



FLAMINGO

FOOT & ANKLE

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www.flamingfoot.com

Patient Registration

Patient Information

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

Insurance

Patient is:			<input type="checkbox"/> Subscribe	<input type="checkbox"/> Spouse	<input type="checkbox"/> 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):					
<input type="checkbox"/> Same as patient <input type="checkbox"/> Same as insured					
Guarantor's Address					
<input type="checkbox"/> Same as patient <input type="checkbox"/> Same as insured					
Guarantor's Telephone					

L&I Injury

If injured on the job, fill this portion out.

Date of Injury		Type of Injury		<input type="checkbox"/> Work	<input type="checkbox"/> Auto	<input type="checkbox"/> Other
Has a claim been filed? <input type="checkbox"/> Yes <input type="checkbox"/> 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 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: yes
Type: _____
- 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 Psoriasis 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

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:

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: _____ / _____ / _____



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 responsible 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: ___/___/_____



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.

<input type="checkbox"/> Visa	<input type="checkbox"/> MasterCard	<input type="checkbox"/> Discover	<input type="checkbox"/> 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: _____



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.



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: _____



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