WELCOME TO OUR OFFICE

Patient Name:______________________DOB:______________SSN:___________________

Address:___________________________ City:________________State:_____ Zip:________

Alternate Address:___________________ City:________________State:_____ Zip:________

Home Phone:______________________ Cell:________________E-mail:________________

Occupation:_________________________ Employer:_________________________________

How did you hear about us?____

This information is required for electronic health records which is mandated by the government to comply with meaningful use

Ethinicity:_____Caucasian ____African American ____Hispanic ____Asian___Other Race ____Declined

Language:____English ____Spanish____Other

INSURANCE INFORMATION:

Primary Insurance:__________________________ Secondary Insurance:__________________

PRIMARY CARE PHYSICIAN:

Dr. ______________________________City:___________________State:_________________

Phone:_________________ Date of Last Visit:________________Hgb A1C (Diabetes):_______

EMERGENCY CONTACT: **RELEASE OF INFORMATION**

Name:____________________________________Name:_______________________________

Relationship:______________Phone:___________Relationship:__________Phone:_______

Do you have a Living Will/Advanced Directive?______________

Signature of Patient/Guardian:_____________________________Date:__________________

MEDICAL INFORMATION

Patient Name: ________________Height:__________Weight:___________Shoe Size:________

What are you being seen for today?____
Was this caused by an injury?_______If yes, Date of Injury________Any previous treatments?________

MEDICATIONS AND DOSES/See attached

__________________________, ____________________, ___________________________

__________________________, ____________________, ___________________________

Have you had any of the following vaccines:______ Flu Shot ____Pneumovax ___Shingles _______Covid

PHARMACY
Name:_______________________Location:________________Phone:________________

ALLERGIES

___Aspirin ___Latex___Dyes____Penicillin____Lidocaine____Codeine ______Shell Fish _____ Sulfa____None

HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS

Arthritis____ Vascular Disease____Kidney Disease____ HIV____Depression____
Osteoporosis____ Hepatitis____ Neuropathy____ IBS____No Past Illness___
Bleeding Disorders____Heart Disease____ Hypertension____ Reflux Disease____
Blood Cots____ High Cholesterol____Epilepsy____ Stomach Ulcers____
Stroke____ Diabetes____ Lung Disease____ Thyroid Disease____

Other:
Do you have bulging or varicose veins? Yes___ No___

Do your legs ever feel heavy, tired, or achy-especially at the end of the day? Yes___ No___

Do your legs swell at the end of the day? Yes___ No___

Have you ever fhad a thrombus or blood clot in your leg(s)? Yes___ No___

Is the skin below your knees darker in color or hard? Yes___ No___

Have you ever had an ulcer or open sore on your lower leg? Yes___ No___

Have you ever worn been advised to wear compression stockings? Yes___ No___

Past Surgical History

_____Heart Surgery _____Spine _____Cancer _____Vein Surgery _____**NO PAST SURGERIES**
_____Pacemaker _____Joint Replacement _____Gynecological _____Vascular Surgery

Have you had any procedures done on your feet or legs? Yes___ No___

If yes, please explain____

Current Informaton

Pregnant?	___Yes	___No
Do you smoke cigarettes/cigars?	___Yes	___No
If Yes, how many per day___________________		
Are you a former smoker	___Yes	___No
Do you have a history of drug use	___Yes	___No
Do you drink alcohol?	___Yes	___No

Family Medical History

Mother_____Alive	____Deceased	Medical Illnesses:______________________	
Father:	_____Alive	____Deceased	Medical Illnesses:______________________
Sister:	_____Alive	____Deceased	Medical Illnesses:______________________
Brother:	_____Alive	____Deceased	Medical Illnesses:______________________

I authorize, Favor Foot and Ankle Podiatry PC and/or any healthcare professional to perform a physical examination, diagnostic testing, procedures and to prescribe a therapeutic regimen. I also authrize Favor Foot and Ankle Podiatry PC and the staff to release and /or collect information including diagnosis acquired in the course of my exam to/from any healthcare facilities, physicians or insurance carriers.

