PATIENT INFORMATION:

Date: __________ Patient Name: ____Date of Birth: _______________

Address: ____ City/State: __________________Zip: _______________

Home Phone: (______) ______-_________ Cell: (______) ______-_________ Prefer ☐Call or ☐Text Reminders?

Email Address: ___________________________________ (For internal use only)

Age: ____ Sex: ☐ M ☐ F Primary Language: ______________ Race: ______________ Ethnicity: ___________

Who is responsible for payment? _________________________________Relationship: ___________________________

Who referred you to us? ______________________________ ☐Friend ☐Web/Mobile ☐Radio Other: __________

Emergency Contact: ________________________ Relationship: ___________ Phone: (______) ______-_________

Spouse Name: ______________________Date of Birth: _______ Is Spouse the insurance policy holder?: ☐Yes ☐No

Employer: ____________________________________Work Phone: (______) ________-_________

Pharmacy: _______________________ City/Street: _________________________Phone: (______) _______-_______

PRIMARY CARE PROVIDER: (**Required** for ALL Medicare/Advantage Plans) ☐ I Do Not Have a PCP

Primary Care Physician: ______________(Last Name) ________________ (First Name) Office Location: ___________

Date Last Seen by PCP: ___________

INSURANCE INFORMATION: ***NOT REQUIRED IF INSURANCE CARD(s) PRESENT***

Primary Insurance Company: ____

Address: ________________________ City/State: ___________Zip: ________ Phone: (______) ______-_________

Insured Name: _________________________________Date of Birth _________Employer _____________________

ID # ____Group # _____________________________________

Secondary Insurance Company: ____

Address: _______________________City/State: _________Zip: _________ Phone: (______) _______-_________

Insured Name: __________________________Date of Birth ________Employer _____________________________

ID # ______________________________________Group # ____

CURRENT PROBLEM:

What is your current foot problem? _________________________ When did this problem begin? _____________

On a scale of 1-10 (10 is highest), what is your CURRENT PAIN SCALE: _____/ 10

What makes your problem better?_________________________ What makes it worse? ________________________

Was this problem caused by an injury? ☐ Yes ☐No (Describe) ____

Was it a work-related injury?☐ Yes ☐ No, Do you plan on filing for workers compensation? ☐ Yes ☐ No

MEDICAL CONDITIONS - HAVE YOU EVER HAD ANY OF THE FOLLOWING:

Diabetes:	Y	N	Bronchitis/Emphysema	Y	N	Kidney Disease	Y	N	Rheumatic Fever	Y	N
Anemia	Y	N	Cancer	Y	N	Liver Disease	Y	N	Sickle Cell Disease	Y	N
Arthritis	Y	N	Fibromyalgia	Y	N	Low Blood Pressure	Y	N	Skin Disorder	Y	N
Asthma	Y	N	Gout	Y	N	Migraine Headaches	Y	N	Sleep Apnea	Y	N
Anxiety	Y	N	Heart Attack	Y	N	Mitral Valve Prolapse	Y	N	Stomach Ulcers	Y	N
Back Trouble	Y	N	Heart Disease/Failure	Y	N	Neuropathy	Y	N	Stroke	Y	N
Abnormal Bleeding	Y	N	Hepatitis	Y	N	Open Sores	Y	N	Thyroid Disease	Y	N
Blood Clots	Y	N	HIV+/AIDS	Y	N	Pneumonia	Y	N	Tuberculosis	Y	N
Blood Transfusion	Y	N	High Blood Pressure	Y	N	Polio	Y	N	Depression	Y	N

OTHER CONDITION(S):____

ALLERGIES: ☐ NONE

☐Anesthesia: ______________________________ ☐Drugs: _________________________________

Foods ____________________________________ ☐Latex ☐ Shellfish ☐ Iodine ☐ Other ______

REACTION: ____

CURRENT MEDICATIONS: Please list ALL medications ☐ NONE

Medication Name	Dose	How often?	Medication Name	Dose	How often?

PREVIOUS SURGERIES: ☐ NONE

Type of Surgery	Date	Type of Surgery	Date

PREVIOUS HOSPITALIZATIONS: ☐ NONE

Reason for Hospitalization	Date	Reason for Hospitalization	Date

SOCIAL HISTORY: Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Use of Alcohol: ☐ Never ☐ Former ☐ History of alcohol abuse

Current USE - Type _________________ ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily

Use of Tobacco: ☐ Never ☐ Quit – how long ago? _________ ☐ Smoke ____ packs/day for ____ years

Use of Recreational Drugs: ☐ Never ☐ Quit – How long ago? _________ ☐ Type __________________

Current USE - Type _______________ ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily

FAMILY HISTORY: ☐ Diabetes ☐ Cancer ☐ Heart Disease ☐ High Blood Pressure ☐ Stroke

☐Bleeding Disorder ☐ Rheumatoid Arthritis ☐Other ____________________

OFFICE POLICIES & PROCEDURES: _______ (Initial)

These policies have been established to help us contain costs and provide the best possible care to all patients. Please acknowledge your understanding of these policies signing the bottom. Please let us know if you have any questions or concerns.

