InStride Capital Foot and Ankle Centers

PATIENT INFORMATION

Today's Date: _____ Patient Name: _____Date of Birth: _____

Address: _____ City/State: _____Zip: _____

Home Phone: (_____) _____-_____ Cell: (_____) _____-_____ We will call/text appointment reminders.

Email Address: _____ (For internal use only)

Age: ____ Sex: ☐ M ☐ F Primary Language: _____ Race: _____ Ethnicity: _____

Who is responsible for payment? _____Relationship: _____

Who referred you? _____ ☐Friend ☐Insurance Co ☐Facebook ☐Google ☐Yelp ☐Instagram

FAMILY INFORMATION

Patient's Emergency Contact: _____ Relationship: _____ Phone: (_____) _____-_____

Patient's Spouse Name: _____ DOB: _____ Is Spouse the insurance policy holder?: ☐Yes ☐No

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PHARMACY INFORMATION

Pharmacy Name: _____ City/Street: _____Phone: (_____) _____-_____

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

Primary Care Physician: _____(Last Name) _____ (First Name) Date Last Seen: _____

Primary Doctor Office Address: _____

CURRENT PROBLEM: ☐ LEFT FOOT ☐ RIGHT FOOT ☐ BOTH FEET

Describe your current foot problem? _____ Current Pain Scale 1-10: ____

How did this problem begin? _____ When did it start? _____

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

ADDITIONAL INFORMATION

Height ___'____" Weight _____lbs Shoe Size _____

Have you had an *Influenza Vaccine* (Flu Shot) within the last year?: __Y / __N

Have you had a *Pneumonia Vaccine* ever in your lifetime? __Y / __N

MEDICAL CONDITIONS _____ **(Initial)**

BLOOD DISORDERS ☐None ☐Blood Clots ☐Take Blood Thinners ☐Sickle Cell ☐_____

CANCER ☐None ☐Melanoma ☐Squamous Cell ☐Basal Cell ☐Bone Cancer ☐_____

DEVELOPMENTAL ☐None ☐Spina Bifida ☐Cerebral Palsy ☐Down Syndrome ☐ _____

ENDOCRINE ☐None ☐Diabetes Type 1 ☐ / Type 2 ☐ ☐Hypothyroid ☐_____

DIGESTIVE SYSTEM ☐None ☐IBD/Crohn's ☐Liver Disease ☐Stomach Ulcers ☐_____

HEART & VASCULAR ☐None ☐Heart Attack ☐Stroke ☐High Blood Pressure ☐Cholesterol ☐_____
☐Heart Disease ☐Heart Failure ☐A-Fib ☐Valve Disorder ☐_____

INFECTIONS ☐None ☐MRSA ☐HIV ☐Hepatitis C ☐Bone Infection ☐_____

IMMUNE SYSTEM ☐None ☐Rheumatoid ☐Lupus ☐Fibromyalgia ☐ _____

KIDNEY ☐None ☐Kidney Disease Stage ___ ☐Dialysis ☐_____

LUNGS ☐None ☐COPD ☐Emphysema ☐_____

MUSCULO-SKELETAL ☐None ☐Arthritis ☐Osteoporosis ☐Fibromyalgia ☐_____

NERVOUS SYSTEM ☐None ☐Stroke ☐Multiple Sclerosis ☐Parkinsons ☐Numbness ☐_____

PSYCHOLOGICAL ☐None ☐Depression ☐Anxiety ☐_____

SKIN ☐None ☐Rashes_____ ☐Skin Cancer _____ ☐Ulcers ☐_____

***OTHER CONDITION*(S):** ☐_____ ☐_____ ☐_____

ALLERGIES: ☐ NONE ☐Latex ☐ Shellfish ☐ Iodine ☐ Food _____ ☐Anesthesia:_____ ☐ Other _____

☐Drug Allergies: _____ 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

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

☐Bleeding Disorder ☐ Rheumatoid Arthritis ☐Other _____

_____ **(Initial)**

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 by initialing above. Please let us know if you have any questions or concerns.

1. Our office will work to determine your insurance benefits prior to your visit. Please note that payment in full is expected at the time of your visit.
2. The patient is responsible for all insurance coverage, co-insurance, deductible, and copays.
3. The patient is responsible for any required referral prior to his/her visit.
4. If your check is dishonored/returned for any reason, we will electronically debit your account for the amount of the check + $35 processing fee.
5. There is a $25.00 fee charged for all paperwork completed by doctors. (i.e. Disability forms, FMLA paperwork, etc.) Please allow at least 3 business days for these requests.
6. 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.
7. All medical devices and durable medical equipment (custom orthotic, insoles, walking cast boots, night splints, surgical shoes, orthotics, etc.) are non-refundable.
8. 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 physician's 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 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.

Patients/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