FLORIDA LOWER EXTREMITY  FOOT & ANKLE CENTER

PATIENT RESPONSIBILITY DISCLAIMER

Dear Patient :

Our staff will verify your insurance and provide your benefits at the time of your visit . Please note that you may be responsible for copays, deductibles, or co-insurances (whichever is applicable) at the time of your visit.

This monetary responsibility is a contract between YOU and your INSURANCE CARRIER .

We **cannot** exempt or waive copays, deductibles, or co-insurances as this is illegal and unethical.

We ask that you please ask our staff regarding your insurance responsibility if you have any.

If there are any balances on your account , they will be collected at the time of your visit .

For your convenience we accept VISA, MasterCard, Discover, Cash , and Checks with proper identification.

If there is a service that is not covered by your insurance , we will ask you to submit FULL payment at the time of service .

If you would like for our office to submit the item not covered to your insurance, we will ask you to fill out a form that grants us permission to process this via insurance. If the service gets covered, we will refund you the difference.

Patient acknowledgement

Print Name :_____
Signature : _____

Date:_____

OFFICE USE ONLY
❑ I attempted to obtain the patient's signature on this *Patient Responsibility Disclaimer* but was unable to do so as documented below:

_____
Reason Initials Date

FLORIDA LOWER EXTREMITY FOOT & ANKLE CENTER

PATIENT REGISTRATION FORM

Patient's Full Name_____ Age_____ Today's Date_____

Social Security # _____ Date of Birth _____ Sex_____

Marital Status (circle one) Minor Single Married Widowed Divorced Separated

Ethnicity: _____ Race: _____ Primary Language: _____

Home Address _____
Street **Apt** **City** **State** **Zip Code**

Home Telephone _____ Cell Phone _____

E-mail _____ Work Telephone _____

Employer _____ Occupation _____

Employer Address _____

Emergency Contact _____Relationship_____ Phone _____

Primary Care Physician _____ Phone _____

Pharmacy _____ Phone _____

How did you hear about us ? Insurance Website Hospital Physician_____

INSURANCE INFORMATION

Insurance Company Name _____ Responsible Person _____

DOB Responsible Person_____ Responsible Person SSN _____

Identification Number _____ Group Number _____

Secondary Insurance Name _____ Responsible Person _____

Identification Number _____ Group Number _____

If patient is a MINOR, please fill in responsible parent or guardian:

Mother's Name _____ Employer _____

Mother's DOB _____Social Security #_____ Work Phone_____

Father's Name _____ Employer _____

Father's DOB _____ Social Security # _____Work Phone _____

PATIENT HEALTH HISTORY

**** PLEASE COMPLETE ENTIRE FORM ****

Reason of Visit : What is the reason for your visit today? (Please describe in detail):

_____

_____

Pain Level : 1-10 _____ (1 –low intensity → 10 high level of pain)

Pain Worse at : Morning Night Constant Intermittent Other: _____

Pain Better at : Morning Night Constant Intermittent Other: _____

Past Medical History: Please **check** all that apply to you:

Arthritis	Epilepsy/Seizures	Stroke
Cancer	Heart Problems	Thyroid
Depression	Heart Surgery	Osteoporosis
Diabetes	High blood pressure	Blood Clots

Other (please list)_____

Family History: Please **write** all that apply:

Please indicate which family member and (A)LIVE or (D)ECEASED

Arthritis_____Epilepsy/Seizures_____Stroke_____
Cancer_____Heart Problems_____Thyroid_____
Depression_____Heart Surgery_____Diabetes_____
Osteoporosis_____High blood pressure_____
Blood Clots_____

Other (please list)_____

Are **you** or anybody in your **family** diabetic? Yes No, If yes relationship?_____

Injury/Surgery: Please describe any serious injuries you have or had:

_____

_____

Medications: Please list any medications you are taking including prescription and over-the-counter
(Name, Dosage)

_____

_____

_____

ALLERGIES

Please check all allergies:

_____Medications: _____
_____Foods: _____
_____Tapes _____Novocain _____Anesthetics _____Silver/Nickel/Costume Jewelry _____Other: _____

Social History:

Do you drink alcohol ? Yes or No	**If yes , how much /week**
Do you smoke? Yes or No	**If yes, how many cigarettes/day?**
Do you use recreational drugs ? Yes or No	**If yes, what type and frequency?**
Do you drink caffeine? Yes or No	**If yes, what type and frequency?**
Do you exercise ? Yes or No	**If yes, what type and frequency?**

I certify the information above is true and accurate to the best of my knowledge.
(print name)_____ Date:_____

