



Please answer for HIPAA compliance (Privacy Act)

May we leave lab, testing results, appointment reminders and surgical procedure dates on your home answering machine or voicemail? YES NO

May we send electronic copy of Continuity of Care Document (CCD) to your email? YES NO

With whom do you allow us to share your health information if you are unavailable?

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Advanced Care Plan

Do you have a Living Will?

Yes _____

No _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

 Patient Name (*please print*)

 Date

 Parent or Authorized Representative (if applicable)

I certify that the information given above is true and correct. I understand that it is my responsibility to notify Boca Raton Podiatry of any changes to the above information.

Patient or Guardian Signature: _____ Date: _____



BOCA RATON PODIATRY ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT

My signature at the bottom of this form authorizes payment for services rendered to myself or my dependent to be made directly to Boca Raton Podiatry. This authorization is valid until I notify Boca Raton Podiatry in writing that it is revoked.

I understand that I am responsible for giving Boca Raton Podiatry the correct insurance information at the time services are rendered. Boca Raton Podiatry agrees to bill your primary insurance carrier. If you have more than one insurance we will bill your secondary insurance one time as a courtesy. If payment is not received from your secondary within 45 days the balance becomes your responsibility. All insurance information must be provided to our office, at time of service.

I understand that I am responsible for obtaining the proper referral and may be held responsible for changes not covered by my Insurance due to my failure to obtain the required referral.

I authorize the release of medical information necessary to process my claim.

I agree to pay for non-covered services under my insurance plan (services for which I have policy exclusion).

I understand that Boca Raton Podiatry is not responsible for knowing if the group/physician is a participating provider with my insurance carrier.

We at Boca Raton Podiatry expect that all accounts should be paid by the receipt of the first two statements. If your account has not been settled either by payment in full or by contacting our billing department to set up a payment plan we will be charging a \$10 re-billing fee for each additional statement sent. Your account will be turned over to collection if you do not fulfill the terms of your financial arrangements.

I understand that there is a \$25 fee for all returned checks.

I understand that if I do not call to cancel my appointment within 24 hours there may be a \$25 fee applied to my account.

I understand that I am responsible for all balances not paid by my insurance carrier, including deductibles, co-pay, and co-insurance and out of network penalties. I further understand that if this balance is turned over to an outside agency that I shall be liable for all costs attorney of collection and any fees and or court costs incurred by this office.

I have read and understand the above policies.

 Patient or Patients Guardian or Legal Representative Signature

 Date

 Printed Name of Patient or Guardian or Legal Representative

 Relationship to Patient



Patient Name _____

History & Medical Information

What is your Height: _____ **What is your Weight:** _____

Past Medical History: (please circle all that apply)

- | | | | |
|--------------------|---------------------|-----------------------|--------------------|
| Anemia | Gout | Kidney Disease | Other Arthritis |
| Bleeding Disorders | Heart Disease | Lung Disorders | Prostate Disorders |
| Cancer | Hepatitis | Mitral Valve Prolapse | Parkinson's |
| Diabetes | High Cholesterol | Nerve Disorders | Thyroid Disorders |
| Epilepsy | HIV/ Aids | Osteoarthritis | Stroke |
| Neurologic | High Blood Pressure | Other: _____ | |

List all Medications/herbs/vitamins: _____

What pharmacy do you use? _____ Phone #: _____

Allergies/ Sensitivities: (please circle all that apply)

- | | | | |
|------------------------|-------------|----------------------|-----------|
| None Known | Sulfa Drugs | X-Ray Contrast/ Dyes | Shellfish |
| Penicillin | Aspirin | Other: _____ | |
| Any Narcotics/ Codeine | Anesthesia | | |

Have you ever had Surgery? (Please list any and all) YES NO

Describe: (surgery/ date): _____

Social History: (please circle all that apply)

Current Tobacco Use Y/N (how much?) _____ Past tobacco use Y/N _____ Alcohol use Y/N _____

Caffeine Use Y/N _____ Drug Use Y/N (recreational, IV) _____ Are you pregnant? Y/N _____ Nursing? Y/N _____

Exercise Habits _____

Family History: (list relationship of member(s) who have had problems)

	Mother	Father	Sibling
Arthritis			
Bleeding Disorders			
Cancer			
Diabetes			
Foot Problems:			
Gout			
Heart Disease			
High Blood Pressure			
Kidney Disease			
Stroke			
Other Family History			

