WELCOME TO OUR OFFICE!

Carteret Foot & Ankle Specialists, P.C. Date: _____

PATIENT INFORMATION

Full Name: _____ Nickname: _____ Social Security #: _____

Birth date: _____ Age: _____ Race: _____ Ethnicity: _____ Sex: □ Male □ Female

Primary Language: _____ Marital Status: □Single □Married □ Divorced □ Widowed

Address: _____ City/State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Ext. _____

Best time / Place to call _____ Email: _____

Occupation: _____ Employer: _____ Employer Phone: _____

Address: _____ City/State: _____ Zip: _____

In case of emergency, contact:

Name: _____ Relationship: _____ Phone number: _____

Who is your Primary Care Physician? _____ Date of last visit: _____

Physician's address/location: _____ Physician's Phone number: _____

Are you under regular care for any specific problem? _____

Name and specialties of other physicians you see: _____

Are you Pregnant? □ yes □ no Pharmacy's Name and Location: _____

FOOT HEALTH INFORMATION

What is your current foot/ankle problem? _____

When did it begin? _____

How have you treated this problem so far? _____

Have you seen another doctor for this problem? _____ If so, whom? _____

Have you ever seen a foot doctor? _____ If so, whom? _____

DIABETICS

How many years have you been diagnosed with diabetes? _____

Blood sugar is checked how many times each day? _____ Average Reading: _____

Who is the doctor that manages your diabetes? _____ last date seen: _____

How did you hear about our office? We would like to thank them!

□Newspaper □Yellow Pages □Website □Insurance Plan □ Friend □ Family □ Physician □ Other: _____

Name: _____ Address: _____ City / State: _____ Zip: _____

ALLERGIES Have you ever experienced any **ALLERGIES** or **ADVERSE EFFECTS** to any of the following?

□ Adhesive / Tape □ Aspirin □ Anti-inflammatories □ Codeine
□ Iodine (IVP dye) □ Latex □ Local Anesthetics (Novocaine / Lidocaine) □ Penicillin
□ Sulfa Drugs □ No known drug allergies □ Other: _____

FAMILY HISTORY please check the appropriate box for any problems that may run in your family

□ Arthritis □ Bleeding disorders □ Blood Clots □ Cancer
□ Diabetes □ Foot Problems □ Heart disease □ Stroke
□ Other: _____

MEDICATIONS Please list all medications you are currently taking – including over-the-counter products, vitamins and herbal supplements.

_____

_____

_____

PAST MEDICAL HISTORY

□ AIDS/HIV □ Arthritis □ Asthma □ Back Problems
□ Blood Clots □ Cancer (type_____) □ Diabetes □ Epilepsy
□ Eye Problems □ Foot / Leg Cramps □ Hepatitis □ High Blood Pressure
□ High Cholesterol □ Kidney Problems □ Liver Problems □ Parkinson's Disease
□ Psychiatric Problems □ Stomach ulcers □ Stroke □ Thyroid Problems
□ History of MRSA infection
□ Other: _____

PAST SURGICAL HISTORY

Please list ALL surgeries and approximate dates: _____

_____

_____

Have you ever been hospitalized for something other than surgery? □ yes □ no If yes, for what? _____

_____

SOCIAL HISTORY

Shoe size: _____ Height: _____ Weight: _____

Do you smoke? □ yes □ no If yes, how much? _____ For how long? _____
If no, have you ever smoked? _____ When did you quit? _____

Do you drink Alcohol? □ yes □ no If yes, how much and how often? _____

Employment: □ sit at job □ stand at job □ stand and walk at job □ retired □ homemaker □ military

REVIEW OF SYSTEMS Please make a check beside any problems you are **currently** experiencing.

CONSTITUTIONAL:
□ fever □ chills □ fatigue □ loss of appetite □ dizziness □ weakness □ weight loss □ weight gain
□ headache

CARDIOVASCULAR:
□ chest or arm pain □ pain or cramping in legs when walking □ cramps when sleeping in legs or feet
□ swelling of hands or feet □ change in color of extremity □ varicose veins
□ blood clots □ high blood pressure □ low blood pressure □ heart attack □ heart murmur □ rapid heart rate
□ irregular heartbeats □ pacemaker □ mitral valve prolapse □ stroke

ENDOCRINE:
□ increase in thirst □ increase in hunger □ diabetes mellitus □ thyroid problems □ post-menopausal

HEENT:
□ blindness □ blurry vision □ cataracts □ glaucoma □ nose bleeds □ sinus pain □ ringing in ears
□ trouble swallowing

GASTROINTESTINAL:
□ abdominal cramps □ inflammation of colon □ constipation □ diarrhea □ nausea □ vomiting
□ heartburn □ difficulty swallowing □ blood in stool □ hemorrhoids □ jaundice

GENITOURINARY:
□ painful urination □ frequent urination □ incontinence □ blood in urine □ kidney problems

HEMATOLOGIC:
□ easy bruising □ easy bleeding □ anemia □ taking aspirin □ sickle cell anemia □ taking blood thinner

