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 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 ☐ NONE - I do not have ANY 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 ☐ I will bring my list to my appointment

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: ☐ NONE ☐ 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 based on the benefits provided by your insurance carrier.
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.

CONSENTS, AUTHORIZATIONS, AND ASSIGNMENT OF BENEFITS : _____ (Initial)

1. **CONSENT TO TREAT**: The undersigned consents to any initial or follow-up evaluations, examinations, x-rays, laboratory procedures, other tests, medications, medical treatment, surgery, physical therapy, home instructions, orthotics, other durable medical equipment, photographing and/or videotaping and/or other services rendered to the patient by INSTRIDE CAPITAL FOOT & ANKLE CENTERS, PLLC, a division of INSTRIDE FOOT & ANKLE SPECIALISTS, LLC and its providers. The undersigned agrees that it is their responsibility to contact and/or schedule for any follow up visits, other services, prescriptions and items ordered for the patient. The undersigned also understands that providers exercise their care with reasonable skill and diligence, but make no guarantee as to the results or cure that will be attained.

2. **DIGITAL E-PRESCRIBING**: I authorize INSTRIDE CAPITAL FOOT & ANKLE CENTERS, PLLC, a division of INSTRIDE FOOT & ANKLE SPECIALISTS, LLC and its associates 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 & ANKLE CENTERS, PLLC, a division of INSTRIDE FOOT & ANKLE SPECIALISTS, LLC 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 & ANKLE CENTERS, PLLC, a division of INSTRIDE FOOT & ANKLE SPECIALISTS, LLC to enroll me in the e-prescribe program. This consent will remain enforced until revoked or changed.

3. **ASSIGNMENT OF BENEFITS**: I hereby irrevocably assign, transfer and convey to INSTRIDE CAPITAL FOOT & ANKLE CENTERS, PLLC, a division of INSTRIDE FOOT & ANKLE SPECIALISTS, LLC and any practitioner providing care and treatment to me/my child, any and all benefits and all interest and rights (including causes of action, the right to enforce payment and the right to appeal an adverse benefit determination) to which I am entitled under an employee benefit plan sponsored by my employer, all insurance policies, benefits, any third-party reimbursement, or prepaid health care plan for services rendered or products I received from INSTRIDE CAPITAL FOOT & ANKLE CENTERS, PLLC, a division of INSTRIDE FOOT & ANKLE SPECIALISTS, LLC.

4. **MEDICARE ASSIGNMENT**: I certify that the information given by me in applying for payment under XVIII of the Social Security Act is correct and agree to complete the Medicare screening form annually. I authorize the release of information concerning me to the Social Security Administration or its intermediaries as well as any information needed for filing a Medicare claim; I request that payment and authorized benefits be made on my behalf. I assign benefits payable for services to INSTRIDE CAPITAL FOOT & ANKLE CENTERS, PLLC, a division of INSTRIDE FOOT & ANKLE SPECIALISTS, LLC.

5. **AUTHORIZATION TO RELEASE INFORMATION**: I consent and authorize INSTRIDE CAPITAL FOOT & ANKLE CENTERS, PLLC, a division of INSTRIDE FOOT & ANKLE SPECIALISTS, LLC and its agents to release my health information for the purpose of payment, treatment, and healthcare operations to any of the following: insurance company and its affiliates, any practitioner, support staff or facility involved in my plan of care or transfer of care. In addition I understand that the potential uses and disclosures of my Health Information are detailed in the Privacy notice. The HIPAA Notice of Privacy Practices are available online at https://www.northcarolinafootandankle.com. Individual copies are also available in the office and posted in the lobby. I have read/had the opportunity to read my HIPAA rights, which include fees for records.

6. **DESIGNATION OF AUTHORIZED REPRESENTATIVE**: I designate and appoint INSTRIDE CAPITAL FOOT & ANKLE CENTERS, PLLC, a division of INSTRIDE FOOT & ANKLE SPECIALISTS, LLC (and its agents) as my authorized representative and authorize it to act on my behalf to 1) request and receive a copy of the summary plan description, 2) pursue a benefit claim, 3) appeal and adverse benefit determination, and/or 4) file a legal/equitable action to recover benefits from my employee benefit plan, insurance policy, and any third-party reimbursement or prepaid health care plan. I understand and agree that my authorized representative shall have full authority to act, and receive notices, on my behalf with respect to an initial determination of the claim for health benefits relating to treatment and health care services received by me/my child at INSTRIDE CAPITAL FOOT & ANKLE CENTERS, PLLC, a division of INSTRIDE FOOT & ANKLE SPECIALISTS, LLC, any requests for documents relating to this claim and appeal of an adverse determination of the claim.

7. **FINANCIAL AGREEMENT**: I hereby promise to pay for all products received or services rendered to me/my child to the extent I am legally responsible for such payment. According to the language of the physician's insurance contract, I understand that I am responsible for all health insurance copayments, deductibles, coinsurances, OTC-over the counter convenience items and NCS noncovered services and any other amounts that apply at the time of service or at the pre- operative appointment. Regardless of the assignment of benefits, should the insurance misrepresent their coverage or delay payment of a claim greater than 60 days, as the designated responsible party, I am responsible for the for all monies owed to INSTRIDE CAPITAL FOOT & ANKLE CENTERS, PLLC, a division of INSTRIDE FOOT & ANKLE SPECIALISTS, LLC. I also understand that the insurance policy is a contract between me and the insurance company; therefore the policy holder should contact the insurance carrier first when there are questions regarding an explanation of benefits.

8. **CONSENT FOR PHOTOGRAPHY**: I authorize INSTRIDE CAPITAL FOOT & ANKLE CENTERS, PLLC, a division of INSTRIDE FOOT & ANKLE SPECIALISTS, LLC to take photographs during the course of my treatment. I understand that the media is the property of INSTRIDE CAPITAL FOOT & ANKLE CENTERS, PLLC, a division of INSTRIDE FOOT & ANKLE SPECIALISTS, LLC, and I may obtain a copy upon my written request. I agree and authorize the use of the media in my medical record and for teaching purposes, which includes being shown to other patients. I am aware that my name and identity will not be disclosed.

9. **CONSENT FOR COMMUNICATION**: I authorize INSTRIDE CAPITAL FOOT & ANKLE CENTERS, PLLC, and its associates to contact me by telephone at any phone number associated with my account, including wireless telephone numbers, which could result in charges to me. INSTRIDE CAPITAL FOOT & ANKLE CENTERS, PLLC, and its associates may also contact me by sending text messages or emails, using any email address you provide us to use. Methods of contact may include using pre-recorded or artificial voice messages and/or use of an automatic dialing device, as applicable.

10. **PRIVACY NOTICE**: I understand that INSTRIDE CAPITAL FOOT & ANKLE CENTERS, PLLC, a division of INSTRIDE FOOT & ANKLE SPECIALISTS, LLC 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 to read the notice at www.northcarolinafootandankle.com, 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 & ANKLE CENTERS, PLLC, a division of INSTRIDE FOOT & ANKLE SPECIALISTS, LLC.

    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 RELATIVES, CLOSE FRIENDS, CAREGIVERS AS REPRESENTATIVE:

I agree that the practice may disclose certain of my health information to a Personal Representative of my choosing, since this 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