Foot & Ankle Center, LLC
1465 Johnston-Willis Drive
Richmond, Virginia 23235

Telephone: (804) 320-FOOT
(804) 320-3668

Fax: (804) 320-2600

Website: www.320-FOOT.com

Thank you for using the services of the Foot & Ankle Center.

Please complete the forms included with this cover letter. After completion, please mail or fax them back to us. Our address and fax number is listed above. By returning the forms to us *before* your visit we can minimize the amount of time you will spend at our clinic. If you are not able to forward the forms to us in advance then please bring the completed forms to us when you come for your visit.

If you have any questions please feel free to contact us by phone or you can e-mail us through our website.

Thank you,

The Staff of Foot & Ankle Center, LLC

Patient Information

PLEASE PRINT ALL INFORMATION LEGIBLY

Patient Personal Information

Name: ______________________ ________ __________________________ Jr Sr II III IV
First MI Last circle if applicable

____
Street Address City State Zip

SSN: _______-_______-_______ Birthdate: _______/_______/_______ Male / Female

Home Telephone: ( )_______-______________ Cellular Phone: ( )_______-______________

Work Telephone: ( )_______-______________ Ext. __________ Marital Status: S M Sep D W
circle one

E-mail address: _______________________ @ __________________________

Employer: ____ Occupation: _________________________________

Emergency Contact Name: _____________________ ______________________ ______________________
First Last Relationship

Emergency Contact Telephone: Home: ( ) _______- _____________ Other: ( ) _______- _____________

Insurance & Payment Information

NOTE: We Will Need Your Insurance Card At The Time Of Treatment

Name Of Primary Insurance Company: ____

Whose Insurance Policy Is This: Mine Spouse Mother Father Other: ____________________________________

What Is The Policy Holders Date Of Birth: / /

Name Of Secondary Insurance Company: ____

Whose Insurance Policy Is This: Mine Spouse Mother Father Other: ____________________________________

What Is The Policy Holders Date Of Birth: / /

Who Is Responsible For Charges Not Covered By Your Insurance:

Me Spouse Mother Father Other: ____

Other Information

Name Of Primary Care Doctor: ____ Date Last Seen: / /

How Did You Hear About Our Office?
- ☐ Referred by primary care doctor
- ☐ Referred by other doctor: *Doctor's Name* ________________________________
- ☐ Telephone book
- ☐ From patient, friend or family member
- ☐ Other: ____

I agree that the information on this form is accurate and up-to-date to the best of my knowledge.

Patient's Signature (legal guardian if a minor): ____Date:________________

Patient Medical Information

PLEASE PRINT ALL INFORMATION LEGIBLY

Medical History

___ Gout	___ Diabetes with insulin	___ Poor Circulation (diagnosed by a doctor)
___ Rheumatic Fever	___ Diabetes without Insulin	___ Arthritis (diagnosed by a doctor)
___ Lung / Breathing Disorder	___ High Blood Pressure	___ Stomach Ulcer / Acid Reflux
___ Anemia (low blood count)	___ Heart Disease	___ Intestinal Disorder
___ Stroke	___ Kidney Disease	___ Glaucoma (pressure in the eye)
___ Bleeding Tendency	___ Hepatitis / Liver Disease	___ Phlebitis (blood clots in veins)
___ Back Trouble	___ Sickle Cell Disease / Trait	___ Joint Replacement / Implants
___ Cancer	___ Venereal Disease	Other ______________________________
___ Convulsions	___ HIV / AIDS	Other ______________________________

Surgical / Hospitalization History (pertaining to feet, legs, circulation or surgeries with complications)

Year: _______ Reason: ____________________________ Complication: ____________________________

_______ Reason: ____________________________ Complication: ____________________________

_______ Reason: ____________________________ Complication: ____________________________

_______ Reason: ____________________________ Complication: ____________________________

Current Medications

Name:	Dosage	Name:	Dosage
____________________________	_______	____________________________	_______
____________________________	_______	____________________________	_______
____________________________	_______	____________________________	_______
____________________________	_______	____________________________	_______
____________________________	_______	____________________________	_______