INTEGUMENT:
□ skin dryness □ skin itching □ blisters □ ulcers □ rash □ eczema □ psoriasis □ athlete's foot
□ nail changes □ hypertrophic scar / keloid □ skin cracking □ non-healing wound

MUSCULOSKELETAL:
□ joint aches or pains □ chronic neck or back pain □ chronic ankle pain □ morning stiffness □ weakness
□ heel pain □ arthritis □ joint swelling □ gout

NEUROLOGICAL:
□ tingling □ numbness □ burning □ increased sensitivity to touch □ decreased cold or warmth sensation
□ shooting pain □ tremors □ paralysis □ muscle weakness

PSYCHIATRIC:
□ ADHD □ depression □ anxiety □ bipolar disorder □ schizophrenia □ dementia □ panic attacks
□ suicidal thoughts □ claustrophobia

RESPIRATORY:
□ difficulty breathing □ cough □ coughing blood □ shortness of breath □ difficulty breathing lying flat
□ waking up at night short of breath □ tuberculosis □ wheezing □ sleep apnea

Carteret Foot & Ankle Specialists
302 N. 35th Street, Morehead City, NC 28557 **Phone**: 252-247-3256 **Fax**: 252-808-3183
923-4 West Corbett Avenue, Swansboro, NC 28584 **Phone**: 910-325-1111

INSURANCE You will present your insurance cards to the front desk. A copy will become part of your medical record.

Insured Name: _____ Relationship to patient: _____

Insured birth date: _____ Sponsor's Social Security #: _____

Is this patient covered by additional insurance? □ yes □no

For minors only
Is the financially responsible party different from the insured party listed above? If so, please list financially responsible party below.

Name of financially responsible party: _____ Relationship to patient:_____

Responsible party birth date: _____ Responsible party SSN: _____

Responsible party address: _____

Responsible party phone number: _____

By signing below, you acknowledge that you are responsible for all charges accrued by patient at this and future dates of service.

Signature of responsible party: _____ Date: _____

MEDICARE PATIENTS: MEDICARE ASSIGNMENT OF BENEFITS

I request that payment of Medicare, Medicaid, or any other supplemental or secondary insurance benefits be made on my behalf to Carteret Foot & Ankle Specialists for any services provided by the physician or group. I authorize the release of any private health information about me to The Centers for Medicare & Medicaid Services and its agents or to any other party necessary for treatment, payment or health care operations.

_____

PATIENT SIGNATURE (OR RESPONSIBLE PARTY) DATE

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POLICIES OF CARTERET FOOT & ANKLE SPECIALISTS

Patient's Name: _____ Date: _____

We are dedicated to providing the best possible care and service to you and regard your complete understanding of our policies as an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff. Suggestions and/or grievances can be directed to the doctor(s) via written correspondence. After reading each policy carefully, please sign your name to indicate that you have read and agree to our policies.

Acknowledgment of Privacy Practices

- I acknowledge that I was provided a copy of the HIPAA Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice. The HIPAA rights are available at the front desk and are also posted at www.carteretfootandankle.com.

By signing below, you acknowledge and agree to all above mentioned policies.
Signature of Patient or Responsible Party: _____

Treatment agreements

- I promise to provide complete and accurate information to the doctors about my medical history, health and medications, including over the counter products. I certify that the information I have provided Carteret Foot & Ankle Specialists is accurate and up to date to the best of my knowledge. I also understand my responsibility to be respectful of the doctors, staff and other patients.
- I hereby give permission to Carteret Foot & Ankle Specialists to administer and perform such procedures as may be deemed necessary in my diagnosis and/or treatment. I promise full cooperation with my treating physician whether by surgical or non-surgical means. I understand that if I do not follow my doctor's instructions concerning my care care and treatment, including any necessary physical therapy or medications, the outcome of my care and treatment could be put in on jeopardy and less than optimal results may occur.
- Prior to any services rendered, I may request a financial estimate. I understand that unsatisfactory results do not prevent me from paying any outstanding amounts related to any medical treatment.

By signing below, you acknowledge and agree to all above mentioned policies.
Signature of Patient or Responsible Party: _____

Additional fees

- There is a $50.00 charge for appointments broken or canceled without 24 hours advanced notice. Repetitive broken or canceled appointments and/or non-compliance may result in your release from this practice. This fee is the sole responsibility of the patient and must be paid in full before the patient's next appointment. Insurance companies are not responsible for these fees.
- Pre-scheduled surgical procedures require pre-payment/deposit which will be estimated based on your insurance benefits. This pre-payment/deposit will be due at your pre-operative appointment. We will bill your insurance for surgical procedures performed in the office, at an outpatient surgical center, or hospital.
- There is a $200.00 fee for all pre-scheduled surgical procedures which are not canceled within 10 days prior to procedure. We suggest you carefully select your surgical date to avoid this charge. This fee is the sole responsibility of the patient and must be paid in full before the patient's next appointment. Insurance companies are not responsible for these fees.
- There is a service fee of $25.00 for all returned checks. This fee is the sole responsibility of the patient and must be paid in full before the patient's next appointment. Insurance companies are not responsible for these fees.
- Past due accounts are subject to collection proceedings including the credit bureau. All fees, including but not limited to collection fees, attorney fees, and court fees, shall become your responsibility in addition to the balance due to this office. Accounts no longer maintaining a financial "Good Faith" status will result in the termination of the relationship between patient and Carteret Foot & Ankle Specialists.

