FLAMINGO
FOOT & ANKLE

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Patient Registration

Patient Information

Patient Full Name: ☐Mr. ☐Mrs. ☐Ms. ☐Dr.	**Last**		**First**		**M.I.**	☐M ☐F	
By what name do you preferred to be addressed?		Single ☐	Married ☐	Divorced ☐	Separated ☐	Widowed ☐	Partner ☐
Patient's Address							
City		**State**			**Zip**		
Preferred Phone ☐ Home ☐ Cell ☐ Work		**Alternative Phone** ☐ Home ☐ Cell ☐ Work					
E-mail Address (required for access to your online patient portal)							
Social Security #	**Birth Date**	**I would like automated reminders by:** ☐ Email ☐ Phone ☐ Text (Choose up to 3)					
Employer		**Occupation**					
Emergency Contact/Relationship		**Phone**					

Insurance

Patient is: ☐ **Subscribe** ☐ **Spouse** ☐ **Dependent**		
Name of insured (if other than self)	**Birth Date**	**SSN**
Name of insured's employer	**Insured's work phone number**	
Name of person responsible for paying the bill (the Guarantor): ☐ **Same as patient** ☐ **Same as insured**		
Guarantor's Address ☐ **Same as patient** ☐ **Same as insured**		
Guarantor's Telephone		

L&I Injury

If injured on the job, fill this portion out.

Date of Injury	**Type of Injury**	☐ Work	☐ Auto	☐ Other
Has a claim been filed? ☐ **Yes** ☐ **No** **Claim#:**	**Where was claim filed?**			
Cause of injury				

Lower Extremity Medical History, Referral Information, Doctors and Pharmacies

Name: _____ **Date:** _____

What is the chief complaint(s) that brings you to our office for medical treatment? (Include foot, ankle, leg, knee, hip and back complaints: _____

_____

_____

_____

Symptoms of Current Problem (circle or fill in your answer)

Which Side : ☐ Right ☐ Left ☐ Both **Type of Pain** :☐ Dull ☐ Achy ☐ Throbbing ☐ Burning ☐ Sharp ☐ Shooting

Area of Pain :☐ Bottom of Heel ☐ Back of heel ☐ Arch ☐ Ball of foot ☐ Big toe ☐ Top of foot ☐ Ankle ☐ No Pain

☐ Other/Details: _____

On set :☐ Slow ☐ Sudden ☐ Traumatic **Has pain gotten** : ☐ Better ☐ Worse ☐ Stayed the Same

How long has this been a problem for you?: ☐ Days ☐ Weeks ☐ Months ☐ Years

What aggravates condition? ☐ Walking ☐ Running ☐ Standing ☐ Shoes ☐ Activities ☐ First steps after rest

☐ Other: _____ **Severity** : ☐ Mild ☐ Moderate ☐ Severe

What have you tried for the pain? ☐ Changing shoes ☐ Anti-inflammatory meds ☐ Decreasing activities ☐ Ice

☐ Heat ☐ Prefabricated Arch Supports ☐ Custom Orthotics ☐ Stretching ☐ Injections ☐ Physical Therapy ☐ Surgery

☐ Antibiotics ☐ Other OTC Meds ☐ Padding ☐ Massage ☐ Acupuncture ☐ Soaking

☐ Other: _____

After it starts, how long does pain last? _____

Have you ever had a similar pain ? (describe, including treatments received) _____

_____

How did you hear about our office?

☐ Relative ☐ Friend ☐ Google ☐ Bing ☐ Other Web Search ☐ Facebook ☐ Yelp

☐ Insurance Company ☐ Mail ☐ Phone Book ☐ TV ☐ Other: _____

☐ From My Doctor (name/specialty/city): _____

Who is your primary care physician and what other doctors treat you regularly?

