FLORIDA ANKLE AND FOOT INSTITUTE

John F. Torregrosa, DPM, FACFAS, FACFAOM
Gon Saman, DPM, AACFAS, FACPM
Fellow American College of Foot and Ankle Surgeons
Fellow American College of Foot & Ankle Orthopedics and Medicine

PATIENT INFORMATION

Today's Date _____ Social Security Number _____

Name _____
Last First Middle Initial

Mailing Address_____City _____ State____ Zip_____

Local Address_____City_____State____Zip_____

Home Phone Number_____ Cell Phone Number_____

Date of Birth_____ Age_____ Sex: ☐ Male ☐ Female

Marital Status ☐ Single/ ☐ Married/ ☐ Widowed/ ☐ Divorced/ ☐ Separated

Employer_____ Occupation_____

Employment Address_____

Work Phone Number_____ Home Email_____

SPOUSE INFORMATION

Name_____ SSN_____

Address_____ City_____ State____ Zip_____

Home Phone_____ Work Phone_____

EMERGENCY CONTACT

In case of emergency, whom should we contact?
Name_____Phone_____
Relation_____

PRIMARY DOCTOR:_____
PHONE NUMBER: _____

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WORK COMP CARRIER: _____
WORK COMP ADJUSTER _____
PH:_____ FX:_____
WORK COMP NCM: _____
PH: FX:

Is this visit accident related? ☐ Yes ☐ No Work related? ☐ Yes ☐ No

Date of accident/onset_____

PRIMARY INSURANCE

Insurance Company_____

Claims Address_____

Insured's Name_____

Insured's SSN_____ Insured's Date of Birth_____

Policy #_____ Group #_____

SECONDARY INSURANCE

Insurance Company_____

Claims Address_____

Insured's Name_____

Insured's SSN_____ Insured's Date of Birth_____

Policy #_____ Group #_____

I authorize the release of medical information necessary to process this claim or provide prudent medical care either by mail, phone or fax. I also request payment of benefits to be made to the party who accepts assignment.

_____ _____

Patient/Responsible Party Signature **Date**

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CANCELLATION POLICY: WE HAVE A 24 HOUR NOTICE CANCELLATION POLICY.

PRESCRIPTION REFILL POLICY: All patients requiring refills of their medications must notify their pharmacy, who will request a refill from our office. Refill requests require 48 hours notice and are handled at the end of our patient day, so please plan ahead.

I have read and understand the above policies.

_____ _____

Patient/Responsible Party Signature **Date**

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91550 Overseas Highway
Suite 107
Tavernier, FL 33070

Mail: P.O. Box 1199, Tavernier, Fl 33070

FINANCIAL RESPONSIBILITY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is an addendum to our existing Financial Policy, we require you to read and sign it prior to treatment.

All patients must complete our information and insurance forms before seeing the doctor.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, AND AMERICAN EXPRESS. WE OFFER EXTENDED PAYMENT PLANS (please consult with our Patient Accounts Representatives).

INSURANCE ASSIGNMENTS

In most cases we will accept assignment of insurance benefits. However, we do require a form of payment to cover amounts not paid by insurance. (Forms of payments include authorizations to pay by credit card, check or cash.) If your insurance company has not paid your account in full within 90 days of date of service we will automatically transfer your balance to your extended plan.

Payment in full is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information and original claim form (when required). Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.

Please be aware that some, and perhaps all, of the services provided may be non-covered services and/or not considered reasonable and necessary under Medicare and/or other medical insurance.

INSURANCE PLANS WHERE WE ARE A "PARTICIPATING PROVIDER"

All co-pays and deductibles are due on the date services are rendered, with the exceptions of Medicare, in which case we will bill once we receive the explanation of benefits from Medicare.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

MISSED APPOINTMENTS

Unless canceled 24 hours in advance, we reserve the right to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping your appointments.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.
I have read this Financial Policy and understand and agree with its terms.

Patient Name **Signature** **Date**

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? ☐ YES ☐ NO

May we leave a message on your answering machine at home or on your cell phone? ☐ YES ☐ NO

May we discuss your medical condition with any member of your family? ☐ YES ☐ NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

MEDICARE RECIPIENTS ONLY

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
	NOT A COVERED SERVICE AND/OR NOT DEEMED A MEDICAL NECESSITY BY MEDICARE	

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☑ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

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NEW PATIENT HISTORY FORM

Please take a moment to answer the following questions as thoroughly and as accurately as possible. Thank you.