By signing below, you acknowledge and agree to all above mentioned policies.
Signature of Patient or Responsible Party: _____

Return policy

- I understand that there will be no refunds made on products dispensed by the office. This includes both over the counter items and durable medical equipment that is billed to insurance. Some items are covered by a warranty, which will be discussed at the time the products are dispensed, and can be brought back to the office for replacement under the warranty. Otherwise, no product that leaves the office may be returned or refunded, even if the product has not been used and/or is in the original packaging.

By signing below, you acknowledge and agree to all above mentioned policies.
Signature of Patient or Responsible Party: _____

Policies concerning insurance

- For the purpose of payment, I allow Carteret Foot & Ankle Specialists to release my Private Health Information including illnesses and treatments to any and all of my insurance carriers, their third payors and claim reviewers, until the claim is resolved. For the purpose of treatment, I also allow the above listed practice to release my information or contact any and all my treating physicians.
- I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Carteret Foot & Ankle Specialists all insurance benefits, if any, otherwise payable to me for services rendered. OR I, the undersigned, certify that I do not have insurance and that payment for all services rendered will be due on date of service. I hereby assign all medical benefits directly to Carteret Foot & Ankle Specialists for the payment of any services rendered.
- You must provide personal (address, phone numbers, etc.) and/or insurance changes (carriers, networks, ID number, etc.) to the office prior to your appointment. I authorize the use of my signature on all insurance claim submissions. I understand I may revoke this release only in writing.
- You are responsible for all authorizations/referrals/precerts needed to seek treatment with Carteret Foot & Ankle Specialists' physicians. I understand that it is ultimately my responsibility to know and understand my insurance plan.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file all insurance claim for you with insurance companies with which we are under contract. When you do an assignment of benefits, you are agreeing to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within 60 days, the patient or guardian seeking care for a minor, will be responsible for payment of services. You are encouraged to contact your insurance company with any questions.
- We have made prior arrangements with insurers and other health plans to accept assignment of benefits. We will bill those plans with which we have an agreement and will require you to pay the co-pay, co-insurance, and deductible at the time of service. It is illegal for our office to waive or not collect co-pays, co-insurances, or deductibles from an insured patient. If you are seeing our doctors on an "Out of Network" basis, you will be subject to our out of network rates.
- Not all services are a "covered" benefit in all insurance policies; some plans even impose a waiting period before covering services. In the event your health plan determines a service to be not covered for any reason, or you do not have an authorization, you will be responsible for all charges. We will attempt to verify benefits for some specialized services. However, you remain responsible for charges to any service rendered. Patients are encouraged to contact their insurance company representatives for clarification of benefits prior to services rendered.
- Your portion of payment for ALL office services is due at the time of service. We will accept VISA, MasterCard, cash, or check. You agree to allow us to keep your credit card information on file securely.

By signing below, you acknowledge and agree to all above mentioned policies.
Signature of Patient or Responsible Party: _____

Office Witness: _____ Date: _____

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Authorization for release of information – Compound Release

Patient Name: _____ **Patient Date of Birth:** _____
Carteret Foot & Ankle Specialists, PC is authorized to release protected health information about the above named patient in the following manner and to identified persons.

PHONE CALLS
May we leave a voice mail for you that includes sensitive information. **YES** **NO**

Please list any additional persons that we may discuss your information with, such as a parent or spouse.

Name	Phone Number	
_____	_____	__Financial __Medical
_____	_____	__Financial __Medical

EMAILS
May we send information to you via email? **YES** **NO**
If yes, please select which type of information that we may send you via email.
__ Appointment reminders __Financial information __Medical information __Breach notification

TEXT MESSAGES
May we send information to you via text message? **YES** **NO**
If yes, please select which type of information that we may send you via text message.
__Appointment reminders __Other: _____

***For email and/or text communication, I understand that if information is not sent in an encrypted manner and there is risk it could be accessed inappropriately. I still elect to receive email and/or text communication as indicated above. **Patient signature:** _____

PHOTOS
May we use photos received by you? **YES** **NO**
If yes, please select how we may use them. __Post in office __Post on website

With prior verbal notification, may we take photos of you? **YES** **NO**
If yes, how may we use those photos? __Pre/post procedure examples __Post in office __Post on website

PATIENT RIGHTS
- I have the right to revoke this authorization at any time. The revocation must be submitted to the office in written form. Revocation is not effective in cases where the information has already been disclosed, but will be effective going forward.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federation or state law.
- I have the right to refuse to sign this authorization. My treatment will not be conditioned on signing.
- This authorization will remain in effect until revoked by the patient.

By signing below, you agree to the authorizations that you made above and understand your rights as a patient concerning this authorization.

Signature of Patient or Responsible Party: _____ Date: _____