HEALTH REVIEW Please circle any symptoms you have had in the past 3 months.	
Mark the applicable below: **NONE** **General :** __Fever __Chills __Fatigue __Weight Loss __Weight Gain **OTHER:**	**Neurological :** **NONE** __Burning __Speech Disorders __Tremors __Charcot __Fainting __Strokes __Unsteady Gait __ Neuromas __ Numbness __Tingling __ Blackouts
Psychiatric : **NONE** __Depression __Anxiety Problems __ Sleeping __ Memory Loss **OTHER:**	**Cardiovascular:** **NONE** __ Chest Pain __Varicose Veins __Extremity(s) Cool __ Hair loss on legs __Heart Murmur __High Blood Pressure __Rheumatic Fever __Camps in legs/Feet __History of MI __Leg or Foot Ulcers __Palpations __Vascular Grafts __Replacement of heart valve Other:
Hematology : __Anemia __Abnormal bleeding/bruising __Blood Clots **NONE** __Other Blood Disorder	**Head :** __Headaches __ Visual Problems __Hearing Problems __Light Sensitivity
Respiratory : **NONE** __Persistent Cough __Wheezing __Shortness of Breath	**Endocrine** **NONE** __Heat/Cold Intolerance __Hot Flashes __Change in hair/skin texture Other
Gastrointestinal : **NONE** __Difficulty swallowing __ Indigestion/Heartburn __Abdominal Pain __Change in Bowel Habits	**Skin :** **NONE** __Itching __Warts__ Dryness__Hives __Lumps __Fungal Nails __Ingrown Nails __ Keloid Scar __Mole Changes _-Rash __Athlete's Foot OTHER: _____
Musculoskeletal : **NONE** __Arthritis __Arch Pain __Joint Pain __Gout __Lower Back Pain __Knee Pain ___Back Problems __Joint Stiffness __Muscles Cramp __Paralysis __Restricted Motion __Weakness __Ankle Sprain __Broken Ankle __Broken Foot Bone(s) __Bunions __Calluses __Corns __Flat Feet __Childhood Foot Problems __Flat Feet __Gait (walking problems) __Hammer/Mallet Toes	**Musculoskeletal Contd:** **NONE** __Heel Pain __High Arch Feet __In-toeing __Joint Implant __Muscle Stiffness __Neuroma __Orthotic Use __Shoe Inserts Use **Other Symptoms/Conditions: Please Indicate Below**

PATIENT INFORMATION :

Height : _____ Weight:_____ Shoe Size:_____

Shoe Type : (sneaker, sandals, high heels, dress shoes) Other: _____

Activity : Active Sedentary Other: _____

I certify the information above is true and accurate to the best of my knowledge.

(print name)_____ Date:_____

GUARANTOR AGREEMENT: As a courtesy to you, we will gladly file all necessary insurance forms for you. It is our policy to accept "allowable/reasonable/customary" charges as indicated by your insurance carrier. However, you are responsible for any deductibles, co-insurance, and amount in excess of your policy maximum provisions, and/or any amounts otherwise not payable by your insurance carrier. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not part of that contract.

I agree to pay all charges connected with this treatment not covered by any insurance responsibility or other third party coverage I may have. I understand I am obligated to pay the patient responsibility portion of the bill immediately. **_____ Initials**

FINANCIAL POLICY: All co-pay's and deductibles are due at time of treatment. Any outstanding balance such as copay's, co-insurance, deductables, denials due to change in coverage or non-participating plans is the patients responsibility. Outstanding patient responsibility older than 60 days after the date of service will be charged a 1.5% late fee per month. Co-pays not paid at time of visit and require patient billing statement may be subject to an addition processing fee of $25.00. Any returned checks shall incur a $25 reprocessing fee assessed to patient's account. **_____ Initials**

CANCELLATION POLICY: The office must be notified 24 hours in advance of a cancellation of the scheduled appointment. After the 2nd no show a cancellation fee of $ 50.00 will be charged and must be paid before the next visit. **_____ Initials**

TO ALL LITIGATION PATIENTS WHO HAVE PRIOR APPROVAL FROM OUR OFFICE TREATMENT: Patients who are being treated with understanding that their charges will be held in pending until the settlement of their court case must furnish this office with a **Letter of Guarantee from their attorney** prior to initial treatment and sign agreement stating that the patient clearly understands that the balance outstanding in our office is due upon settlement whether or not the suit is in favor of the patient or the party or parties involved. This balance becomes **due in full** upon settlement of the case and is the sole responsibility of the patient.
NO PATIENT WILL BE TREATED FOR MORE THAN TWO WEEKS WITHOU A SIGNED LETTER OF GUARANTEE IN OUR FILES "EXCEPT ON CASH BASIS ONLY".