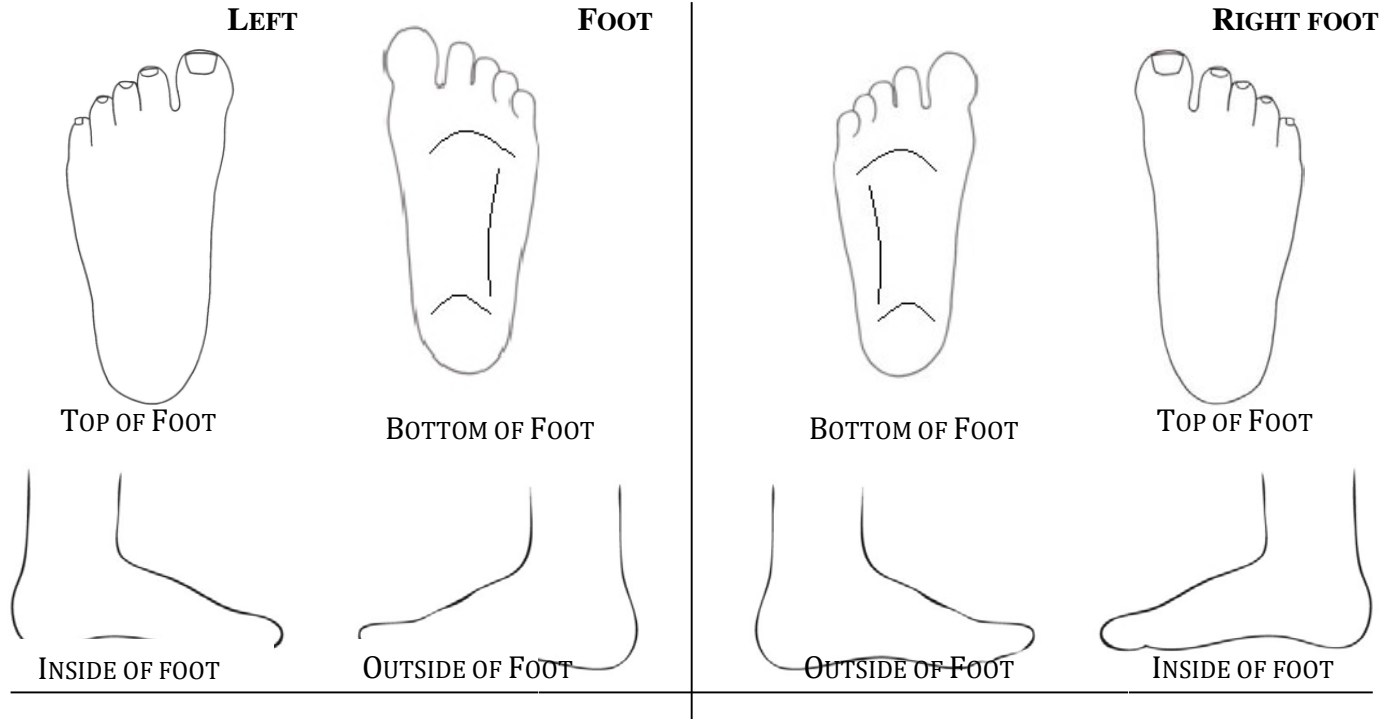


Patient Name: _____

CURRENT PROBLEM

What specific problem brings you to our office today? _____

Where is the pain/problem located? Please mark on the pictures below.



How long ago did this problem first start? _____ Days / Weeks / Months /

Did your pain or problem: Begin all of a sudden Gradually develop over time

How would you describe your pain? No pain Sharp Dull Aching Burning

Radiating Itching Stabbing Other _____

How would you rate your pain on a scale from 0 to 10? (please circle)

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain possible)

Since the time your pain or problem began, has it: Stayed the same Become worse Improved

What makes your pain or problem feel worse?

Walking Standing Daily activities Flat shoes Any closed toe shoe
 Resting Dress shoes High heels Running Other _____

What makes your pain or problem feel better? _____

What treatments have you had for this problem? _____

How has this problem affected your lifestyle or ability to work? _____

Was this problem caused by an injury? No Yes (describe) _____

If yes, was it a work-related injury? Yes No

Completed By: _____ Date: _____