Welcome to our office! Thank You for choosing Sole Foot & Ankle Specialists!

Sole Foot & Ankle Specialists

68 N High Street, Suite 150
New Albany, Ohio 43054
P: 614-741-4001, F: 614-656-7065

Patient's Name: _____ **Date of Birth**: ____/____/____

Gender: Male Female **Email**: _____

Marital Status: Married Single Divorced Widowed

Address: _____

City: _____ **State**: _____ **Zip**: _____

Cell Phone: (____) _____ **Home Phone**: (____) _____

Alternate Phone Number: (____) _____ **Work Phone**: (____) _____

Primary Doctor: _____ **Address**: _____

Primary Doctor's Phone: (____) _____ **Date Last Seen**: ____/____/____

Pharmacy: _____ **Location**: _____

Occupation: _____ **Employer**: _____

How did you hear about our office? Google / Internet / Primary Care: _____

Friend/Relative: _____ Other: _____

Emergency Contact's Name: _____ **Phone Number**: _____

Insurance Information:

Insurance Company: _____ **Policy Number**: _____

Primary Policy Holder's Name: _____

Policy Holder's D.O.B ____/____/____ **Social Security #** ____-____-____

Policy Holder's Relationship to Patient: _____

Secondary Insurance: _____ **Policy Number**: _____

Tertiary Insurance: _____ **Policy Number**: _____

Patient Medical History

Please circle all **Allergies** or adverse reactions to medications: None Penicillin Sulfa Drugs Ibuprofen Aspirin Food/**Others**: _____

Please circle your **Current Medications:** Atorvastatin 10/20/40/80mg Omeprazole Albuterol Levothyroxine 25/50/75/100/125 mcg Lisinopril 2.5/5/10/20/30/40 Amlodipine 5/10mg Metformin 500/1000 mg Gabapentin 100/300mg Losartan25/50/100mg
Others: _____

Please circle your **Medical History**: Diabetes type I/ Type II Hypertension Depression Cholesterol Heart Disease Psychotic Disorder CHF Prostate Disorder MI DVT Poor Circulation Varicose Veins Clotting Disorder Thyroid Disease
Others: _____

Please list all **Surgeries or Hospitalizations**: _____

Please list your **Family's Medical History** _____

Height: _____ **Weight:** _____ **Shoe Size:** _____

Most Recent Blood Pressure: _____

Most Recent HgA1c (Diabetics): _____

Do you **smoke**? Yes ____ No ____ How much per day? _____

Do you **drink**? Yes ____ No ____ How much per day? _____ Per week _____

Do you use **illicit drugs**? Yes ____ No ____ Please describe: _____

Please describe (in detail) the reason for your visit:

_____

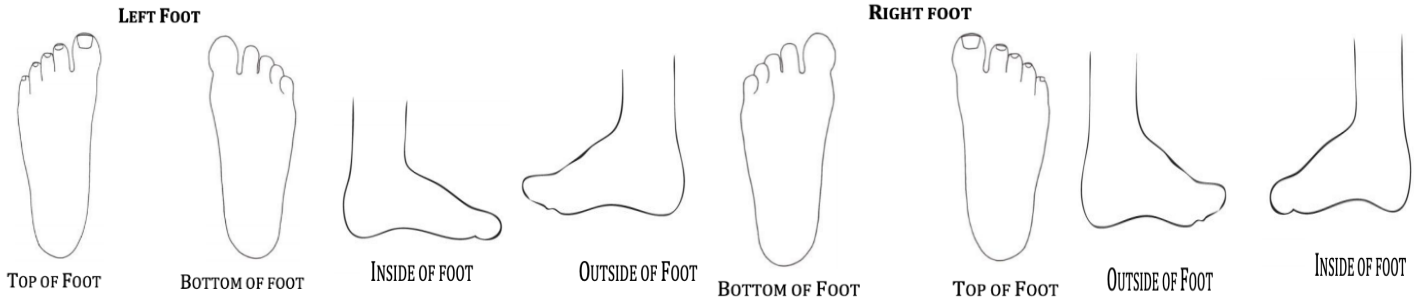
_____

How would you describe your pain? (Circle)

Aching / Throbbing / Sharp / Pins&Needles / Electrical Sensation / Burning / Cramping / Numbness

Rate your pain on a scale of 1-10, with 10 being the worst **1 2 3 4 5 6 7 8 9 10**

Where is the pain/problem located? Left Right Foot Ankle Leg



Authorization for Release of Case Records

I hereby authorize my **Primary Physician, Dr.** _____,
to disclose to **Sole Foot and Ankle Specialists** any information which they may have acquired by examination of my physical or mental condition. I hereby release them of any Consequence.

