PRECISION
FOOT AND ANKLE, P.A.
P: (727) 399-7167
www.precisionfootandankleFL.com

Pinellas Park Location
7800 66th Street N Ste 207
Pinellas Park, FL 33781

New Patient Paperwork

Today's Date: _____/_____/_____

Patient Name: *Last* *First* *MI*		*Date of Birth*	Sex (Circle): M F
Home Address:	*City/State*	*Zip*	
Home Phone #	*Work Phone #*	*Cell Phone #*	
Email Address (Mandatory)		*Primary Language*	
Race		*Ethnicity*	
Emergency Contact:	**Relationship:**	**Phone Number:**	
Primary Care Doctor:		**Phone:**	
Primary Insurance Company Name		*Member Number*	
Preferred Pharmacy		*Pharmacy Phone Number*	

How did you hear about us? ☐ Insurance Company Website ☐ Referral ☐ Google ☐ ZocDoc ☐ Friend ☐ Online ad ☐ Medical Lecture ☐ Postcard ☐ Other: _____

Current Problem

What is the reason for your visit today?

How long ago did this problem start? _____ ☐ Days ☐ Weeks ☐ Months ☐ Years

Did the pain or problem: ☐ Begin all of a sudden ☐ Gradually develop over time

How would you describe the pain? ☐ No pain ☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Radiating ☐ Itching ☐ Stabbing ☐ Other _____

How would you rate the pain on a scale from 0 to 10? (Please Circle)
(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worse pain possible)

Since the pain began, has it: ☐ stayed the same ☐ become worse ☐ improved

What makes your pain or problem worse? ☐ Walking ☐ Standing ☐ Daily Activities ☐ Resting ☐ Dress shoes ☐ High Heels ☐ Flat Shoes ☐ Closed Toe Shoes ☐ Running ☐ Other:_____

What makes the pain or problem feel better?

What treatments have you had for this problem?

What treatments have you tried for this problem?

Was this problem caused by an injury? ☐ YES (describe) _____ ☐ NO

If so, was this injury work-related? ☐ YES ☐ NO

Medical History

Do you have any of the following medical problems? ☐ Anemia ☐ Anxiety ☐ Back pain ☐ Bleeding problems ☐ Blood clots ☐ Cancer: type _____ ☐ COPD ☐ Depression ☐ Diabetes: type_____ last hemoglobin A1c % _____ ☐ Fibromyalgia ☐ Gout ☐ Heartburn/Reflex ☐ Heart Failure ☐ Heart Problems ☐ Heart Attacks ☐ HIV/AIDS ☐ High Blood Pressure ☐ Joint Implants ☐ Kidney Problems ☐ Liver Problems ☐ Migraines ☐ Neuropathy ☐ Open Sores ☐ Osteoporosis ☐ Peripheral vascular disease ☐ Polio ☐ Rheumatoid Arthritis ☐ Skin Problems ☐ Sleep Apnea ☐ Stomach Ulcers ☐ Stroke ☐ Thyroid Disease

Other Medical Problems Not Listed Above:

Surgical History – Please List All Prior Surgeries and the Date of The Surgeries

☐ Foot or ankle surgery (type: _____)
☐ Other surgeries: _____
☐ None

Family History (First-Degree Relatives):

☐ Diabetes ☐ Heart disease ☐ Cancer ☐ Stroke ☐ Other: _____ ☐ None known

Social History

Do you smoke? ☐ Yes ☐ No ☐ Quit_____ years ago If yes, how much? _____
Do you drink alcohol? ☐ Yes ☐ No If yes, how often? _____
Occupation: _____ Are you ☐ Working ☐ Retired ☐ Disabled

Allergies: Please List All Of Your Allergies Below:

☐ No known drug allergies. ☐ Allergic to: _____
Reaction: _____

Medications – Please List All Medications You Are Currently Taking (Including prescriptions, over-the-counter and herbal supplements)

Please list current medications or provide a medication list:

_____

_____

Review of Systems

Check any current or recent symptoms:

☐ I have no symptoms at this time
Constitutional: ☐ None ☐ Weight change ☐ Fatigue ☐ Fever
Eyes: ☐ None ☐ Vision changes ☐ Eye pain
ENT: ☐ None ☐ Hearing loss ☐ Sore throat
Cardiac: ☐ None ☐ Chest pain ☐ Palpitations
Respiratory: ☐ None ☐ Cough ☐ Shortness of breath
GI: ☐ None ☐ Nausea ☐ Constipation
GU: ☐ None ☐ Frequent urination ☐ Painful urination
Musculoskeletal: ☐ None ☐ Joint pain ☐ Foot/ankle pain
Neuro: ☐ None ☐ Numbness ☐ Dizziness ☐ Headache
Skin: ☐ None ☐ Rash ☐ Wounds
Psych: ☐ None ☐ Anxiety ☐ Depression

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.

