialists

Financial Policy

- For patients with Insurance:
  - I have provided correct insurance information and understand I will be **responsible for payment at time of service** if I fail to disclose correct information to Foot and Ankle Center of Durham (FAD).
  - I authorize FAD to file a computerized claim form (paper or electronic) on my behalf.
  - I authorize benefits to be paid to me or on my behalf to the provider for the covered services. I authorize the release of any medical information to my carrier or its agents needed to determine benefits. I authorize FAD to pursue a formal appeal or grievance on my behalf for any denied claim that they feel should not have been denied. If my insurance fails to respond to the claim within **60 days,** FAD reserves the right to collect full payment from me.
  - I also agree to be responsible for any **co-payments, co-insurance, unmet deductibles, and non-covered services or supplies and understand that payment is due at the time of service.**

    Note: We recognize it is difficult to understand many of the points in today's insurance policies, with new plans and companies emerging constantly. Our office staff will make every attempt to follow the guidelines required by your insurance company. However, please understand that the contract is made between the insurance company and the patient. Therefore it is **your responsibility** to know and understand the details of your specific coverage.

- For patients with Medicare
  - Medicare will only pay for services that they determine to be "reasonable and necessary" under Section 1862(a)(1) of the Medicare law. The following services are ones we know are not covered by Medicare:
    - Routine Foot Care (debridement, cutting, or trimming of corns, toenails, or calloused tissues)
    - Prescription Foot Orthotics
    - Post-operative Surgical Shoes

- For patients with Medicare and that have changed to an HMO Insurance Policy (Medicare replacement plan):
  - I understand that if FAD does not participate with my HMO plan, I may be responsible for **payment in full** if there are no out-of-network benefits.

- For patients without insurance or on a plan that FAD does not participate with:
  - I understand that FAD's financial policy requires payment **in full at time of service.**

- Late Cancellation or No Show Fees:
  - There will be a fee of $50 for any appointment cancelled with less than 24 hours' notice or any appointment missed without prior communication to FAD.
  - There is a **cancellation fee** of $100 for surgeries cancelled with less than 1 full weeks' notice of the surgery date.

- Payments
  - FAD accepts American Express, Discover, MasterCard, Visa, Debit Cards, personal check, and cash.
  - If I am unable to pay my balance in full when due, I understand I need to contact FAD's **immediately at 919-471-1002.** I understand that failure to make payment on my account as required every 30 days will require further action to collect the balance in full and my credit rating will be affected. I understand that if regular monthly payments are not received, and no payment arrangements are made, FAD will no longer be able to extend credit to you for future visits and that an additional collection agency fee will also be added to the outstanding balance at the time of transfer to collections.

I have read the above financial policy in full and agree to comply with all of the listed policies.

_____ _____

Signature of Patient or Authorized Representative Date

Welcome to our New Patients

Our practice is a division of the **InStride Foot & Ankle Specialists, PLLC**. We have divisions across North and South Carolina, and we operate under one tax id number. As such, if you have seen any of the following physicians in the past three years, we need to know so that we will not file a new patient code for your visit today. Since the insurance carriers look at us as one large practice, if you have been seen at any of the following divisions, you will not be considered a new patient in our practice. **Visits prior to 2014 do not need to be disclosed**.

Please review the names of the divisions and podiatrists below and indicate if you have been seen at any of these divisions by putting a √ on the line to the left of the practice name. Thank you for disclosing this information to us – it will allow us to be in compliance with nationally mandated correct coding initiatives.

	Division	Podiatrist
___	Alta Ridge Foot Specialists	Robert van Brederode, William Broyles, Thomas Verla
___	Ankle & Foot Center of Charlotte **(Resigned from group 7/1/2017)**	Scott Basinger
___	Brunswick Foot & Ankle Surgery, PA	Joseph Kibler
___	Carmel Foot Specialists	Barbara Kaiser, Richard Lind, Richard Miller, Kevin Molan, Tori Simmons-Lewis
___	Carolina Foot & Ankle Health Center	Millicent Brown
___	Carolina Foot Care Associates, PLLC	Ashma Davidson, Terry Donovan, William O'Neill
___	Carolina Podiatry Group	Brandon Percival, Julie Percival, William Harris
___	Central Carolina Foot & Ankle Associates	Melissa Hill, Gary Liao, Alan Sotelo, Phil Ward (retired), John Iredale (retired)
___	Chapel Hill Foot & Ankle Associates, P.A.	Jane Andersen, Alan Bocko, Katherine Williams
___	Charlotte Foot & Ankle Specialists, PLLC **(resigned from group 8/1/2017**	Kristine Strauss
___	Coastal Carolina Foot & Ankle	Thomas Hagan, Tyler Hagan
___	Comprehensive Foot & Ankle Center, P.A.	Zack Nellas
___	Crystal Coast Podiatry	Thomas Bobrowski
___	Eastover Foot & Ankle, P.A. **(Resigned from Group 1/1/17)**	Chris Fuesy, Ron Futerman, Kent Picklesimer
___	Family Foot & Ankle Center, P.A.	Patrick Dougherty, Doug Smith
___	Family Foot Care	Kevin McDonald
___	Foot & Ankle Center of Durham	Eric Simmons
___	Foot & Ankle of the Carolinas, PLLC	Eric Ward, Blaise Woeste
___	Gaston Foot & Ankle Associates, P.A.	David Kirlin, Ryan Meredith, Wagner Santiago, **Randell Contento (7/1/2017)**
___	Greensboro Podiatry Associates, P.A.	Martha Ajlouny, N'Tuma Jah
___	Hendersonville Podiatry	Russ Barone, Pam Stover
___	James Mazur, D.P.M., P.A.	James Mazur
___	Kinston Podiatry	Dale Delaney
___	Matthews Foot Care	Brian Killian, Kevin Killian, David Ellenbogen
___	Mt. Airy Foot & Ankle Center, PLLC	Jim Shipley
___	Myers Podiatric Clinic	William Myers
___	Piedmont Foot & Ankle Clinic	Rick Hauser, Rob Lenfestey (retired), Jason Nolan, Joel Kelly, Elizabeth Bass Daughtry, Jacob Panici
___	Piedmont Podiatry Associates	Subodh Choudhary, Nicholas Canoutas, Cassandra Pike, Sarah Fitzgerald, Smitha Jospeh (retired)
___	Queen City Foot & Ankle Specialists, P.C.	Roxanne Burgess, Alison Garten
___	Raleigh Foot & Ankle	Alan Boehm, Robert Hatcher, Jordan Meyers, Kirk Woelffer
___	Ryan Foot & Ankle Clinic	David Garchar, Jeff Glaser, Michael Ryan, Scott Whitman, Matthew Borns
___	Salem Foot Care	Walter Falardeau, Scott Matthews
___	Summit Podiatry (Starting 5/1/2017)	Derek Pantiel
___	Upstate Foot Care	Hans Blaakman
___	Wake Foot & Ankle Center	Mike Hodos, Jim Judge
___	Wilson Podiatry Associates, PA	Kendall Blackwell

__ I attest that I have been seen in the above indicated division of the InStride since 01/01/2013.

__ I attest that to my best recollection, I have not been seen by any of the above divisions/physicians since 01/01/2013.

Signature of patient: _____ Date: _____

Printed Name: _____ DOB: _____