Primary Care Physician: _____ ☐ MD ☐ DO ☐ PN

Date last seen: _____ ☐ I don't have a primary care physician

Other doctors and their specialties: _____

_____

List your primary pharmacy (name and location) - This is where we will send any prescriptions

Primary pharmacy (include city and street): _____

NAME: _____ DATE: _____

Past Medical History, Social and Family History Form

General

What is your weight: _____

What is your height: _____

What is your shoe size: _____

Allergies and Drug Intolerance

- ☐ Adhesive/Tape
- ☐ Aspirin
- ☐ Codeine
- ☐ Iodine
- ☐ Local Anesthetics
- ☐ Penicillin
- ☐ Seafoods
- ☐ Sulfa
- ☐ Other: _____

No Known Allergies

Medications

List all medications(and doses) you are taking:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Surgeries, Injuries, Illnesses

List surgeries, serious injuries, and illnesses not previously listed:

_____

_____

_____

_____

_____

_____

_____

_____

General Medical History

Mark "yes" or "no" to indicate if you or a family member have any of the following:

Personal			Family
☐ yes	☐ no	Anemia	☐ yes
☐ yes	☐ no	Arthritis: Type: _____	☐ yes
☐ yes	☐ no	Artificial Heart Valve or Joints	☐ yes
☐ yes	☐ no	Asthma	☐ yes
☐ yes	☐ no	Back Problems	☐ yes
☐ yes	☐ no	Bleed easily	☐ yes
☐ yes	☐ no	Cancer	☐ yes
☐ yes	☐ no	Chemical Dependency	☐ yes
☐ yes	☐ no	Chest Pain	☐ yes
☐ yes	☐ no	Circulatory Problems	☐ yes
☐ yes	☐ no	Diabetes	☐ yes
☐ yes	☐ no	Epilepsy	☐ yes
☐ yes	☐ no	Fibromyalgia	☐ yes
☐ yes	☐ no	Gout	☐ yes
☐ yes	☐ no	Heart Disease	☐ yes
☐ yes	☐ no	Hemophilia	☐ yes
☐ yes	☐ no	Hepatitis	☐ yes
☐ yes	☐ no	High Blood Pressure	☐ yes
☐ yes	☐ no	HIV Positive	☐ yes
☐ yes	☐ no	Kidney Problems	☐ yes
☐ yes	☐ no	Leg Cramps	☐ yes
☐ yes	☐ no	Liver Disease	☐ yes
☐ yes	☐ no	Lung/Respiratory	☐ yes
☐ yes	☐ no	Menopause	☐ yes
☐ yes	☐ no	Mental Illness	☐ yes
☐ yes	☐ no	Phlebitis / Clots	☐ yes
☐ yes	☐ no	Psoraisis	☐ yes
☐ yes	☐ no	Rheumatic Fever	☐ yes
☐ yes	☐ no	STD	☐ yes
☐ yes	☐ no	Stroke	☐ yes
☐ yes	☐ no	Thyroid Problems	☐ yes
☐ yes	☐ no	Tuberculosis	☐ yes
☐ yes	☐ no	Ulcers—Stomach	☐ yes
☐ yes	☐ no	Weight Change	☐ yes

Mental / Emotional

☐ yes	☐ no	Eating Disorder
☐ yes	☐ no	Anxiety
☐ yes	☐ no	Depression
☐ yes	☐ no	Psychiatric
☐ yes	☐ no	Alcoholism

Exercise and Orthotics

In what athletic activities do you participate?

_____

days per week exercising? _____

Do you wear store-bought arch supports? ☐ yes ☐ no

Do you wear custom orthotics? ☐ yes ☐ no

If yes, who made them: _____

How old are the orthotics: _____

Social History

Your occupation?

