CENTRAL CAROLINA FOOT & ANKLE ASSOCIATES
A division of InStride Foot & Ankle Specialists

Chart No: ______________
(staff use only)

Patient Registration Form
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): ___ ___/___ ___/___ ___ ___ ___ Pref. Language: ☐English ☐Spanish ☐ Other: ____________

Phone: (______) ____________ ☐Home ☐Cell Secondary Phone: (______) ____________ ☐Home ☐Cell ☐Other: _________

Reminder preference: ☐ Email ☐ Text ☐ Phone Call

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

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

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 CCFA 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 ☐ As follows:__________________

☐ Primary Care Provider: _____________________________________ Phone: (______) ____________
Approximate date of last visit:___________ Information to be released: ☐ Any ☐ As follows:__________________

☐ Other: ____ Phone: (______) ____________
Relationship to patient: __________________ Information to be released: ☐ Any ☐ 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 **Central Carolina Foot & Ankle Associates, Medical Records, Attn: Security Officer; 4119 Capitol Street; 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 Date
(Representative must provide proof of authority over patient)

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

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Chart No: ______________ (staff use only)

Patient Name: __________________________ Height: ________ Weight: ________ Shoe Size: _______

Reason for Visit

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 how the injury occurred: ____

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

☐ Treated by Dr. _____________ ☐ Surgery: ______________ When? ________ ☐ Antibiotic ☐ Anti-inflammatory

☐ Change in shoegear ☐ 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 Please check box on any of your current/past conditions: ☐ None of the following apply

☐ Alzheimer's ☐ Blood Clots ☐ Gout ☐ Liver disease/hepatitis ___ ☐ Stroke

☐ Anemia ☐ Cancer (type:____________) ☐ Heart disease ☐ Osteoporosis/penia ☐ Thyroid disease

☐ Arthritis ☐ Diabetes Type: ☐ I ☐ II ☐ Hypertension ☐ Periph. Vasc. Disease(PVD) ☐ Tuberculosis

☐ Asthma ☐ GI problems: (___________) ☐ HIV ☐ Renal (kidney) disease ☐ Other:_______

Surgical History Please check all that apply ☐ None of the following apply

☐ Angio ☐ Stent placement ☐ Back surgery ☐ Hip replacement ☐ Knee replacement ☐ Pacemaker

☐ Surgery of the Ankle/Foot: ☐ Bunion ☐ Hammertoe ☐ Joint fusion ☐ ORIF

Social History

Tobacco: ☐ Current smoker ☐ Former Smoker ☐ Never smoker Alcohol: ☐ Never ☐ Drinks alcohol ☐ Formerly

Family Medical History Which of your family members (Father, Mother, Brother, Sister) have/had the following:

Alcoholism	Father Mother Brother Sister	Heart Disease	F M B S
Diabetes	F M B S	Hypertension	F M B S
Gout	F M B S	Osteoarthritis	F M B S
Cancer	F M B S	Osteoporosis	F M B S
Type?	_______ _______ _______ _______		

Peripheral Vascular Disease	F M B S
Renal (kidney) disease	F M B S
Stroke	F M B S
☐ Other: _________________	F M B S
☐ No relevant family history	

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

GU: ☐ Frequent urination ☐ Urinary incontinence

Endo: ☐ Heat/cold intolerance ☐ Excessive sweating ☐ Loss of body hair

Neuro: ☐ Headaches ☐ Memory loss ☐ Numbness/tingling

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

Skin: ☐ Dry skin ☐ Itchy skin ☐ Rash

Hem: ☐ Easy bleeding ☐ Easy bruising

Resp: ☐ Cough ☐ Shortness of breath

Psych: ☐ Anxiety ☐ Depression

____ ___________

Signature of Patient or Person Completing Medical History Date

____ ___________

Signature of Physician Reviewing Medical History Date

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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 Central Carolina Foot & Ankle Associates (CCFA).
    - I authorize CCFA 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 CCFA 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**, CCFA 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**. Re-billing and collecting fees may apply for past due accounts.

        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)
        - Post-operative Surgical Shoes
        - Wound care supplies
        - Vitamin B-12 injections
        - Prescription Foot Orthotics
        - Laser treatments
        - Routine Pre-operative blood work/lab handling fees
        - Treatment of warts or benign lesions
        - Night Splints/podous boots)

- For patients with Medicare and that have changed to an HMO Insurance Policy (Medicare replacement plan):
    - I understand that if CCFA 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 CCFA does not participate with:
    - I understand that CCFA's financial policy requires payment **in full at time of service**.

- Late Cancellation or No Show Fees:
    - There will be a fee (according to the length of the appointment) for any appointment cancelled with less than 24 hours' notice or any appointment missed without prior communication to CCFA.
        - Less than 30 min: $35
        - 30 minutes: $50
        - 1 hour/orthotic casting: $75
    - There is a **cancellation fee** of $100 for surgeries cancelled with less than 1 full week's notice of the surgery date.

- Payments
    - CCFA accepts American Express, Discover, MasterCard, Visa, Honor Debits, and CareCredit Cards, personal check, and cash.
    - I understand there is a $100 minimum charge to use **CareCredit** and that CCFA only participates with the 6-month, no interest plan.
    - If I am unable to pay my balance in full when due, I understand I need to contact CCFA's **billing supervisor immediately at 919-421-3701.** A re-billing fee of $5.00 will be charged monthly to any balance over 30 days past due. 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, CCFA 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