Patient Information

Patient Legal Name_____**Date** _____

SS# _____ **D.O.B** _____ **Sex** _____

Marital Status **Single** **Married** **Divorced** **Widowed** **Life Partner**

Home Address _____

Home Phone_____**Cell** _____

can we text you for appointment reminders or Follow up: *Yes* *No*

E-mail _____

Preferred Language_____

Ethnicity: **Hispanic** **Non-Hispanic**

Race: **African American** **White** **Asian** **Other:**_____ **Decline**

Spouse Name_____

Home Phone _____ **Cell**_____

Occupation _____

Employment Status: **Full Time** **Part Time** **Retired** **Unemployed** **Other**

Employers Name _____

Employers Address _____

Student **Yes** or **No** **Full Time** **Part Time**

Insurance Information

Policy Holder Name_____

Relationship _____ **D.O.B** _____

Primary Insurance Name _____

Phone _____

Policy # _____ **Group #** _____

Secondary Insurance Name _____

Phone _____

Policy # _____ **Group #** _____

Emergency Contact Name_____

Phone #: _____**Cell** _____

Relationship _____

Do you have a living will or a medical advance directive? ___**Yes** ___ No

Patient Name:_____ Patient DOB:_____

How did you hear about us:

Doctor (referral) Insurance Google Social Media Other: _____

Reason for your visit?_____

How long with issue ? _____

Circle Pain Level ***1 2 3 4 5 6 7 8 9 10***

Allergies: _____

SOCIAL HISTORY

Drug Use: Current Past Never
Frequency: _____

Smoking: **Current Past Never**
Packs / Days: _____

Alcohol : **Current Past Never**
Drink/ Day _____

Physical Activities: Running Walking Cycling Gym other:_____
Frequency:_____

Way of Eating: REgular Vegetarian/Vegan Paleo Keto WW Other:_____

List *ALL* **MEDICATIONS** you take, including Over the counter (OTC) medications and vitamins. Include Specific doses and when taken. If you don't know, please call your pharmacist to confirm.

Prescribed Meds	Frequency	Dose	OTC / Vitamin	Frequency	Dose

List other medical providers you see on a regular basis (i.e Cardiologist, Mental Health Provider, Kidney Doctor)

Name	Specialty

Patient Name:_____ Patient DOB:_____

Personal Medical History

Check all that apply

ADHD	**COPD**	**HIV**	**Neuropathy**	**Ulcerative Colitis**
Arthritis	**Lupus**	**Bipolar**	**Hepatitis**	**Thalassemia**
Cancer	**Dementia**	**High Blood Pressure**	**Osteopenia**	**Bleeding disorders**
Anemia	**Depression**	**High Cholesterol**	**Parkinson's Disease**	**Allergies (seasonal)**
Anxiety	**Heart Attack**	**Hiatal Hernia**	**Bleeding problems**	**Diabetes 1 or 2**
Arrhythmia	**Diverticulitis**	**Kidney Stone**	**Peptic Ulcer alcoholism**	**Thyroid Disorder**
Heart Disease	**Stroke**	**Crohn's Disease**	**Pulmonary Embolism (PE)**	**GERD (acid Reflux)**
Asthma	**Eczema**	**Kidney Disease**	**Rheumatoid Arthritis**	**Peripheral Vascular Disease**
Headaches	**Emphysema**	**Glaucoma**	**Sciatica**	**Irritable Bowel Syndrome**
Carpal Tunnel	**Gallstones**	**Bladder Problems**	**Seizure Disorder**	**Macular Degeneration**
Nosebleeds	**Migraines**	**Liver Disease**	**Sleep Apnea**	**DVT (Blood Clot)**

Other Medical Problems:

_____ _____ _____

_____ _____ _____

Surgical History: Please list all prior Surgeries and approximate dates performed.

Procedure	**Date**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

*Patient Name:*_____ *Patient DOB:*_____

Family History

(M): ***Mother****:* ***Living*** *Age*_____ ***Deceased*** *Age* _____
(F) ***Father*** *:* ***Living*** *Age*_____ ***Deceased*** *Age*_____
(S) ***Sibling*** *:*_____

Please write abbreviation to the family member who has had diagnosis with M for Mother, or F *for father or* ***S for a sibling:***

Alcoholism	**Migraines**	**Depression**	**Thyroid Cancer**	**COPD/Emphysema**
Skin Cancer	**Anemia**	**Lymph Cancer**	**Prostate Cancer**	**Blood Cancer**
Arthritis	**Stroke**	**Diabetes 1 or 2**	**Ovarian Cancer**	**Thyroid Disorder**
Dementia	**Asthma**	**Colon Cancer**	**High Cholesterol**	**Heart Disease**
Bipolar	**Kidney Disease**		**Blood Clots / DVT**	**High Blood Pressure**

Other _____

Authorization for Treatment

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

_____ _____

Signature of Patient / Guardian or Authorized Representative Date

_____

Print Name of Authorized Representative

PATIENT CONTRACT

I, _____ understand that I am being seen for podiatric issues. The care 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, ineffective or made worse.. 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, which benefits are covered and which are not.
17. Notifying the office if any contact or coverage information changes occurred.
18. Having an emergency contact listed should critical information needs 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) 391-3344. 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 an 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 canceling, someone else who could have been seen in your place is delayed, unnecessarily. We track missed (non-canceled) appointments. A "No Show / Late Cancellation" is defined as missing an appointment without canceling at least 24 hours before the scheduled time. There will be a charge for missed or non-canceled 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 appointments 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 the time of the 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 device (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 purposes

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 to 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

CONSENT FOR TRANSFER OF BIOLOGICAL SPECIMEN

Florida law (Section 817.5655, Florida Statutes) prohibits the sale or transfer of a person's biological specimen from which DNA can be extracted to a third party without the express consent of such person.

During the course of your care at ON 2 FEET, it may be medically necessary to obtain a blood, urine, stool, tissue or other type of biological specimen for analysis. This analysis **will not** involve the examination of your DNA to identify the presence and composition of genes in your body. After the analysis has been performed and the sample is no longer needed, it will be stored as medical waste and then transferred to a third party for disposal in accordance with all local, state and federal requirements.

It may also be the case that a biological specimen (such as blood, urine, hair, bodily fluids, etc.) from you may be deposited on medical instruments, bedding, clothing or other objects. These objects may then be transferred to a third party for cleaning or disposal.

By signing this document, you affirmatively state that it is your intentional decision to consent to the transfer of any and all biological specimens collected by or deposited with ON 2 FEET to a third party as set forth above. This consent does not authorize the sale or transfer of a biological specimen for the purpose of DNA analysis.

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 the 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 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 a 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