_____

Do you smoke? ☐ yes ☐ no

Are you a past smoker? ☐ yes ☐ no

How Much? packs/day _____

Years Smoked: _____

Drink Alcohol?: ☐ yes ☐ no

How Much: _____

Recreational Drugs? ☐ yes ☐ no

What: _____

Pregnant or possibly pregnant? ☐ yes ☐ no

The US HITECH Act requires us to ask the following questions:

Preferred Language: ☐ English

☐ Other: _____

Race:
- ☐ American Indian or Alaska native
- ☐ Asian ☐ Asian Indian
- ☐ Black/African American
- ☐ European
- ☐ Native Hawaiian/Pacific Islander
- ☐ White
- ☐ Other: _____
- ☐ **Decline**

Ethnicity:
- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino
- ☐ Other: _____
- ☐ **Decline**

Review of Symptoms

Check all that you are currently experiencing.

GENERAL

- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Other_____

EYES

- Please circle right, left or both
- ☐ Vision changes☐R ☐L☐Both
- ☐ Eye injury ☐R☐L☐Both
- ☐ Eye irritation ☐R ☐L ☐Both
- ☐ Other_____

EARS/Nose/Throat

- Please circle right, left or both
- ☐ Hearing loss ☐R ☐L ☐Both
- ☐ Earache ☐R ☐L ☐Both
- ☐ Smell Disorder
- ☐ Balance problem
- ☐ Sore Throat
- ☐ Other_____

CARDIOVASCULAR

- ☐ Chest Pain
- ☐ Irregular beat
- ☐ Heart Valve problems
- ☐ Edema
- ☐ Other_____

RESPIRATORY

- ☐ Cough
- ☐ Difficulty sleeping
- ☐ Wheezing
- ☐ Other_____

GASTROINTESTINAL

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Abdominal pain
- ☐ Other_____

GENITOURINARY

- ☐ Pain with urination
- ☐ Frequent urination
- ☐ Difficulty starting or maintaining urination
- ☐ Other_____

MUSCULOSKELETAL

- ☐ Muscle cramps or aches
- ☐ Joint pain or swelling
- ☐ Back pain
- ☐ Other_____

CIRCULATION

- ☐ Leg cramps
- ☐ Blood Clots
- ☐ Other_____

NEUROLOGICAL

- ☐ Headaches
- ☐ Seizures/Stroke
- ☐ Numbness/Tingling
- ☐ Other_____

PSYCHOLOGICAL

- ☐ Depression
- ☐ Anxiety
- ☐ Other

ENDOCRINE

- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Excessive thirst or urination
- ☐ Other_____

HEMATOLOGICAL

- ☐ Abnormal bruising
- ☐ Abnormal bleeding
- ☐ Other_____

SKIN

- ☐ Rash
- ☐ Itching
- ☐ Suspicious lesions
- ☐ Other_____

I have answered the above questions to the best of my ability. By typing your name below, you are signing this document electronically. You agree your electronic signature is the legal equivalent of your manual signature on this Agreement.

Signature/e-Signature_____ Date:_____/_____/_____

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Financial Policy

Your insurance policy is a contract that exists between you and your insurance company. Our relationship is with you, the patient, and not the insurance company. If you have questions about your policy, please call the phone number provided on the back of your insurance card. The patient or responsibly party is responsible for their bill being paid in full. Upon your initial visit you will be asked to provide a photo ID. Please inform us at every visit of any changes to your insurance coverage and provide us with your most recent insurance card.

Please initial each line indicating your understanding of our policies:

____**COPAYMENTS:** It is a requirement of your insurance company that we collect your co-pay. Payment is required before meeting with the doctor.

_____**DEDUCTIBLES & CO-INSURANCE:** If you have a high deductible plan, we may collect a **$125** deposit to apply towards your deductible and co-insurance. Any remaining balance after submission to your insurance company is your responsibility.

_____**SELF-PAY (for non-covered products and services and for patients without insurance coverage):** Full payment is due at time of service. Payment for evaluation and management services at minimum will be required before seeing the doctor. Additional procedures/services may be recommended by the doctor. You will be informed of these charges before proceeding with treatment.

_____**REFERRAL:** If your insurance plan requires a referral from your primary care doctor, this will be required at the time of your visit. Without a referral available, we will need to reschedule your appointment.

____**NO SHOW(failure to present for your appointment): 24 hours-notice** is required for cancellation of your appointment and failure to do so will incur a **$50** fee. Failure to provide **24 hours-notice** for a scheduled office procedure will incur a **$100** fee.

____**SURGERY CANCELLATION:** Failure to provide **5 business-days'** notice before surgery will incur a **$500** fee.

_____**BALANCES/COLLECTION FEES:** If payment of an outstanding balance is not received within 30 days from the postmark date of a mailed statement or e-statement time stamp, a **$10** re-billing fee may be added to each additional statement. Our patient portal offers the ability to view statements and submit payments conveniently and securely. Patients with balances more than 90 days overdue will be turned over to collections and a **$35** administrative fee will be applied.

____**FMLA/DISABILITY/MEDICAL RECORDS:** There is a **$40** charge for having the doctor complete these forms. Requested forms will be completed within 72 hours of diagnosis and care plan. There is a **$30** fee to obtain a copy of your medical records.

I have read and understand these financial policies. Patient

Name (print):_____

Patient/Responsible Party Signature:_____

Date: ___/___/_____

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Credit Card on File Agreement

Much like other businesses such as hotels or car rental agencies, upon check-in, a member of our staff will ask you to provide a valid credit card which will be stored securely on file. Following submission of claim and response from your insurance carrier, if a balance is due (from you, the patient or guarantor), a statement will be sent promptly. If no payment has been made after 30 days, your credit card will be charged automatically. Please note that co-payments and any cash products and services provided are due at the time of service.

Your ability to dispute a charge or question your insurance company's determination of payment will remain unchanged. If you have any questions about our policy, please do not hesitate to ask.

By signing below, I authorize Flamingo Foot & Ankle to keep my signature and credit card information securely on-file in my account. I authorize Flamingo Foot & Ankle to charge my credit card for any outstanding balances when due.

If the credit card that I provide today changes, expires, or is declined for any reason, I agree to promptly provide Flamingo Foot & Ankle with a new, valid credit card of which I will allow them to use for payment processing over the telephone. Even though Flamingo Foot & Ankle is not processing in person, I agree that my updated card may be used with the same authorization as the original card presented.

Visa □ **MasterCard** □ **Discover** □ **American Express**

□ Patient's Name (Print):_____ DOB: ____/

_/ Name on Card (Print):_____

Last Four Digits of Credit Card Number:_____ Exp. Date:_/_____

Please fill out information below for any other person(s) you authorize this credit card for:

Patient Full Name (Print):_____ DOB:__/___/___

Patient Full Name (Print):_____ DOB:__/___/___

Patient Full Name (Print):_____ DOB:__/___/___

Credit Card Holder's Signature:_____Date: _____

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Frequently Asked Questions Regarding the Credit Card on File Agreement

Do I have to leave my credit card information to be a patient at this practice?
Yes. This is our policy, and it is a growing trend in the healthcare industry. Insurance reimbursements are declining and there has been a large increase in patient deductibles. These factors are driving offices to either squeeze more patients into shorter periods of time or to stop accepting insurance. We have decided to focus on becoming more efficient in our billing and collections processes instead.

How much and when will money be taken from my account?
The insurance companies on average take between 2-6 weeks to process submitted claims. Whatever the allowed amount is, your copay, coinsurance, and deductible are taken into consideration. Your individual policy determines what you may owe. Once the insurance explanation of benefits (EOB) is received and posted to your account, you will be sent a statement showing your portion. You will have 30 days to send an alternative form of payment if you prefer. If no alternative payment is received, your patient financial responsibility will be processed.

How do you safeguard the credit information you keep on file?
We use the same methods to guard your credit card information as we do for your medical information. The card information is securely protected by the credit card processing component of our HIPAA compliant practice management system. This system stores the card information for future transactions using similar technologies as an online retailer. Our billing and office staff are not able to see the card number – only the last four numbers, giving us no way to use the card outside of the billing system. The only way to use it is to process a payment in our practice management system.