1. All insurance coverages and referral requirements are the responsibility of the patient.
2. Your insurance company requires us to collect co-pays and/or other fees to meet your annual deductible. Payment is expected at the time services are rendered. We accept most major credit cards, personal checks, & cash. There will be an additional $10.00 processing fee assessed if co-pays are not paid at the time services are rendered.
3. If your check is dishonored/returned for any reason, we will electronically debit your account for the amount of the check + $35 processing fee.
4. There is a $15.00 fee charged for all paperwork completed by staff or doctors. (i.e. Disability forms, FMLA paperwork, etc.) Please allow at least 3 business days for these requests.
5. Requests for copies of medical records: Pursuant to North Carolina code § 90.411 the fee is $10.00 plus 50 cents per page for the first 50 pages; then 25 cents per page thereafter. Any applicable postage fees will also be assessed. There is a $10 fee to copy x-rays to disc. Please allow at least 3 business days for these requests.
6. Durable medical equipment (walking cast boots, night splints, surgical shoes, orthotics, etc.) are non-refundable. Please note that your insurance may require you to make co-payments and/or fulfill deductibles for these items. Balances not covered by insurance are the patient's responsibility.
7. Billing questions pertaining to lab fees should be directed to the lab from which the bill was received.

DIGITAL PRESCRIBING: _______ (Initial)

E-Prescribing is defined by a physicians ability to electronically send an accurate, error free, and understandable prescription directly to your pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The medicare modernization act 2003, listed standards that have to be included in an e-prescribing program. These include: (1) Formulary and benefit transactions, which gives the prescriber information about which drugs are covered by a drug benefit plan; (2) medication history transactions, which provides the physician with information about medications the patient is already taking to minimize adverse drug events.

I authorize **Instride Capital Foot and Ankle Centers, PLLC** to view my external prescription history via electronic e-prescribing services. I understand that prescription history from multiple, other unaffiliated, providers, insurance companies, pharmacies and pharmacy benefit managers may be viewable by the providers and staff of **Instride Capital Foot and Ankle Centers, PLLC** and it may include prescriptions back in time for several years and may include prescriptions to treat HIV, substance abuse and psychiatric conditions. If applicable, I understand that my prescription history will become part of my record at this practice. I understanding all of the above, I hereby provide informed consent to **Instride Capital Foot and Ankle Centers, PLLC** to enroll me in the e-prescribe program. This consent will remain enforced until revoked or changed.

MEDICARE AUTHORIZATION: (Medicare Patients ONLY) _______ (Initials)

I request that payment of authorized Medicare benefits be made on my behalf to **Instride Capital Foot and Ankle Centers, PLLC** for any service rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms, or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurances and deductibles are based upon the charge determination of the Medicare carrier. I understand that Medicare has a yearly deductible of $183.00 for 2018, for which I am financially responsible.

PRIVACY NOTICE: ________ (Initial)

I understand that **Instride Capital Foot and Ankle Centers, PLLC** may use and disclose my protected health information for purposes of treatment, payment, and health care operations. We participate in Organized Healthcare Arrangements with providers in UNC Health Care Alliance and the UNC Senior Alliance. We may use your protected health information for our own health care operations and for those of the Organized Health Care Arrangements in which we participate. I also acknowledge that I have received, have been offered, or have received in the past a copy of the **Practice's Notice of Privacy Practices**, which provides information about how the practice, and individuals involved in my care in the practice, may use and disclose my protected health information. As provided in the notice, the terms of the notice may change. To obtain a copy of any current notice, contact the privacy office at **Instride Capital Foot and Ankle Centers, PLLC**.

I understand that I have the right to request that the practice restrict how my protected health information is used or disclosed for treatment, payment or health care operations, but I also understand that the practice is not required to agree to a requested restriction. However, if the practice does agree, it is bound by that agreement. I understand that I have the right to revoke this consent in writing at any time, except to the extent that the practice, or individuals involved in my care in the practice, have already used or disclosed protected health information in reliance on my prior consent.

Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:
I agree that the practice may disclose certain of my health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my health care. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Print Name: ________________________________ Phone Number ____________________ Relation _____________
Print Name: ________________________________ Phone Number ____________________ Relation _____________
Print Name: ________________________________ Phone Number ____________________ Relation _____________

AFFIRMATION:

I certify, to the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

I give permission to the doctors at **Instride Capital Foot and Ankle Centers, PLLC** to administer and perform any diagnostic, therapeutic and/or operative procedures as may be deemed medically necessary in diagnosis and/or treatment of my condition.

Patient/minors under the age of 18, will not be treated without a parent or legal guardian present. If another family member, caretaker or friend, over the age of 18 will be present; written consent from the parent/legal guardian stating as such must be presented at the time of the appointment. Thank you.

______________________________________ ______________________________________
Patient Name (PRINT) Legal Guardian (PRINT)

______________________________________ ______________________________________
Patient Signature Legal Guardian Signature

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, Kevin Molan, Tori Simmons-Lewis
	Carolina Foot & Ankle Health Center	Millicent Brown
	Carolina Foot Care Associates, PLLC	Ashma Davidson, Terry Donovan (ret), 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 (eff: 1/1/18) term 5/10/18**
	Hendersonville Podiatry	Russ Barone(ret), 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 group 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:3/1/18)
	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	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 0**1/01/2016.**

________ I attest that to my best recollection, I have not been seen by any of the above divisions/physicians since **01/01/2016.**

Signature of patient: ____ Date: _____________________________