LEXINGTON FOOT & ANKLE CENTER, PSC

WELCOME TO OUR OFFICE

Date: Patient Number:

Name_____ Gender Age_____ Date of Birth ____-_____-_____
First Middle Last □ M □ F

Address_____
City State Zip Code

Patient Social Security # _____- _____- _____ Marital Status: □ Single □ Married □ Divorced □ Widowed

Home Phone (_____) _____ Cell Phone (_____) _____ Work (_____) _____

Email_____ Employer_____

Occupation_____ Work Address_____
City State Zip

Family Physician: _____ Last visit date: _____

Are you under a doctor's care for any reason? _____

Pharmacy Name/Number _____

Parent/Spouse's Name _____ DOB _____-_____-_____ SS# _____-_____-_____

Spouse's Employer _____ Occupation _____

In Case of Emergency, Contact

Name _____ Relationship_____ Home Phone (_____) _____

Work Phone (_____) _____ ext _____ Cell Phone (_____) _____

Primary Insurance Information

Policy Holders Name _____ Policy Holders DOB _____-_____-_____

Insurance Company/Phone _____ Insurance ID# _____ Group # _____

Is your insurance plan an HMO? □ Yes □ No If yes, have you obtained a referral? □ Yes □ No

Secondary Insurance Information

Policy Holders Name _____ Policy Holders DOB _____-_____-_____

Insurance Company/Phone _____ Insurance ID# _____ Group # _____

REASON FOR TODAY'S VISIT: PLEASE INDICATE THE PROBLEM

What is the main Foot or Ankle problem today?

Do you have any other Foot Or ankle problems needs attention?

HISTORY OF PRESENT ILLNESS: BRIEFLY ANSWER THE FOLLOWING QUESTIONS

When did your main problem begin? _____
Locate the area of the problem: _____

Describe any pain and/or disability: _____
Is the pain: □ Burning □ Throbbing □ Sharp □ Dull □ Aching □ Other: _____

What causes the problem or makes it worse? _____

Is there any other pertinent background information? □ No □ Yes (explain) _____
Was it caused by an injury? □ No □ Yes (explain) _____

Are there any associated signs or symptoms? □ No □ Yes (explain) _____

Have you treated or had anyone else treat this problem? □ No □ Yes (explain) _____
Did it help? □ No □ Yes (explain) _____

PAST MEDICAL HISTORY

Injuries: □ No injuries of consequence
List any serious injuries and approximate age: _____
Major Illnesses: □ No serious past illnesses
List serious illnesses: □ Diabetes □ Arthritis □ Heart □ Hypertension □ Cancer □ HIV □ Hepatitis

Surgeries & Hospitalization: □ None □ List: _____
_____

Do you have a pacemaker? **□ No** **□ Yes**

Medications: Prescriptions: _____
_____
Over-the-counter medications and vitamins: _____
Do you take oral contraceptives? □ Yes □ No

Allergies: □ Latex □ Adhesive tape □ Anticoagulant Therapy □ Aspirin □ Codeine □ Demerol □ Iodine □ Sulfa
□ Morphine □ Novocain □ Local Anesthetics □ Penicillin □ Seafood
Reaction Type: □ Rash □ Trouble Breathing □ Other:_____

Immunizations: □ Measles □Mumps □ Polio □ Tetanus □ Typhoid □ Flu □ Pneumonia □ TB □ Hep B

Family History: □ TB □ Gout □ High blood pressure □ Diabetes □ Arthritis □ Kidney disease □ Heart attack □ Cancer

Social History: Use of: □ Tobacco Pack/Day_____ □ Alcohol How much per/day_____ □ Drugs □ Caffeine
Level of education: Years of school: _____ Degrees: _____

Office Use Only: Height: _____Ft. _____in. Weight _____lbs. ____oz. Shoe size _____ Blood pressure ____/_____
Heart rate _____ Temp _____ SPO2% _____

Patient Signature: _____ Date:_____

GASTROINTESTINAL **Review of Systems** **Please check the boxes that apply to you:**

☐ Poor appetite	☐ Excessive Hunger	☐ Difficult chewing	☐ Nausea
☐ Vomiting	☐ Excessive thirst	☐ Difficult swallowing	☐ Diarrhea
☐ Abdominal pain	☐ Constipation	☐ Black stool	☐ Hemorrhoids
☐ Liver trouble	☐ Gallbladder trouble	☐ Bloody stool	☐ Weight loss
☐ Belching	☐ Stomach trouble	☐ Appendicitis	☐ Weight gain
☐ Indigestion	☐ Ulcers	☐ Gas	☐ Reflux

