COMPLETE FOOT & ANKLE CARE

2701 N. Tenaya Way #230, Las Vegas, NV 89128 (702) 248-FOOT (3668)

INTAKE PAPERWORK

Last Name:_________________________________ First Name:___________________________ Middle Initial:____

Birth Date:________________ SS# ________-_____-________

Street:____

City:_______________________________________ State:____________ Zip:____________

Preferred

Home Phone:__________________ ☐

Cell Phone:____________________ ☐

Email: ____

Marital Status (circle one): Single Married Separated Divorced Widowed

Sex: M F Race: ______________________________ Ethnicity (circle one): Hispanic or Latino / Not Hispanic or Latino

Employer: ____ Occupation: ____

Employer address: ____

____

Work Phone: ________________

In case of emergency, contact:

Name: ____Relationship: ______________Phone: ______________

Address: ____

____

How did you hear about our office?

☐ Doctor referral. Name of Dr.:_____________________________ ☐Internet. Which site? ______________________________

☐ Friend. Name of friend __________________________________ ☐ Direct mail

☐ Other. Specify ____

Confidential Communications / HIPAA

I request that all written or oral communications to me (by telephone, mail or otherwise) by Complete Foot & Ankle Care and /or its staff be handled by using the above address and telephone number. I am responsible to notify the office of any change of above.

I have been offered a copy of the Privacy Practice Notification of Complete Foot & Ankle Care and have read and understand it.

Patient Signature ____

Complete Foot and Ankle Care wants to ensure your privacy. This form is intended to give you the opportunity to release medical information to designated parties (this does not apply to minors under the age of 18).

You may release pertinent medical information related to diagnosis and treatment from my office visits to the following parties:

Name: ____ Relationship _______________ Phone: _________________

Name: ____ Relationship _______________ Phone: _________________

Patient Signature ____ Date: ______________

Insurance Information

Name of Insurance: ____

Name of Insured: _______________________________________Relationship to patient: _____________________

Birth Date of Insured ____________________

Address of Insured ____

____

Policy # ______________________ Group # _________________________

Secondary Insurance

Name of Insurance: ____

Name of Insured: _______________________________________Relationship to patient: _____________________

Birth Date of Insured ____________________

Address of Insured ____

____

Policy # ______________________ Group # _________________________

Assignment and Release

I, the undersigned, certify that I (or mydependent) have insurance coverage with ___________________________ and assign directly to Complete Foot & Ankle Care all insurance benefite, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all insurance submissions.

Responsible Party Signature:______________________________________ Relationship:____________ Date:____________

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Complete Foot & Ankle Care for any services furnished to me by that physician. I authorize any holder of medical information about me to release to Complete Foot & Ankle Care 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 HCJA-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, coinsurance, and non-covered services. Coinsurance and deductibles are based upon the charge determination of the Medicare carrier.

Beneficiary Signature:____Date:_______________

Patient Health History

Name ____ Height ________ Weight _________
Primary Doctor ____ Phone______________________

Preferred Pharmacy
Name of Pharmacy: ____
Pharmacy Address (or cross streets) ____

Allergies to medication: ____
Other Allergies: ____

List of Medications you are currently on:

Name of medicine	Dose	Frequency	Reason for taking

List Surgeries you have had:

____
____
____
____
____

Family History
List medical conditions that any blood relatives have

Relative's relationship to you (ex. Son, maternal grandmother, etc)	Medical Condition

Do you smoke? YES / NO **Type** (circle any that apply) Cigarettes Cigars Pipe Other Amount per day: ____ Years smoked___
Do you drink alcohol? YES / NO **Type** (circle any that apply) Beer Wine Hard Liquor Amount per day ____ month____Year___

Please mark any of the following that you have

Constitutional
___ Chills
___ Fatigue
___ Fever
___ Loss of Appetite
___ Weakness
___ Weight Gain
___ Weight Loss

Head
___ Dizziness
___ Fainting
___ Headache
___ Pain
___ Sweats

ENT
Nose
___ Bleeding
___ Discharge
___ Infection
___ Obstruction
Mouth
___ Bleeding
___ Dentures
___ Dry Mouth
Ears
___ Hearing Aid
___ Infections
___ Ringing
Throat/Neck
___ Hoarseness
___ Lumps
___ Sore Throat
___ Tenderness

Eye
___ Blurred Vision
___ Cataracts
___ Contacts
___ Eyeglasses
___ Glaucoma
___ Infections

Respiratory
___ Asthma
___ Bronchitis
___ COPD
___ Cough
___ Short of breath
___ TB
___ Wheezing

Cardiovascular
___ Chest Pain
___ Cramps in legs/feet
___ Extremity(s) cool
___ Hair loss on legs
___ Heart murmur
___ High Blood Pressure
___ History of Heart Attack
___ Leg or Foot Ulcers
___ Palpatations
___ Replacement Heart Valve
___ Varicose Viens

Gastrointestinal
___ Constipation
___ Excessive Thirst
___ Gall Bladder Disease
___ Heartburn
___ Hepatitis
___ Jaundice
___ Liver Disease
___ Nausea
___ Rectal Bleeding
___ Swallowing Problems

Psychiatric
___ Depression
___ Disorientation
___ Memory Loss

Musculoskeletal
___ Ankle Sprain
___ Arch Pain
___ Arthritis
___ Back Problems
___ Broken Ankle
___ Broken Foot Bone
___ Bunions
___ Callouses
___ Childhood Foot Problems
___ Corns
___ Flat Feet
___ Gait (walking) problems
___ Gout
___ Hammer/Mallet Toes
___ Heel Pain
___ High Arch Feet
___ In-toeing
___ Joint Implants
___ Joint Pain
___ Joint Stiffness
___ Knee Pain
___ Lower Back Pain
___ Muscle Cramps
___ Muscle Stiffness
___ Neuroma
___ Paralysis
___ Restricted Motion
___ Shoe insert use
___ Toe Walking
___ Weakness