Patient/Guardian Signature:_____________________________ Date:_____________

Photo and Promotional Release Form

I hereby consent to be interviewed, recorded, photographed, videotaped or filmed by representative of the Favor Foot and Ankle Podiatry PC for purposes of publicaton, display or broadcast (print,web,digital display and all other forms of media).

I agree that such interviews, recording, articles, quotes, photographs, films, audio or video and /or any reproductions of same in any form, are the property of Favor Foot and Ankle Podiatry PC, and I relinquish any present or future claim for reimbursement for said photographic of film reproduction of my likeness or for said testimonials by me.

I hereby release the Favor Foot and Ankle Podiatry PC , its affiliates, employees, representatives and agents from any and all claims, demands, costs and liability that may arise from the use of these interviews, recordings, photographs, videotapes or films and/or any reproductions of same in any form, as the described above, arising out of being interviewed, recorded, photographed, videotaped or filmed.

I acknowledge I have read this consent form in its entirety, or has been read (or translated) to me, and I have had the opportunity to ask questions about it and understand it.

____
Name/Parent or Legal Guardian name *(print)

___________________________ ___________________
Signature/Signature Parent or Legal Guardian * Date

___________________________ ___________________
Witness Date

Parent or Legal Guardian anme and signature required for individuals under age of 18

___ I do not wish to consent to any photography or promotional represenation. I opt ouf of any interviews, recordings, photographs, videotape and filming.

FINANCIAL POLICY

PLEASE read and understand Favor Foot Ankle Leg and Wound Centers financial policy that is as follows:

I understand that it is ultimately my responsibility to understand my insurace contract and what I will be responsible for financially.

I understand and agree that **I am responsible** for any copay, coinsurance and deductible amounts that are part of my insurance contract.

We have prepared this to help you understand the complexities of medical insurance, realizing how confusing it can be. To begin, we would like to highlight a misconception; medical insurance was not designed for to pay for all medical care. Most contracts have limits and or various degrees of payment.

All levels of payment by insurance companies, including allowed fees, usual and customary UCR, are governed by the premiums paid. They have nothing to do with the actual charges by a position. Our fees are based upon a combination of our cost, our time, and our constant dedication to supplying our patients with the highest quality medical care. The treatment recommended by our office is never based on what your insurance company will pay; your treatment should not be governed by our your insurance contract.

I hereby except responsibility to pay for any services provided to me that is not covered by my insurance, along with DME products: ace bandages, shower bags, stockings, orthotics, walking boots, postop shoe, creams, lotions, etc.). All products are nonrefundable. Payments are due at time of service. If the balance or payment arrangements are not paid within the first 30 days of the statement, then the account will be sent to a collection agency. At which time the current balance will encourage an additional 35% collection fee.

Our office has a policy for any self-pay treatments with the doctor and our medical pedicure program that are canceled in less than a 24 hours from your schedule appointment time or you should parentheses no show there will be a $50 fee. The reason for this is to encourage our patients to take their appointments as seriously as we do. That time is reserved for you and if you do not keep your appointment then other patients who need an appointment the schedule permits are being obligated to wait longer than necessary.

Signing below means you have read and agree to all terms of this policy.

I hereby authorize payment a medical benefits bill to my insurance to Favor Foot Ankle Leg and Wound Center.

Print Patient Name:___________________________________

Patient Signature:____________________________________ Date:____________

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plan for a future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care. A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that service is billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of health care professionals.

I understand and have been provided with a notice of privacy practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and that I may contract this organization at any time at the address above to obtain a current copy of the notice of privacy practices. I understand that I have the right to request restrictions as to how my health information maybe used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Patient Name: ____

Relationship to Patient: ____

Signature: ____

Date: ____

OFFICE USE ONLY

I attempted to obtain the patient signature and acknowledgment on this Notice of Privacy practices acknowledgment, but was unable to do so as documented below:

Date:	Initials:	Reason: