Patient Information

Información Del Paciente

Date / *Fecha* _____

Patient Legal Name / *Nombre legal del paciente*: _____
SS# / *Nro Social* _____ **D.O.B** / *Fecha De nacimiento* _____**Sex** / *Sexo*_____
Marital Status / *Estado Civil*: ___ **Single** /*Soltero* ___ **Married** / *Casado* ___ **Divorced** / *Divorciado* ___ **Widowed** / *Viudo* ___ **Life Partner /** *Compañero de Vida*
Home Address / Direccion de casa _____
Home Phone / teléfono de casa _____ **Cell** /*Celular* _____
E-mail / Correo Electronico _____
Preferred Language / *Idioma Preferido:* _____
Ethnicity /*Origen Etnico:* ____ **Hispanic**/ *Latino* ___**Non-Hispanic** / *No Hispano*
Race / *Raza :* ____**Black** / afroamericano___ **White** / Blanco ___**Asian** / Asiatica ____ **Other** / Otro:_____ ___ **Decline** / *no quiere decir*

Spouse Name / Nombre del Cónyuge _____
Home Phone / teléfono de casa _____ **Cell** /*Celular* _____

Student / *Estudiante*____ **Yes** / Si ____**No** **Full Time** / Tiempo Completo / **Part Time** / Tiempo Parcial
Occupation / *Ocupacion* _____
Employment Status / *Estado de Empleo* _____ **Full Time** / Tiempo Completo ____ **Part Time** / Tiempo Parcial ____**Retired** / Retirado ____ **Unemployed** / Desempleo ____ **Other** / Otro
Employers Name / *Nombre del empleado* _____
Employers Address / *Dirección del Empleado* _____

Insurance Information / Información del Seguro

Policy Holder Name */ Nombre del titular de la póliza* _____
Relationship / relación _____ **D.O.B** / *Fecha De nacimiento* _____

Primary Insurance Name / *Nombre del titular de la póliza* _____
Phone / Teléfono _____
Policy # / *Póliza #* _____ **Group #** / Grupo #_____

Secondary Insurance Name / *Nombre del titular de la póliza* _____
Phone / Teléfono _____
Policy # / *Póliza #* _____ **Group #** / Grupo# _____

Emergency Contact Name / *contacto de emergencia* _____
Phone #: Home / *Casa* _____**Cell** /*Celular* _____
Relationship / *relacion con el paciente* _____

Do you have a living will or medical advance directive ? / Tiene un testamento vital o una directiva médica anticipada?
___**Yes** / Si ___ No

Date / *Fecha* _____

Patient Legal Name / *Nombre del Patiente legal*: _____
D.O.B / *Fecha De nacimiento:* _____

How did you hear about us / *Como supiste de nosotros*:
___ **Doctor (referral)** / *Doctor (referido)* ____ **Insurance** / *Seguro* ____ **Google** / *Internet*
___ **Social Media** / *Media social* (Facebook, Twitter, Instagram) **Other**/ *Otro* _____

Reason for your visit / motivo de tu visita?_____

How long with issue *Icuanto tiempo con problema* **?** _____

Pain Level */ (dolor) 1 to 10* _____

Allergies / *Alergias* _____

SOCIAL HISTORY / *HISTORIA SOCIAL*

Drug Use / *El consumo de drogas*: **Current** / *Corriente* **Past** / *Pasado* **Never** / *Nunca*
Frequency / *Frecuencia:* _____

Smoking / *fumar:* **Current** / *Corriente* **Past** / *Pasado* **Never** / *Nunca*
Packs / Days / paquetes / dias _____

Alcohol : **Current** / *Corriente* **Past** / *Pasado* **Never** / *Nunca*
Drink/ Day / *bebida / día* _____

List *ALL* **MEDICATIONS** you take, including Over the counter (OTC) medications and vitamins. Include Specific doses and when taken. If you dont know, please call your pharmacist to confirm.
Enumere TODOS los ***MEDICAMENTOS*** *que toma, incluidos los medicamentos de venta libre y las vitaminas. Incluir dosis específicas y cuando se toma. Si no sabe, llame a su farmacéutico para confirmar*

Prescribed Meds / Medicamentos prescritos	**Dose / Dosis**	**Frequency / Frecuencia**	**OTC / Vitamine / Vitamina**	**Dose /Dosis**	**Frequency / Frecuencia**

Date / *Fecha* _____

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D.O.B / *Fecha De nacimiento:* _____

Personal Medical History / *Historia Médica Personal*

Check all that apply / *Marque todo lo que corresponda*

___ **ADHD**	___ **COPD**	___ **HIV**	___ **Neuropathy** / *Neuropatía*
___ **Arthritis**	___ **Lupus**	___ **Bipolar**	___ **Hepatitis**
___ **Allergies (seasonal)** / *Alergias (estacionales)*	___ **Dementia** / *Demencia*	___ **High Blood Pressure** / *Alta presion sanguinea*	___ **Osteopenia** / *Osteoporosis*
___**Anemia**	___ **Depression** / *Depresión*	___ **High Cholesterol** / *Colesterol Alto*	__ **Parkinson's Disease** / *Enfermedad de Parkinson*
___ **Anxiety** / *Ansiedad*	___ **Heart Attack** / Ataque al corazón	___ **Irritable Bowel Syndrome** / *Síndrome del intestino irritable*	___ **Peripheral Vascular Disease** / *Enfermedad vascular periférica*
___ **Arrhythmia** / *Arritmia*	___ **Diverticulitis** / *Diverticulitis*	__ **Kidney Stone** / *Cálculos renales*	___ **Peptic Ulcer alcoholism** / *Úlcera péptica alcoholismo*
___ **Heart Disease** / *Enfermedad del corazón*	___ **DVT (Blood Clot)** / *TVP (coágulo de sangre)*	___ **Crohn's Disease** / *Enfermedad de Crohn*	___ **Pulmonary Embolism (PE)** / *Embolia pulmonar (EP)*
___ **Asthma** / *Asma*	___ **Eczema**	___ **Kidney Disease** / *Enfermedad del riñon*	___ **Rheumatoid Arthritis** / *Artritis Reumatoide*
___ **Headaches** / *Dolores de cabeza*	___ **Emphysema** / *Enfisema*	___ **Stroke** / *Carrera*	___ **Sciatica** / *Ciática*
___ **Carpal Tunnel** / *Tunel carpal*	___ **Gallstones** / *Cálculos biliares*	___ **Bladder Problems** / *Problemas de vejiga*	___ **Seizure Disorder** / *Trastorno convulsivo*
___ **Bleeding problems** / *Problemas de sangrado*	___ **GERD (acid Reflux)** / *ERGE (Reflujo ácido)*	___ **Liver Disease** / *Enfermedad del higado*	___ **Sleep Apnea** / *Apnea del sueño*
___ **Cancer**	___ **Glaucoma**	___ **Macular Degeneration** / *Degeneración macular*	___ **Hiatal Hernia** / *Hernia hiatal*
___Diabetes 1 or 2	___ **Nosebleeds** / *Hemorragias nasales*	___ **Migraines** / *Migrañas*	___ **Thyroid Disorder** / *Trastorno de la tiroides*
			___ **Ulcerative Colitis** / *Colitis ulcerosa*

Other Medical Problems / *Otros problemas medicos* :

_____
_____
_____
_____
_____

Date / *Fecha* _____

Patient Legal Name / *Nombre del Patiente legal*: _____
D.O.B / *Fecha De nacimiento :* _____

Surgical History: Please list all prior Surgeries and approximate dates performed.
Historial quirúrgico: enumere todas las cirugías anteriores y las fechas aproximadas realizadas.

Procedure / *Procedimiento*	**Date** / *Fecha*

List other medical providers you see on a regular basis (i.e Cardiologist, Mental Health Provider, Kidney Doctor)
Enumere a otros proveedores médicos que vea regularmente (es decir, cardiólogo, proveedor de salud mental, médico del riñón)

Name	**Specialty**

Authorization for Treatment
Autorización de Tratamiento

I _____Authorize On 2 Feet, LLC to perform procedures and treatments, including administration of medicine and local anesthetics along with other surgical and medical procedures that may be medically necessary. I understand that some treatments or procedures may not be covered by my insurance carrier and that I will be responsible for full payment of services or procedures

I _____ Autorice On 2 Feet, LLC para realizar el procedimiento y el tratamiento, incluida la administración de medicamentos y anestésicos locales, junto con otros procedimientos quirúrgicos y médicos que puedan ser médicamente necesarios. Entiendo que algunos tratamientos o procedimientos pueden no estar cubiertos por mi compañía de seguros y que seré responsable del pago completo del servicio o procedimiento.

_____ _____
Signature of Patient / Guardian or Authorized Representative Date

Date /*Fecha* _____

Patient Legal Name /*Nombre del Patiente legal*: _____ **D.O.B** / *Fecha De nacimiento*

Family History */ Historia familiar*

(M): ***Mother*** */ Madre:* ***Living*** */ Vivo: Age*_____ ***Deceased*** */ Muerto* *Age* _____
(F) ***Father*** */ (P) Padre :* ***Living*** */ Vivo: Age*_____ ***Deceased*** */ Muerto* *Age*_____
(S) ***Sibiling*** *:*_____

Family History: please mark which ones with M or F*(P)* ***or S***
Historia familiar: por favor marque con M or P or S

___ **Alcoholism** / Alcoholismo	___ **Depression** / Depresión	___ **Migraines** / Migrañas	___ **Breast Cancer** / Cáncer de mama	___ **Thyroid Cancer** / Cáncer de tiroides	
___ **COPD/Emphysema** / *EPOC / enfisema*	___ **Skin Cancer** / Cáncer de piel	___ **Colon Cancer** / Cáncer de colon	___ **High Cholesterol** / Colesterol alto	___ **Heart Disease** / Enfermedad del corazón	___ **Blood Clots / DVT** / Coágulos De Sangre / DVT
___ **Stroke** / Carrera	___ **Anemia**	__ **Osteoporosis**	___ **Diabetes 1 or 2**	___ **Bipolar**	___ **Arthritis**
___ **Lymph Cancer** / Cáncer de linfa	___ **Asthma** / Asma	___**High Blood Pressure** / *Alta presion sanguinea*	___ **Dementia**	___ **Blood Cancer** / *Cáncer de sangre*	___ **Thyroid Disorder** / Trastorno de la tiroides
___ **Kidney Disease** / Enfermedad del riñón	___ **Ovarian Cancer** /Cáncer de ovarios	__ **Prostate Cancer** / Cancer de prostata		___ **Other** / *Otro:*	

_____ _____
Signature of Patient / Guardian or Authorized Representative Date

_____
Print Name of Authorized Representative

I AM A RESPONSIBLE PATIENT

I, _____ understand that I am being seen for Wound Care treatment in order to assist healing of my wound(s). This treatment is known to be effective only when provided on a regular basis. Lapses in my treatment, such as missed days or sporadic days, or failure to comply with the plan of care can result in this therapy becoming less effective or ineffective. I understand that, without my active participation, my doctor's ability to help me is limited. My responsibilities include but are not limited to:

1. Learning how to promote my own health and wellness. Being an active partner in my medical care/healing.
2. Learning how to manage illness, both acute and chronic.
3. Actively working to eliminate those unhealthy habits I have acquired over my lifetime.
4. Eating properly, exercising if indicated, and striving to eliminate those stressors within my control.
5. Understanding my diagnosis, learning about its effects on my body and how I can help manage it.
6. Understanding the medical advice I receive. Asking questions when I do not understand the advice offered.
7. Taking my medications as prescribed if prescribed.
8. Notifying On 2 Feet, LLC prior to stopping or changing dressing treatment or my medication.
9. Notifying On 2 Feet, LLC should I have any adverse reaction from my prescribed treatment.
10. Completing diagnostic tests (lab, x-ray, EKG, etc.) in a timely fashion.
11. Appearing for treatment as scheduled. If I am unable to appear for a scheduled appointment, I will notify On 2 Feet, LLC, and also make every arrangement possible to reschedule for that same day during regular business hours.
12. That I will not miss any more than one (1) day of treatment in the entire recommended treatment plan.
13. Notifying my doctor when I have added other professionals to my healthcare team.
14. Notifying On 2 Feet, LLC if other professionals have prescribed new medication and what that medication is, and why it is being prescribed.
15. Being honest about what I am doing, taking, and who I am getting treatment from.
16. Know the rules of my insurance policy, what benefits are covered and what are not.
17. Notifying the office if any contact or coverage information changes occured.
18. Having an emergency contact listed should critical information need to be relayed.
19. I understand that a violation of any of these conditions may result in my discharge from On 2 Feet, LLC care.

My health is important to me, my family, and loved ones. I will work hard to care for myself. I understand that my doctor cannot help me if I will not help myself. I expect my doctor to offer me his/her best advice based on his/her medical training.

_____ _____

Signature of Patient / Guardian or Authorized Representative Date

_____

Print Name of Authorized Representative

Appointment / Cancellation / No Show Policy

Appointments

Office visits are by appointment only, please call (407) 955-4511. The receptionist may ask about the reason for your visit. This helps us schedule the doctor's time more efficiently. Please arrive 10 minutes early for your appointment. Patients who are late for any appointment may be asked to reschedule at the physician's discretion. Remember, it is your responsibility to update staff of any changes to your address, phone number, insurances, medications or any new specialist or primary physician treating you. We know that your time is valuable. Except in the case of emergencies, you can expect us to be running on schedule .

Cancellation

We would like to thank you for being a patient in our office. We value *ALL* of our patients and strive to provide the best podiatric care possible in the most comfortable setting. Please understand that when we schedule your appointment, we are reserving time for your particular needs - a room is reserved, records are prepared, and special instruments are readied for your visit. We kindly ask that if you must change an appointment, please give us at least 24 hours advance notice. This courtesy makes it possible to give your reserved time to another patient who is in need.

Missed Appointment (non-Cancellation)

We understand that occasional missed appointments can occur for a variety of reasons. When you miss an appointment without cancelling, someone else who could have been seen in your place is delayed, unnecessarily. We track missed (non-cancelled) appointments. A "No show / Late Cancellation" is defined as missing an appointment without cancelling at least 24 hours before scheduled time. There will be a charge for missed or non-cancelled appointments of $25.00. Insurance will not cover charges for no show/late cancellation. The $25.00 charge is in addition to any other charges you may have incurred. No refunds will be given. Repeated missed appointment may result in your physician sending a letter discharging you from the practice. We will offer to transfer your medical records to your new podiatrist, meanwhile we will offer 30 days of emergency care only.

Payment

Payment is due when you call us to reschedule an appointment or at time of visit.

_____ _____

Signature of Patient / Guardian or Authorized Representative Date

_____

Print Name of Authorized Representative

Notice of Privacy Practices Acknowledgement Form

On 2 Feet, LLC Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this form. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting On 2 Feet, LLC.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations as described in our notice. You have the right to revoke this consent in writing, except where we have already made disclosure in reliance on your prior consent.

AUTHORIZATION FOR RECEIVING MESSAGES AND AUTOMATED CALLS: I give On 2 Feet, LLC permission to contact me by telephone at the telephone number or numbers I provided during the registration process, or at any time in the future, including wireless telephone numbers or other numbers that may result in charges to me. The Hospital and its agents may leave messages for me at these numbers and may send text messages or email communications using the email address or addresses I provide. These voice messages and email and text communications may include information required by law (including debt collection laws) related to amounts I owe On 2 Feet, LLC as well as messages related to my continued care and treatment.

I also understand On 2 Feet, LLC and its agents, including debt collection agencies, may use pre-recorded/artificial voice messages and/or use an automatic dialing devise (an autodialer) to deliver messages related to my account and amounts I may owe On 2 Feet, LLC. I also authorize the On 2 Feet, LLC and its agents to use the number or numbers provided for such pre-recorded or auto dial messages. If I want to limit these communications to a specific telephone number or numbers, I understand that I must request that only a designated number or numbers may be used for these purpose

_____ _____

Signature of Patient / Guardian or Authorized Representative Date

_____

Print Name of Authorized Representative

Medical Records Request

Patient Name _____ DOB _____

SSN# **(Last 4 Digits)** _____ Telephone # _____

Address _____

I request and authorize the release of *ALL* general and sensitive medical records to ***ON 2 Feet, LLC***. Including but not limited to the following categories protected by state or federal law: (1) Substance abuse (drug or alcohol) treatment (2) Mental health treatment and (3) HIV-AIDS-related information, if such information is contained in the records. This request includes any reports, correspondence, test results, and any other information contained in the records, whether generated by the authorized provider or another entity.

Specific Authorization: Dates and Type of information to be released

- ❑ 2 years prior from the last date seen **(including but not limited to, Facesheet, history & physical, progress notes, operative notes, lab, diagnostic test and X Ray, discharge orders)**
- ❑ Dates _____ To _____
- ❑ Specific Information Requested _____

Please issue records by: **_X_** Fax to **407.392.2211** ___ Email to **On2feet.org** ___ CD
___Paper (Patient Pick-up) ___ Mail: **On 2 Feet, LLC** PO Box 470118 Lake Monroe , FL 32747

I understand I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to ***On 2 Feet, LLC*** . I understand that the revocation will not apply to information that has already been obtained or released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the release of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in *CFR 164.524.* I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above Authorization for Release of Information and do hereby acknowledge that I am familiar with, and fully understand the terms and conditions of this authorization.

_____ _____

Signature of Patient / Guardian or Authorized Representative Date

_____

Print Name of Authorized Representative

Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor. ·

As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office. · Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check. ·

Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. ·

We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible. ·

If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service. · All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered. ·

You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied. ·

For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility. ·

There are certain elective surgical procedures for which we require prepayment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery. ·

Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office. · There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

_____ _____

Signature of Patient / Guardian or Authorized Representative Date

_____

Print Name of Authorized Representative