Patient Name: _____ **Date:** _____

Date of Birth: _____ **Age:** _____ **Sex** ☐ **M** ☐ **F** **Occupation:** _____

Height: _____ **Weight:** _____

Reason for your visit: _____

Whom may we thank for referring you? _____

Who is your primary doctor? _____

If female, are you or could you be pregnant? ☐ **Yes** ☐ **No**

Was your injury sustained at work? ☐ **Yes** ☐ **No** **If yes is it Worker's Comp?** ☐ **Yes** ☐ **No**

Is this injury the subject of litigation? ☐ **Yes** ☐ **No**

Are you currently working? ☐ **Yes** ☐ **No**

If no, when did you last work? _____

Please list *ALL* current and past medical illnesses/problems:

_____

_____

_____

Please list *ALL* previous surgeries/procedures:

_____

_____

_____

_____

_____

_____ _____

Patient or Legal Guardian

John F. Torregrosa, DPM, FACFAS, FACFAOM
Gon Saman, DPM, AACFAS, FACPM

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Patient Name: _____ Date:_____

Please list *ALL* current medication, including vitamins/supplements:

Name of Medication	**Rason**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Pharmacy Name: _____ PH: _____

Please list any illnesses that run in your immediate family (i.e. parents, siblings):

_____

Please list any *ALLERGIES* to medications, foods, contrasts, or dye:

_____

Do you smoke? ☐ If yes, how many pack(s)____/day, for ____years Quit ____years ago

Do you drink beer, liquor, or wine? ☐ If yes, how much and how often? _____

Do you currently use any illicit drugs? ☐ Yes ☐ No

Can you take Aspirin? ☐ Yes ☐ No

Have you ever had stomach ulcers? ☐ Yes ☐ No

Have you taken a Steroid medication (e.g., Prednisone, Cortisone) within the past 6 months?
☐ Yes ☐ No

Do you require Antibiotics before dental procedures (i.e., antibiotic prophylaxis)? ☐ Yes ☐ No

Have you ever been treated for nervous or emotional problems? ☐ Yes ☐ No

Have you ever had or been treated for KIDNEY PROBLEMS?

Y	**N**		**Y**	**N**	
☐	☐	**Kidney failure**	☐	☐	**Stones/Calculi**
☐	☐	**Pain with urination**	☐	☐	**Blood in urine**
☐	☐	**Incontinence**			

_____ _____

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NEW PATIENT HISTORY FORM
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Have you ever had or been treated for HEART PROBLEMS?

Y	N		Y	N	
☐	☐	Chest pain/Angina			
☐	☐	Heart Attack	☐	☐	Murmur
☐	☐	Stroke	☐	☐	Irregular heart beat
☐	☐	Heart failure	☐	☐	High blood pressure
☐	☐	Palpitations	☐	☐	Low blood pressure

Have you ever had or been treated for LUNG PROBLEMS?

Y	N		Y	N	
☐	☐	Asthma	☐	☐	Wheezing
☐	☐	Bronchitis/Chronic cough	☐	☐	Emphysema
☐	☐	Pneumonia	☐	☐	Tuberculosis
☐	☐	Shortness of breath			

Have you ever had or been treated for DIGESTIVE TRACT PROBLEMS?

Y	N		Y	N	
☐	☐	Ulcer disease/Gastritis	☐	☐	Chronic indigestion
☐	☐	Reflux	☐	☐	Hernia
☐	☐	Hepatitis/Jaundice	☐	☐	Liver problems/Cirrhosis
☐	☐	Gall bladder problems	☐	☐	Pancreatitis

Have you ever had or been treated for METABOLIC or ENDOCRINE PROBLEMS?

Y	N		Y	N	
☐	☐	Diabetes	☐	☐	Low blood sugar
☐	☐	Thyroid disease	☐	☐	Fatigue
☐	☐	Weight loss/gain	☐	☐	Fainting

Have you ever had or been treated for PROLONGED BLEEDING or EASY BRUISING?

Y	N
☐	☐

Have you ever had or been treated for NEUROLOGICAL PROBLEMS?

Y	N	
☐	☐	Convulsions/Epilepsy
☐	☐	Numbness/Tingling in arms or legs
☐	☐	Blurred/Double vision
☐	☐	Low back pain/Sciatica
☐	☐	Muscle weakness
☐	☐	Spasms

Have you ever had or been treated for MUSCLE, BONE, JOINT PROBLEMS?

Y	N	
☐	☐	Arthritis
☐	☐	Osteoporosis
☐	☐	Muscle pains

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