What are the benefits?
It saves you time and eliminates the need to write checks, buy stamps or worry about delays in the mail. It also drives our administrative costs down because our staff sends out fewer statements and spends less time taking credit card information over the phone or entering it from the billing slips sent in the mail, which are less secure methods than storing the information in our practice management system. The extra time the staff has can now be spent on directly helping the patients, either over the phone, with insurance claims, or in person.

I always pay my bills on time. Why do I have to do this?
The entire billing process is time consuming and wasteful, and the few patients that we do have to send to a collection agency end up costing a lot of money. Reducing unnecessary costs are essential to allowing us to continue to be an in-network provider with most insurance companies.

What if there is a payment discrepancy or I have other payment questions?
Please contact our billing department directly to settle payment discrepancies or for other payment questions. This policy in no way compromises your ability to dispute a charge or question your insurance company's explanation of benefits.

Will I still receive a paper statement by mail (or electronically if I prefer)?
Yes. You will receive one statement displaying the amount to be charged to your card in 30 days. If you prefer to pay by an alternative method, you may do so during that period. If you do not wish to make any payment method changes, keep the statement for your records and your card will be automatically charged.

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NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1998 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on the Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

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CONSENT FOR TRANSFER OF BIOLOGICAL SPECIMEN

Florida law (Section 817.5655, Florida Statutes) prohibits the sale or transfer of a person's biological specimen from which DNA can be extracted to a third party without the express consent of such person.

During the course of your care at Flamingo Foot & Ankle, it may be medically necessary to obtain a blood, urine, stool, tissue or other type of biological specimen for analysis. This analysis **will not** involve the examination of your DNA to identify the presence and composition of genes in your body. After the analysis has been performed and the sample is no longer needed, it will be stored as medical waste and then transferred to a third party for disposal in accordance with all local, state and federal requirements.

It may also be the case that a biological specimen (such as blood, urine, hair, bodily fluids, etc.) from you may be deposited on medical instruments, bedding, clothing or other objects. These objects may then be transferred to a third party for cleaning or disposal.

By signing this document, you affirmatively state that it is your intentional decision to consent to the transfer of any and all biological specimens collected by or deposited with Flamingo Foot & Ankle to a third party as set forth above. This consent does not authorize the sale or transfer of a biological specimen for the purpose of DNA analysis.

_____

Signature of Patient

_____

Printed Name of Patient

_____

Date

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CONSENT FOR USE OF VIRTUAL SCRIBE SERVICES

At Flamingo Foot and Ankle, we strive to enhance the quality of your healthcare experience by utilizing modern technology. As part of our commitment to providing efficient and accurate medical documentation, we use a virtual scribe service. This service allows a trained professional to document medical notes remotely in real time during your visit.

What is a Virtual Scribe? A virtual scribe is a remote professional who listens to the provider-patient interaction and documents necessary medical information into your electronic health record (EHR). The virtual scribe does not participate in your medical care and only transcribes information as dictated by the provider.

How Does This Affect Your Visit?

- Your provider will use a secure and HIPAA-compliant connection to communicate with the virtual scribe.
- The scribe will only have access to necessary medical information and will not store, share, or use your information outside of documentation purposes.
- This service allows your provider to focus more on your care rather than data entry, improving the quality of your visit.

Confidentiality and Security

- The virtual scribe service is compliant with the Health Insurance Portability and Accountability Act (HIPAA), ensuring the confidentiality and security of your protected health information (PHI).
- Your medical records remain private and are only accessible by authorized personnel.

Your Rights

- Your participation is voluntary, and you may decline or revoke your consent at any time without affecting your medical care.
- If you prefer that a virtual scribe is not used during your visit, please inform your provider.

By signing below, you acknowledge that you have read and understand the above information. You consent to the use of a virtual scribe for medical documentation purposes during your visit at Flamingo Foot and Ankle.

Printed name: _____ **Date:** _____

Patient/Legal Guardian Signature: _____ **Date:** _____

Provider/Witness Signature: _____ **Date:** _____