ADVANCED FOOT & ANKLE, PLLC

JOHN T. SANDERS, D.P.M. MELISSA A. DORSETT, D.P.M.

MR. MRS. MISS. MS. TODAY'S DATE: _____

NAME: _____ DATE OF BIRTH: ____ / ____ / ____ AGE: ____

ADDRESS: _____ SS# _____

CITY: _____ STATE: _____ ZIP _____

HOME PHONE: _____ CELL PHONE: _____ OTHER: _____

EMPLOYED BY: _____ WORK PHONE: _____

(if student or minor list parent's information)

NAME OF SPOUSE: _____ EMPLOYED BY: _____

FAMILY PHYSICIAN: _____ PHONE #: _____

EMERGENCY CONTACT: _____ PHONE #: _____

(Someone other than your home #)

PHONE #: _____

PHARMACY NAME: _____ PHONE #: _____

NAME OF PRIMARY INS: _____ ID #: _____ GROUP # _____

SUBSCRIBER NAME: _____ DOB _____

(Who carries the insurance? i.e. Spouse/Mother/Father)

NAME OF SECONDARY INS: _____ ID #: _____ GROUP # _____

SUBSCRIBER NAME: _____ DOB: _____

(Who carries the insurance? i.e. Spouse/Mother/Father)

IS THIS WORKMANS' COMPENSATION: ❑ YES ❑ NO CLAIM #: _____

ADJUSTER'S NAME: _____ PHONE #: _____

WE WILL FILE INSURANCE FOR COVERED SERVICES FOR ALL PLANS WITH WHICH WE PARTICIPATE. IF YOU ARE COVERED BY INSURANCE YOU SHOULD BE PREPARED TO PAY YOUR DEDUCTIBLE AND CO-PAYMENT AMOUNTS AT THE TIME OF YOUR VISIT. YOU SHOULD CONTACT YOUR INSURANCE CARRIER FOR YOUR BENEFIT INFORMATION AND WHETHER OR NOT SERVICES WILL BE COVERED IN OUR OFFICE. IF YOU ARE A MEMBER OF AN HMO YOU WILL NEED TO HAVE AN AUTHORIZATION OR REFERRAL FROM YOUR PRIMARY CARE PHYSICIAN IN ORDER FOR US TO SEE YOU. WE WILL MAKE EVERY EFFORT TO ASSIST YOU IN OBTAINING THESE AUTHORIZATIONS, BUT IF YOU NEGLECT TO INFORM US OF YOUR COVERAGE AND YOUR INSURANCE COMPANY REFUSES TO PAY, YOU ARE RESPONSIBLE FOR PAYMENT FOR ALL SERVICES RENDERED.

ANY BALANCE ON YOUR ACCOUNT NOT PAID BY INSURANCE WITHIN 90 DAYS WILL BECOME YOUR RESPONSIBILITY AND PAYMENT WILL BE DUE FROM YOU. WE ARE UNABLE TO ACT AS AN INTERMEDIARY BETWEEN YOU AND YOUR INSURANCE CARRIER. PLEASE CONTACT THE CUSTOMER SERVICE REPRESENTATIVE OF YOUR INSURANCE PLAN, IF YOU ARE DISSATISFIED WITH YOUR CLAIM DENIAL OR FEEL THAT A SERVICE SHOULD BE COVERED.

I AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS ANY INSURANCE CLAIMS SUBMITTED BY DRS. SANDERS/ DORSETT FOR MYSELF/DEPENDENTS. I ALSO AUTHORIZE PAYMENT OF MEDICAL/SURGICAL BENEFITS TO DRS. SANDERS/ DORSETT FOR SERVICE RENDERED BY HIM/HER. IF THE USE OF AN OUTSIDE AGENT IS NECESSARY TO COLLECT ANY OUTSTANDING BALANCES, YOU WILL BE RESPONSIBLE FOR ANY ADDITIONAL COLLECTION FEES.

BY SIGNING, I AGREE TO READING A COPY OF THE HIPAA REGULATIONS AND AUTHORIZE ADVANCED FOOT & ANKLE, PLLC TO USE AND/OR DISCLOSE CERTAIN PROTECTED HEALTH INFORMATION (PHI) ABOUT ME. WE ARE REQUIRED BY LAW TO MAINTAIN THE PRIVACY OF YOUR PHI AND TO PROVIDE YOU WITH A NOTICE OF PRIVACY PRACTICES UPON REQUEST.
WE FOLLOW AND ENFORCE HIPAA REGULATIONS. A HIPAA FORM IS AVAILABLE TO YOU AT THE FRONT DESK.

