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

Primary Care Doctor: _____ Phone: (_____) _____

Approximate date of last visit:_____ Information to be released: ☐ Any ☐ As follows:_____ ☐**NONE**

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:_____

☐ 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. (located in brochure holder at check-in area)

_____ _____

Patient Signature, or Parent or Authorized Representative Signature Date

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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

Pharmacy: _____ **City/Street:** _____

Allergies Please check any drug/medication allergies you may have: or ☐ 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): or ☐ No current medications ☐ See attached list

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

Medical History Please check box on any of your current/past conditions: or ☐ None of the following apply

☐ Alzheimer's
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Cancer (type:_____)
☐ Blood Clots
☐ Diabetes ☐ I ☐ II
- Last A1C:_____
- Result:_____
☐ GI problems:_____
☐ Gout
☐ Heart disease
☐ Hypertension
☐ HIV
☐ Liver disease
☐ Hepatitis ___
☐ Osteoporosis
☐ Osteopenia
☐ Periph. Vasc. Disease(PVD)
☐ Renal (kidney) disease
☐ Stroke
☐ Thyroid disease
☐ Tuberculosis
☐ Other:___

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

☐ Angio ☐ Stent placement ☐ Back surgery ☐ Bunion ☐ ORIF ☐ Hammertoe ☐ Hip replacement
☐ Knee replacement ☐ Pacemaker ☐ Other: _____

Social History

Tobacco: ☐ Current smoker - Type: ☐ Cigarettes (packs per day:_____) ☐ Cigar ☐ E-Cigarette ☐ Chewing tobacco
☐ Former Smoker - Age stopped: _____ ☐ Never smoker

Alcohol: ☐ Never ☐ Drinks alcohol ☐ Former

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

Alcoholism	Father	Mother	Brother	Sister
Diabetes	F	M	B	S
Gout	F	M	B	S
Cancer	F	M	B	S
Type?	_____	_____	_____	_____

Heart Disease	F	M	B	S
Hypertension	F	M	B	S
Osteoarthritis	F	M	B	S
Osteoporosis	F	M	B	S

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: or ☐ None of the following apply

☐ Fatigue
☐ Fever/Chills
☐ Night Sweats
☐ Recent weight loss
☐ Recent weight gain
☐ Vision impairment
☐ Vision loss
☐ Blurry vision
☐ Hearing loss
☐ Ringing in ears
☐ Chest pain
☐ Palpitations
☐ Leg pain with exercise
☐ Varicose Veins
☐ Cough
☐ Shortness of breath
☐ Difficulty swallowing
☐ Heartburn
☐ Nausea
☐ Vomiting
☐ Abdominal pain
☐ Diarrhea
☐ Constipation
☐ Frequent urination
☐ Urinary incontinence
☐ Heat/cold intolerant
☐ Excessive sweating
☐ Loss of body hair
☐ Easy bleeding
☐ Easy bruising
☐ Loss of muscle strength
☐ Muscle weakness
☐ Joint pain
☐ Back pain
☐ Joint stiffness
☐ Muscle aches
☐ Headaches
☐ Memory loss
☐ Numbness/tingling
☐ Anxiety
☐ Depression
☐ Dry skin
☐ Itchy skin
☐ Rash

Have you had your flu shot this season?
☐ Y ☐ N

Have you had your dilated eye exam in the last 12 months ?
☐ Y ☐ N

_____ _____
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, personal check, money order and cash. CCFA also participates with the CareCredit 6-month, no interest plan.
  - I understand that a $25 fee will be applied to my account for returned checks.
  - 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

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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 2016 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
	Capital Foot and Ankle Centers	Eldon Peters(eff: 10/1/2018)
	Carmel Foot Specialists	Barbara Kaiser, Richard Lind, Richard Miller, K. Molan, T. 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 (ret.), John Iredale (ret)
	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
	Coastal Carolina Foot & Ankle Associates	Jeffrey Pupp, Kevin Bachman (eff: 1/1/2019)
	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
	Greensboro Podiatry Associates, P.A.	Martha Ajlouny, N'Tuma Jah (resigned 12/21/17), Jonathan Simpson
	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, David Collard, Walter Falardeau, Thurmond Siceloff (left 10/23/2018)
	Myers Podiatric Clinic	William Myers
	Piedmont Foot & Ankle Clinic	Rick Hauser, Rob Lenfestey (ret.), Jason Nolan, Joel Kelly, Elizabeth Bass Daughtry, Jacob Panici, Brian Futrell (eff: 3/1/2018)
	Piedmont Podiatry Associates	Subodh Choudhary, Nicholas Canoutas, Cassandra Pike, Sarah Fitzgerald, Smitha Joseph (ret.)
	Queen City Foot & Ankle Specialists, P.C.	Roxanne Burgess, Alison Garten
	Raleigh Foot & Ankle **(Resigned from Group 1/1/2018)**	Alan Boehm, Robert Hatcher, Jordan Meyers, Kirk Woelffer
	Roberson Foot Care, PC	Ainsley Rusevlyan (eff: 2/1/2019)
	Ryan Foot & Ankle Clinic	David Garchar, Jeff Glaser, Michael Ryan, Scott Whitman, Matthew Borns
	Salem Foot Care	Walter Falardeau, Scott Matthews
	Summit Podiatry	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 **01/15/2016.**
_____ I attest that to my best recollection, I have not been seen by any of the above divisions/physicians since **01/15/2016.**

Signature of patient: _____ Date: _____

Printed Name: _____ DOB: _____