CENTRAL CAROLINA FOOT & ANKLE ASSOCIATES

A division of InStride Foot & Ankle Specialists

Patient Intake Form (New)

Date: _____ MRN: _____

Patient Demographics

Last: First: Middle: Gender: ☐ M ☐ F

Birth Date: ☐☐-☐☐-☐☐☐☐ Social Security#: ☐☐☐-☐☐-☐☐☐☐

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Spouse's name:

Race: ☐ Caucasian/White ☐ Black/African American ☐ Hispanic ☐ Asian Other:

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino Language: ☐ English ☐ Spanish Other:

How did you hear about our practice? ☐ Website ☐ Google ☐ Yellow Pages ☐ Insurance plan ☐ Other patient ☐ Referred by Physician:

Patient Information **Contact Preference:** ☐ Patient Portal ☐ Call - Home ☐ Call - Cell

Address Line 1 | Apt./Lot # | City | State | Zip

Home: ☐☐☐-☐☐☐-☐☐☐☐ Cell: ☐☐☐-☐☐☐-☐☐☐☐

Email address:

Employment (list for parent if patient is minor) ☐ Retired

Employer: Position:

Work Phone: ☐☐☐-☐☐☐-☐☐☐☐ Ext:

Responsible party (if not patient) ☐ Patient is responsible party

Last: First: Relationship to patient:

Address Line 1 | Apt./Lot # | City | State | Zip

Is this who we should contact in case of an **emergency**? ☐ Yes ☐ No

If not, who? Last: First: Relationship to patient:

Phone: ☐☐☐-☐☐☐-☐☐☐☐

Insurance – please provide ***all current*** insurance card(s) to front desk so we can make copies for your chart.

IMPORTANT!!! If you are not the policy holder on any of your insurance plans, who is? ☐ Self

Last: First: Middle:

Address Line 1 | Apt./Lot # | City | State | Zip

Insured's Social Security#: ☐☐☐-☐☐-☐☐☐☐ Insured's Birth Date: ☐☐-☐☐-☐☐☐☐

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Notice of Privacy Practices

Patient Name: _____ MRN: _____ DOB: _____

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

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

Central Carolina Foot & Ankle Associates is authorized to discuss my medical care and may release my confidential protected health information (PHI) to the following:

Entity to Receive Information Check each person/entity that you approve to receive information	**Information to be released** Check what information each person/entity can have access to
☐ Spouse (provide name & phone number) _____	☐ Any information ☐ Information as follows: _____ _____
☐ Parent (provide name & phone number) _____	☐ Any information ☐ Information as follows: _____ _____
☐ Other (provide name & phone number) _____	☐ Any information ☐ Information as follows: _____ _____
☐ **Family Doctor** (provide name & phone number) _____ Approximate date of last visit: _____	☐ Any information ☐ Information as follows: _____ _____ ☐ A copy of our physician's note from this visit

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 ofthe 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 effectice 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.

_____ _____

Signature of patient or personal representative Date

(Personal representative must provide proof of authority over patient)

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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

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-inflammatories ☐ Change in shoegear

☐ Orthotics or insoles ☐ Over-the counter 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: _____

Prescription/Pharmacy

Please list all medications you currently take (if you have a list, we will copy it for your record):

☐ No current medications ☐ See attached list

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

Pharmacy: _____ Location (street or city): _____

Medical History

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

☐ Alzheimer's ☐ Cancer Type: _____ ☐ Hepatitis _____ ☐ Peripheral Vascular Disease

☐ Anemia ☐ Cerebrovascular accident (stroke) ☐ High blood pressure ☐ Renal disease

☐ Arthritis ☐ Diabetes Type: ☐ I ☐ II ☐ HIV ☐ Stomach ulcers

☐ Asthma ☐ GERD (Gastric Reflux) ☐ Irritable bowel (IBS) ☐ Thyroid disease

☐ Blood Clots ☐ Gout ☐ Liver disease ☐ Tuberculosis

☐ COPD ☐ Heart disease (CAD) ☐ Osteoporosis ☐ Other: _____

Surgical History

Please check all that apply (indicate the **year performed):** ☐ None of the following apply

☐ Angio w/stent ☐☐☐☐ ☐ Colectomy ☐☐☐☐ ☐ Hip replacement ☐☐☐☐

☐ Arthroscopic knee ☐☐☐☐ ☐ Fracture repair(ORIF) ☐☐☐☐ ☐ Knee replacement ☐☐☐☐

☐ Back surgery ☐☐☐☐ ☐ Hammertoe correction ☐☐☐☐ ☐ Pacemaker ☐☐☐☐

☐ Bunion correction ☐☐☐☐ ☐ Joint fusion ☐☐☐☐ ☐ Thyroidectomy ☐☐☐☐

Family History

Who in your *immediate* family (mom, dad, sister, brother) has had: ☐ None of the following apply

☐ Alcoholism _____ ☐ CVA (stroke) _____ ☐ High blood pressure ___ ☐ Peripheral vasc. disease ____

☐ Alzheimer's _____ ☐ Diabetes _____ ☐ Obesity _____ ☐ Renal disease _____

☐ Blood disease _____ ☐ Gout _____ ☐ Osteoarthritis _____ ☐ Seizure disorder _____

☐ Cancer Type: _____ _____ ☐ Heart disease _____ ☐ Osteoporosis _____ ☐ Other: _____

Social History

Smoker Status: ☐ Current every day smoker ☐ Current social smoker ☐ Former Smoker ☐ Never smoker

Alcohol Use: ☐ Never ☐ Rarely ☐ Socially ☐ Daily ☐ Weekly ☐ Former

_____ _____

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 (PinPointe and MLS)
    - 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 919-908-8851.** A re-billing fee or $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

Thank you for complying with these policies so that we can keep your costs as low as possible.