_____ _____/_____/_____

Patient's Signature **Date**

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

. Acknowledgement of Practice's *Notice of Privacy Practices*

By subscribing to my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

II. Designation of Certain Relative, close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain of my health information to a personal Representative of my choosing, since such a 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 Names: _____

III. As provided by the Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed on Page 1 (including, cell/work/home phone number and email address). I also agree that it is OK to leave a message with detailed information regarding my health records. I also agree that practice may send and may share my email for marketing purposes.

III. E-PRESCRIBING CONSENT

E-Prescribing is defined by a Physician's ability to electronically send an accurate, error free, and understandable prescription directly to your pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-prescribing greatly reduces medication errors and enhances patient safety. The Medicare modernization act of 2003, listed standards that have to be included in an e-prescribing program. These include (1) Formulary and benefit transactions which gives the prescriber information about which drugs are covered by a drug benefit plan (2) Medication history transactions, which provides the physician with information about medications the patient is already taking to minimize adverse drug events. I authorize **Sole Foot and Ankle Specialists**, to view my external prescription history via electronic E-prescribing services. I understand that prescription history from multiple, other unaffiliated, provider, insurance companies, pharmacies and pharmacy benefit managers may be viewable by the providers and staff of **Sole Foot and Ankle Specialists**, 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. Understanding all of the above, I hereby provide informed consent to **Sole Foot and Ankle Specialists** to enroll me in the E-prescribe program. This consent will remain enforced until revoked or changed.

V. 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 my changes in medical status.

V. I give permission to the doctors at **Sole Foot and Ankle Specialists** to administer and perform any diagnostic, therapeutic and operative procedures as may deemed medically necessary in diagnosis and treatment of my condition.

V. Patients/Minors under the age of 18 will not be treated without a Parent or Legal Guardian present.

I have read, understood, and agreed to the above terms and conditions.

_____ _____/_____/_____

Patient/Parent/Guardian Signature **Date**

FINANCIAL POLICY – Please Read Carefully!

Thank you for choosing **Sole Foot and Ankle Specialists** as your provider. We are committed to providing you with quality and affordable health care and to being transparent with our billing process. Please read the following policy. Feel free to ask us any questions that you may have. When you have accepted the policy, please **sign** in the space provided. A copy will be provided to you upon request.

It is my responsibility to provide up-to-date insurance information prior to my appointment and each time my insurance changes.
Office must maintain a copy of my Insurance and ID Cards as protection for me against fraud.
If I do not have insurance that the office participates in or fail to provide up-to-date insurance information for a plan office to participate in, I will need to pay in full for all charges.
It is my full responsibility to know and understand the details of my insurance policy including, but not limited to, in vs.out of network, co-pays, deductibles, co-insurance and non-covered services.
Coverage & benefits quotes I am given are provided in good faith from what office/staff has been told by my insurance but are in no way a guarantee of payment or coverage. It is my responsibility to contact my insurance company with questions I have on my coverage.
If required, it is my responsibility to obtain a proper referral. Failure to do so will result in my paying in full for all charges. This payment will be held for 48 hours and will become non-refundable if proper referrals are not presented by that time.
All anticipated patient responsible charges must be paid at the time of service, this includes co-pays, co-insurance, deductibles and non-covered services. If it is not known that a service is non-covered until after the appointment, I will be billed for that service.
Services associated with my visit will be promptly sent to insurance for claim processing. After my insurance has processed the claim(s), I will receive a statement listing charges that are my responsibility. I agree to pay in full within 30 days of the statement date.
Office will NOT enter into a dispute with my insurance company over my claim. I understand this is my responsibility and obligation.
If there is an outstanding balance on my or my family's account(s), I will need to pay in full at the time of check-in.
Unpaid balances past 30 days are subject to a $10 repeat statement fee.
Unpaid balances past 60 days may be sent to a collection agency and fees associated with that agency will be added to my balance.
Office will submit my claims and assist me in any way reasonable to help get my claims paid. My insurance company may need me to supply certain information directly. It is my responsibility to comply with their request. Failure to do so, will result in my paying in full for all charges
Cancellations must be made 24 hours in advance. Failure to do so will result in a $35 fee.
Appointments not canceled, and not kept are deemed 'No-shows' and will incur a $50 fee.
After 3 No-shows and/or late cancellations, I will be required to leave a non-refundable deposit for future appointments. The deposit will be applied to any balance due at kept appointments.
The office staff will submit the requested documentation on my behalf to my insurance company. The charge for completing medical forms (disability, leave of absence, etc.) is $25.00. Forms will be completed as time. permits usually within 7 business days. Copies of medical records are available at $1.00 per page. All returned. checks will be assessed an additional charge of $30.00 per check.

I have read and understand the payment policy and agree to abide by its guidelines:

_____

Print name of patient or responsible party

_____ _____

Signature of patient or responsible party **Date**