Allergies

		Describe Reaction
_______	Novocaine/Local Anesthetic	______________________________
_______	Penicillin	______________________________
_______	Codeine	______________________________
_______	Aspirin	______________________________
_______	Iodine	______________________________
_______	Sulfa Drugs	______________________________
_______	Other Drugs	______________________________
Other	(Tape, Latex, etc.)	______________________________

Patients Name: ____ **Date:** _______________

Patient Consent Form

The Foot & Ankle Center, LLC

NOTE: Signing the consent form below does ***NOT*** mean that we can perform any treatment we desire without your consent. Except in an emergency situation we will always discuss ***BEFOREHAND*** any treatment we feel would benefit you.

(Please Read and Sign)

I, the undersigned, hereby consent to the following Treatment;

- Administration and performance of all treatments and the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient.
- Administration of any needed anesthetics and use of prescribed medication.
- Performance of examinations, diagnostic procedures/tests, cultures and other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this consent is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I, the undersigned, authorize The Foot and Ankle Center, LLC to use and disclose my information for the purposes of treatment, payment and healthcare operations as described in the Notice of Privacy Practices. I acknowledge that I have been given the Foot & Ankle Center, LLC Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official.

MEDICARE PATIENTS: I authorize the release of medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to The Foot & Ankle Center, LLC.

Payment of the patient's portion of all charges is due at the time of service. If, for any reason, it is necessary to bill the patient (or the responsible party) a $5.00 billing fee will be added to the account and we will send a minimum of 3 monthly statements requesting payment of the account balance. If payment is not received and we send the account to a third party for collection then you acknowledge and agree that a collection fee of 30% of the outstanding amount or $20.00, whichever is greater, will be added to your account as well as any additional related legal fees or court costs.

A $25.00 charge will be applied to the account of any person that fails to show for their appointment. This charge will NOT apply if the appointment is cancelled or rescheduled at least one business day prior to the appointment.

A photocopy of this consent shall be considered as valid as the original.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

____ ____________________

Patient (or Responsible Party) Signature ***Date***

Foot & Ankle Center, LLC

Permission To Obtain Health Information & Share Limited Health Information With Family/Friends

Patient Name: ______________________________ DOB: ____________________

By signing this form, I give permission to the person(s) listed in the table below to receive limited information about my care. I understand my healthcare provider will use their professional judgment to ensure that information is shared with my family/friend in order to assist with my continuing care. Any information that does not pertain to assisting with my health care and any copies of medical records will require a signed HIPAA compliant authorization. This permission will be considered ongoing until I state in writing otherwise.

Date of Permission	**Name of Individual & Relationship to Patient**	**Comments/Instructions** *(i.e.; may pick up meds, may disclose test results, may give all information, etc)*	**Patient/ Guardian Initials**

THE PHYSICIAN / STAFF HAS MY PERMISSION TO: (Please check all boxes that apply)

☐ Obtain my health information from any physician, hospital, laboratory, radiology center or from any other entity that is holding my health care information.

☐ Leave message at home with my spouse or with: ____________________ (Name) ____________________ (Relationship) ____________ (DOB)

☐ Leave a detailed message on cell phone. Cell Phone Number: ____________________

☐ Leave a detailed message on work voicemail. Work Voicemail Phone Number: ____________________

☐ Leave a detailed message on home voicemail / answering machine. Home Answering Machine number: ____________________

In order to obtain information by telephone, the party (listed in the box above) calling the practice must be able to share the patient identifier / password with the staff. Please make them aware of your identifier / password.
Please write the password you would like to use: ______________________________

____
Signature of Patient or Legal Guardian

____
Date

____
Printed Name of Patient or Legal Guardian

____
Relationship (if not the patient)