SIGNATURE OF PATIENT OR PARENT OF MINOR: _____ DATE: _____

PLEASE CIRCLE IF YOU ARE ALLERGIC TO ANY OF THE FOLLOWING MEDICATIONS.

PENICILLIN KEFLEX TYLENOL NOVACAINE/XYLOCAINE
SULFA CODEINE ASPIRIN
OTHER: _____

PLEASE LIST ANY MEDICATIONS YOU ARE TAKING AND FOR THE CONDITION YOU ARE TAKING IT.

MEDICATION	REASON

PLEASE CIRCLE IF YOU HAVE/EVER HAD ANY PROBLEMS IN THE AREAS BELOW:

DIABETIC INSULIN DEPENDENT
DIABETIC NON-INSULIN DEPENDENT
HIGH BLOOD PRESSURE
WEIGHT LOSS
KIDNEY
PHLEBITIS
CIRCULATION
GALLBLADDER
ALLERGIES TO MEDICINES
ASTHMA/EMPHYSEMA/SHORTNESS OF BREATH
ANEMIA/ABNORMAL BLEEDING
LIVER
HEART
HEADACHE
STOMACH
CHEST PAIN
GOUT
ARTHRITIS
THYROID
EARS/EYES
LUNGS

OTHER _____

DO YOU DRINK ALCOHOL / SMOKE / USE ILLEGAL DRUGS: YES NO

HAVE YOU EVER HAD SURGERY? DATE AND REASON:

_____

_____

ARE YOU PREGNANT? _____ DUE DATE: _____

DOES ANYONE IN YOUR FAMILY HAVE A HISTORY OF ANY SERIOUS CONDITIONS/DISEASES, SUCH AS DIABETES, HEART DISEASE, ETC. _____

_____

_____

WHAT TYPE OF FOOT / ANKLE PROBLEM ARE WE SEEING YOU FOR TODAY? _____

_____

WHAT SIZE SHOES DO YOU WEAR? _____ WIDTH: _____

PLEASE SIGN THE FOLLOWING: IT STATES THAT YOU HAVE FILLED THIS OUT TO THE BEST OF YOUR KNOWLEDGE AND IT IS AN AUTHORIZATION TO DR. SANDERS/DORSETT TO TREAT YOU AND PERFORM ANY FURTHER DIAGNOSTIC TEST, I.E. X-RAYS, BLOOD TEST, THAT MAY BE REQUIRED.

PATIENT SIGNATURE: _____ DATE: _____

PARENT (IF MINOR): _____ DATE: _____

Dear Patient:

We want to make you aware of a condition that may affect you. As many as 12 million Americans have **Peripheral Arterial Disease (PAD)** and many go dangerously unrecognized. It is a condition in which the arteries that carry blood to the muscles of the legs become narrowed and hardened due to the build up of plaque. This is the same disease process that causes blockages in the heart.

Poor circulation may result in the legs when the blood flow becomes sluggish or even blocked. It can result in leg pain or "fatigue," which can limit your physical activity. PAD can also increase your risk of having a heart attack or stroke if untreated.

Please take a moment to answer the questions below so that we may briefly screen you for PAD. If you have any questions or concerns regarding PAD and your risk, or would just like more information please do not hesitate to ask.

1) Do you have any discomfort or aching in the muscles of your legs when you walk that is relieved by rest?	YES	NO
2) Do your legs ever feel fatigued or heavy when walking or active:	YES	NO
3) Do you ever need to stop and rest when walking or have difficulty keeping up with others?	YES	NO
4) Do your feet or toes bother you at night?	YES	NO

5) Would you have difficulty doing any of the following because of leg fatigue, weakness or discomfort?

	No Difficulty	Some Difficulty	Unable
Walking one block?	1	2	3
Climbing one flight of stairs?	1	2	3
Walking at an increased pace?	1	2	3

6) Do you have a history of, or take medication for any of the following? (please check)

{ } Diabetes or "borderline" diabetes

{ } Smoking or history of smoking or tobacco use

Thank you!

Name_____ Date_____

ADVANCED FOOT & ANKLE PLLC

You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded artificial voice messages and/or use of an automatic dialing device, as applicable.

I/We have read this disclosure and agree that the Lender / Creditor may contact me/us as described above.

_____ _____

Borrower / Customer Signature Date

POS° Reorder # 1517600