GENITOURINARY

☐ Bladder trouble	☐ Excessive urination	☐ Scanty urination	☐ Painful urination
☐ Discolored urine	☐ Frequent urination	☐ Prostate trouble	☐ Kidney disease
☐ Blood in urine	☐ Kidney stones	☐ Difficult urination	

NERVOUS

☐ Numbness	☐ Loss of feeling	☐ Paralysis	☐ Dizziness
☐ Fainting	☐ Headaches	☐ Muscle jerking	☐ Convulsions
☐ Forgetfulness	☐ Confusion	☐ Depression	☐ Tingling
☐ Stroke	☐ Weakness	☐ Seizure	☐ Burning

EYES

☐ Eye Strain	☐ Glaucoma	☐ Eye inflammation	☐ Glasses
☐ Eye disease	☐ Cataracts	☐ Eye injury	☐ Impaired sight

EARS / NOSE / THROAT

☐ Ear pain	☐ Ear noises	☐ Ear discharge	☐ Hearing loss
☐ Nose pain	☐ Nose bleeding	☐ Nose discharge	☐ Sore mouth
☐ Breathing difficulty	☐ Sore gums	☐ Sore throat	☐ Hoarseness
☐ Speech difficulty	☐ Dental problems	☐ Other _____	

CARDIOVASCULAR

☐ *Chest pain*	☐ Pain over heart	☐ Leg pain on walking	☐ Heart attack
☐ High blood pressure	☐ Rapid heartbeat	☐ Varicose veins	☐ Heart problems
☐ Night sweats	☐ Tiredness	☐ Weakness	☐ Hands swell
☐ Feet swell	☐ Heart valve replacement	☐ Mitral Valve Prolapse	☐ Other _____

RESPIRATORY

☐ Persistent cough	☐ Difficult breathing	☐ Bronchitis	☐ Asthma
☐ Lung problems	☐ Coughing blood	☐ Coughing phlem	☐ Emphysema
☐ Shortness of breath	☐ Wheezing	☐ Hay fever	☐ Other _____

INTEGUMENTARY

☐ Itching	☐ Psoriasis	☐ Bruises	☐ Skin rash	☐ Moles
☐ Abrasions	☐ Ulcerations	☐ Discolorations	☐ Skin cancers	☐ Eczema
☐ Deformed nails	☐ Birth marks	☐ Hives	☐ Other _____	

MUSCULO-SKELETAL

☐ Arthritis	☐ Stiffness	☐ Club foot	☐ Atrophy
☐ Artificial joints	☐ Joint disease	☐ Bursitis	☐ Fractures
☐ Muscle pain	☐ Lumbago	☐ Sprains	☐ Sciatica
☐ Gout	☐ Rheumatoid Arthritis	☐ Other _____	

HEMATOLOGIC

☐ Anemia	☐ Jaundice	☐ Bleeding disorder	☐ Venereal disease
☐ Take coumadin	☐ Take aspirin	☐ AIDS/HIV	☐ Hepatitis ____
☐ Sexually transmitted disease	☐ Other _____		

Patient's(or my dependent)_____ **Date**____-____-____

I certify that the above information is true and correct to the best of my knowledge. I give my permission to Lexington Foot And Ankle Center, PSC to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment.

Patient Name(print): **Date:** **Patient Number:**

Do I Need a Test For PAD?

Peripheral Arterial Disease (PAD) is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain and kidneys, becomes narrowed or clogged. It affects over 8 million Americans, most over the age of 50. It may result in leg discomfort with walking, poor healing of leg sores/ulcers, difficult to control blood pressure, or symptoms of stroke.

People with PAD are at significantly higher risk of stroke and heart attack. Answers to these questions will help determine if you are at risk for PAD and if a vascular exam will help us better assess your vascular health status.