Endocrine
___ Goiter
___ Sweats
___ Thyroid

Skin
___ Athlete's Foot
___ Dryness
___ Eczema
___ Fungal Nails
___ Hives
___ Ingrown Nails
___ Itching
___ Keloid Scar
___ Lumps
___ Mole Changes
___ Rash
___Warts

Neurological
___ Blackouts
___ Burning
___ Charcot Neuroarthropathy
___ Fainting
___ Neuromas
___ Numbness
___ Speech Disorders
___ Strokes
___ Tingling
___ Tremors
___ Unsteady Gait

Hematologic/Lymph
___ Anemia
___ Bleeding Easily
___ Blood Clots
___ Bruises Easily
___ Recent Chemotherapy
___ Slow Healing Cuts
___ Swollen Glands
___ Transfusion Reaction

Please mark any of the following Medical Conditions that you have/had

__ Anemia	__ Cancer	__ Epilepsy	__ Heart Attack
__ Anxiety	Type _______	__ GERD	__ Migraine
__ Arthritis	__ High Cholesterol	__ Glaucoma	__ Pneumonia
__ Asthma	__ Dementia	__ Gout	__ Kidney Stone
__ Back Problem	__ Depression	__ HIV	__ Stroke
__ Coronary Artery Disease	__ Dermatitis	__ Headache	__ TB
__ CHF	__ Diabetes	__ Hepatitis	__ Thyroid Disease
__ COPD	(circle) Type 1 / Type 2	__ Hypertension	__ Ulcer (GI)

Have you ever broken a bone in your foot or ankle? YES /NO
Which bone? ____________________________When? _________
Have you had a problem with this area since that time?

What is your normal shoe size? ______________

Please answer the following:

1. Do you have difficulty sleeping as a result of foot or leg pain? Yes/ No
2. Do you have persistent stomach problems not associated with another diagnosis? Yes/ No
3. Do you have a loss of balance and coordination, difficulty walking or moving your arms? Yes/ No
4. Do you have pain, tingling, loss of sensation, burning or freezing sensation, in your hands or feet? Yes/ No
5. Do you have abnormalities in blood pressure or pulse or unusual sweating? Yes/ No
6. Do you have dry skin in the upper or lower extremities? Yes/ No

What is the purpose of your visit today?

____

____

____

On a scale of 1 –10, how does your condition make you feel? (Please circle)

1 2 3 4 5 6 7 8 9 10

No Pain Moderate pain Severe Pain

COMPLETE FOOT & ANKLE CARE OFFICE POLICIES

COLLECTIONS POLICY

- In the event your account is assigned to a collection agency, you agree to pay a collection fee in the amount equal to 30% of the balance due assigned to the collection agency.
- There is a returned check fee of **$50.00**. If for any reason you write a check to our office that does not clear, This fee will be added to your account and collected at next visit.

DURABLE MEDICAL EQUIPMENT

- These items include, but are not limited to:

  Walking Boots, Night Splint, Ankle & Trilok Brace, Custom Orthotic & Children's Orthotic Inserts, Ped Pillows Inserts, Vionic footwear, Any accommodative over the counter items

- Items listed above are NON-RETURNABLE. We are restricted from re-selling items that have been taken from this office due to health regulation.

INSURANCE POLICY

- Please check with your insurance to find out if we are "in-network" with your policy and if you need a referral.
- Your insurance policy is a contract between you and your insurance company; therefore, you are responsible for payment whether or not your insurance company pays. If proper authorizations or referrals are not obtained, this may reduce the benefits paid by your insurance company. This would be patient responsibility.
- Failure to inform us of any changes to insurance may result in denied claims, and responsibilities being 100% patients.

MEDICAL RECORDS/ X-RAYS

- Your records are the property of the office. The original copy must stay in the office. As a patient, you may request medical records and purchase copies per the State of Nevada fee schedule. We require a signed waiver and request 2 weeks notice. We do not print or place your X-ray images on a CD. You must bring a USB drive into the office for X-rays.

NEW PATIENT, BOOTS, PROCEDURE & OA DEPOSITS

- Based on your deductible and amount met, we may take a deposit for the above-mentioned items. This deposit will be applied to your billed responsible amount. Remaining money will be re-issued via our billing department. If these services are non-covered by insurance they will be marked down as Self pay.

LATE/NO-SHOW POLICY

- If you are unable to keep your scheduled appointment, please notify us **at least 24 hours** in advance so we can accommodate our other patients.
- We strive to take time with each individual patient. Your punctuality affects your appointment, as well as others'. If you are **15 minutes late**, we may be able to work you into the schedule at a later time or we may ask you to reschedule.
- Our office strives to stay punctual- this is because we do not overbook appointments in anticipation of cancellations. However, certain medical circumstances may be allowed exceptions.
- A no-show or short notice cancellation will result in a charge of **$50.00**.
- On the second no-show or late cancellation appointment, it will be up to the Doctor's discretion as to whether a discharge letter will be sent disengaging you from the practice.
- For **CANCELED PROCEDURE**, you will be charged **$350.00** for cancelation. (**If less than 7 days prior to scheduled procedure date.**)

PLEASE SIGN BELOW THAT YOU HAVE READ AND UNDERSTAND OUR POLICIES:

I ____ have reviewed the above policies.

Signature____Date________________________________