Patient Name (Print here)	***Signature***	***Date***

Physician Signature	***Date***

Patient Name:	**Date of Birth:**
AUTHORIZATION FOR TREATMENT & RELEASE OF INFORMATION	**SUMMARY OF NOTICE OF PRIVACY PRACTICES**

I, the patient, legal guardian or health care surrogate, hereby authorize Precision Foot and Ankle, P.A. doctors and staff to examine and treat the aforementioned, if necessary. I understand that this consent may be withdrawn at any time and withdrawal of consent must be in writing to the Precision Foot and Ankle, P.A. doctors and staff. I understand that photographs may be taken by Precision Foot and Ankle PA doctors and staff for documentation purposes to be included as part of the medical record.

The patient, legal guardian or health care surrogate authorizes Precision Foot and Ankle PA doctors and staff to disclose appropriate and necessary clinical information to other facility staff for the purpose of treatment. Clinical information can be released to family members listed below for purposes of treatment:

1.
2.
3.

ASSIGNMENT OF BENEFITS

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. You agree to allow Precision Foot and Ankle, P.A. to bill your insurance directly and receive payments for services rendered. You may be responsible for any non-covered services and your portion of payments that are patient responsibility.

Uses and Disclosures of Health Information We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please feel free to contact us.

If you believe that your privacy rights have been violated, you may file a complaint with our HIPPA Privacy Manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Requested medical records will be provided *within 30 days of the date of request.*

ACKNOWLEGEMENT OF AUTHORIZATION FOR TREATMENT, RELEASE OF INFORMATION, AND NOTICE OF PRIVACY PRACTICES

I, the patient or legal representative have reviewed the above information and agree to allow Precision Foot and Ankle, P.A. doctors and staff to proceed with treatment of the above-mentioned payment and agree to the above terms of service.

Signature of Patient or Legal Representative	***Date***

Financial Policy

Your clear understanding of our Financial Policy is important to our professional relationship. We are a Medicare provider and also a provider for most PPO and some HMO insurance plans in our area. It is your responsibility to make sure we are on your insurance plan. If your insurance requires a referral, it is your responsibility to make sure that it is in place prior to your appointment. We will be glad to assist you if you need help. If a referral is required but not on file, you will personally be financially responsible for the visit.

Balances/Collection Fees: We bill your insurance company as a courtesy to you. We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. You agree to allow Precision Foot and Ankle, P.A. to bill your insurance directly and receive payments for services rendered. **All co-payments are due at the time of your visit. If you have an unmet deductible we pre-collect 60% of the charges incurred that your insurance will apply towards your deductible.** You are responsible for all fees not covered by your insurance company or transferred to patient responsibility by your insurance carrier. Past due accounts more than 90 days will be turned over to our collection agency and a 30% fee of the balance due will be added to cover collection costs. I also understand that failure to pay my bill implies discontinuation of podiatry services.

Routine foot care services such as trimming nails or calluses (“chip and clip”) or ingrown toenail procedures without severe infection are typically not considered medically necessary by most insurance companies, including Medicare. These are **self-pay services**, and payment is due at the time of service. If you are unsure whether a service is covered, please ask the doctor before it is performed.

Complete payment for all podiatry soft goods, medical products and supplies are due at the time they are dispensed. All sales are final and there are no refunds of any kind on products dispensed including custom orthotics, fracture boots, products, etc.

A 24-hour notice is mandatory for cancellation of appointments. If you cancel in less than 24 hours, you will be charged a **$75 cancellation fee** or as permitted by your insurance contract. If you fail to show for an appointment without calling, you personally will be charged a **$100 no-show fee**. Repeat cancellations or no-shows may result in dismissal.

I have read the above policy and understand my financial responsibility to Precision Foot and Ankle for medical services rendered. I agree to pay any balance due/or unpaid by my insurance carrier for myself or the below named person.

Financially Responsible Party:

Patient Name: _____ Signature: _____

Parent or Authorized Representative: _____ Date: _____