Check All Applicable Boxes

1. Do you have foot, calf, buttock, hip or thigh discomfort (aching, fatigue, Tingling, cramping, or pain) when you walk which is relieved by rest? 443.9 □
2. Do you have a history of cardiovascular disease or diabetes and experience Any pain or swelling at rest in your lower legs or feet? 440.22 □
3. Do you have a history of cardiovascular disease or diabetes and experience Leg, foot, or toe pain that often disturbs your sleep? 440.22 □
4. Do you have an ulcer on your thigh, calf, ankle, foot or toe that is slow to heal? 707.14 □
5. Do you have diabetes and unusual hair loss or skin discoloration in your legs? 250.70 □
6. Do your fingers or toes feel numb or cold in response to temperature changes Or stress? 443.0 □
7. Have you suffered a severe injury to your leg(s) or feet? 904.8 □
8. Do you have an infection of the leg(s) or feet that may be gangrenous (Black skin tissue)? 440.24 □

Patient Signature: _____ **Date:**_____

NOTE: Providers are advised that insurance carriers have policies regarding when diagnostic services are considered medically necessary. These policies may vary between carriers and are subject to change at any time. Providers should check coverage requirements with specific insurance plans before testing.

LEXINGTON FOOT & ANKLE CENTER, PSC

FINANCIAL POLICY

Welcome to Lexington Foot and Ankle Center, P.S.C. We are glad you have chosen us to provide you with your health care needs. We are dedicated to the honorable practice of medicine. The mission of our practice is to provide high quality medical care at a fair and reasonable cost.

Our office does its best to assist our patients understand their insurance benefits. However, knowing the details of insurance policy coverage is a patient's responsibility. Please understand our office cannot accept responsibility for guaranteeing coverage, collecting insurance claims or negotiating a settlement on a disputed claim. Patients are responsible for payment of account balances. Past-due accounts are an extra cost in operating an office. Our costs, and therefore patient costs, are substantially increased when statements are not paid promptly.

If we are a participating provider for a patient's insurance company, we will submit claims directly to the managed care insurer. Co-payments or deductibles, if applicable, will be collected at the time of the office visit. Acceptable payment methods include cash, personal checks and credit cards.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE IF YOU ARE SELF-PAY.

Please be aware there is a possibility that some and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary under your medical insurance. If a non-covered service is provided or a deductible that has not yet been met, we will request payment in full on date of service. Some insurance companies require a pre-certification prior to treatment. Please check your policy for this requirement so that pre-certification may be obtained.

Finance charges will accrue at a rate of 2% per month on account balances. Account balances may fluctuate depending upon applicable insurance payments, co-insurance, co-pays, deductibles, additional services provided or other responsibilities as indicated by patient's insurance carrier.

Thank you for reading and understanding our Financial Policy.

Please let us know if you have any questions or concerns.

I give Lexington Foot and Ankle permission to check my credit and will answer questions about my credit experience with this Practice. This Practice has the option to report my account status to any credit reporting agency, such as a credit bureau. If the Practice has to refer my account to an outside collection agency, I agree to pay all of the collection costs incurred.

I have read, understand, and agree to this Financial Policy. I fully understand that in the addition to the office visit charges today, there may be additional charges for labs, xrays, MRI, immunizations, tests, etc. I fully understand that if there are any additional charges, I will receive a statement with any balance due and agree to pay for all additional charges incurred.

Patient Name:_____

Responsible Party (if other than the patient):_____

SIGNATURE:_____**Date:**_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____
And assign directly to Lexington Foot and Ankle Center, PSC all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party
Signature_____ Relationship _____ Date _____

ACKNOWLEDGE RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Practices and that I have read (or had the opportunity to read if I so chose) and understood the notice.

Responsible Party
Signature_____ Relationship_____ Date _____

MEDICARE AUTHORIZATION (If applicable)

I request that payment of authorized Medicare benefits be made to Lexington Foot and Ankle Center, PSC for any services furnished by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related service. I request payment of authorized Medigap benefits be made to this provider and also authorize any holder of medical information about me to release to the below named Medigap insurer any information needed to determine benefits payable for services from this provider.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary
Signature_____ Date _____

PERMISSION TO RELEASE PROTECTED HEALTH INFORMATION

(Please choose one or more of the following)

○ I give Lexington Foot and Ankle Center, PSC, permission to release information regarding my health and medical care to the following person: Name: _____ Relationship: _____

○ I give Lexington Foot and Ankle Center, PSC, permission to leave voicemail messages at _____ regarding the following information: (please check all that apply) ○ Labs ○ Appointments ○ Test Results ○ Insurance/Billing information

○ I give Lexington Foot and Ankle Center, PSC, permission to send emails regarding my health and medical care, including but not limited to appointments, lab results and test results.

○ I ***do not*** give Lexington Foot and Ankle Center, PSC, permission to release information regarding my health and medical care to anyone other than myself.

Signature_____ Date _____

HOW WERE YOU REFERRED TO THIS PRACTICE:

Circle: Family/Friend Online Physician **: _____**