TO ALL WORKER'S COMPENSATION PATIENTS: If Worker's Compensation insurance coverage can be verified, all patents treated by our office for injuries sustained while on the job will have their treatment charges billed directly to the insurance carrier monthly. Prior to treatment under this classification, employment, insurance coverage and all information pertaining to your claim will be verified. It is the responsibility of the patient to furnish our office with the necessary information and name(s) in order for out office to verify coverage ****NOTE:** If your Worker's Compensation claim is in litigation, a Letter of Guarantee from your attorney will be necessary in order for this office to hold your account balance in pending until settlement is reached, otherwise you will be treated on a **cash only** basis. Our office will also request your personal insurance carrier information. If a settlement is reached and it is not your advantage, payment will then be due immediately from the patient. If you cannot pay the balance in full at that time, you will be required to make monthly payments agreed upon with our office and a signed agreement will be required in order to avoid legal action. **IT IS THE RESPONSIBILITY OF THE PATIENT TO PAY THE TREATMENT CHARGES AT THE TIME OF A SETTLEMENT WHETHER OR NOT THE SETTLEMENT IS IN YOUR FAVOR.**

CONSENT FOR TREATMENT: I hereby consent to such treatment procedures and patient care which, in judgment of my physician, may be considered necessary or advisable while a patient at Pedro M. Abrantes, DPM, PA dba Florida Lower Extremity Foot & Ankle Center.

MEDICAL INFORMATION & ASSIGNMENT RELEASE: I authorize the release of any medical information necessary to process claims for payment. I permit a copy of this authorization to be used in place of the original. I authorize direct payment to Pedro M. Abrantes, DPM, PA dba Florida Lower Extremity Foot & Ankle Center.
I have read the above statements of this document and fully understand my obligation toward Pedro M. Abrantes, DPM, PA dba Florida Lower Extremity Foot & Ankle Center. All the information on this form is correct and accurate. I am responsible to notify the office of any changes in address, phone, employment, and insurance information. As well as the conditions upon which these services are provided. I have read the **Financial Policy**. I understand and agree to this Financial Policy.

_____ _____ _____

Patient's Name/Resp Person **Signature of Patient/Resp Person** **Date**

NOTICE OF PRIVACY PRACTICES, ACKNOWLEDGEMENT AND CONSENT
This notice describes how patient protected health information may be Used and disclosed and the patient's right to access to this information.

Please review carefully.

The ***Health Insurance Portability & Accountability Act of 1996*** **("HIPAA")** requires that all medical records and other individually identifiable health information used or disclosed by this organization be kept properly confidential. The patient has the right to understand and control how their health information is used or disclosed. Any misuse personal health information is subject to penalties.

❏ We may use and disclose patient medical records only for the following purposes:
❏ **Treatment:** providing, coordinating, or managing health care and related services by one or more health care providers.
❏ **Payment:** activities related to obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. (e.g., billing insurance provider for patient visit)
❏ **Health care operations:** conducting quality assessment and improvement activities, auditing functions, cost-management analysis, customer services and as required by law.
❏ We may create and distribute non-identified health information by removing all references to individually identifiable information.
❏ We may contact patients to provide appointment reminders, information about treatment alternatives or other health-related benefits and services.
❏ Any other uses and disclosures may be made only with patients written authorization. Patient may revoke such authorization in writing, except to the extent that we have already taken actions relying on patient authorization.
❏ We have the right to change our *Privacy Practices* from time to time. Patients may request a current copy by writing to address indicated above.

Patients have the following rights with respect to their protected health information. Patient may exercise these rights by submitting a written request to the address indicated above, attention Privacy Officer:

❏ The right to request restriction on certain uses and disclosures of protected health information, including those related to family members, other relatives, close personal friends, or any other person identified by patient. We are not required to agree to a requested restriction. However, if we do, we must abide by it unless patient agrees in writing to remove it.
❏ The right to reasonable requests to receive confidential communications of protects health information from this organization by alternative means or locations.
❏ The right to inspect and copy protected health information.
❏ The right to amend protected health information.
❏ The right to receive an accounting of disclosures of protected health information.
❏ The right to request a paper copy of this notice.

I hereby acknowledge that I have been given the right to review this organization's Privacy Practices and give my consent to use my protected health information under the conditions provided.

_____ _____
Patient or (Guardian) Signature **Date:**

_____
Relationship to Patient:

OFFICE USE ONLY
❏ I attempted to obtain the patient's signature on this *Notice of Privacy Practices, Acknowledgment and Consent*, but was unable to do so as documented below:

_____ _____ _____
Reason Initials Date