

NextStep Foot and Ankle Centers

Patient Registration Form

All information provided on this form will remain confidential in compliance with HIPPA guidelines.

PATIENT INFORMATION

Today's Date: _____

Name: _____ Preferred Name: _____

Date of Birth: _____ Male Female SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Occupation: _____

Is it ok to call you at work? Yes No Do you work? Full Time Part Time Student

Employer: _____

Employer's Address: _____

City, State, Zip: _____

Primary Care Physician: _____

Diabetic Physician: _____

Emergency Contact: _____

Relationship: _____ Daytime Phone: _____

INSURANCE (Please provide a copy of ALL insurance cards)

Responsible Party	
First and Last Name	
Date of Birth	
SSN	
Relationship to patient	
Home Address	
City, State, Zip	
Home Phone	
Work Phone	
Cell Phone	

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Referral Information: How did you hear about our practice?

Primary Care Dr.	<input type="checkbox"/>	Insurance Company	<input type="checkbox"/>
Newspaper	<input type="checkbox"/>	Internet	<input type="checkbox"/>
Direct Mail	<input type="checkbox"/>	Personal Referral	<input type="checkbox"/>
Driving by	<input type="checkbox"/>	TV/Radio	<input type="checkbox"/>

Other: _____

Allergies

NO ALLERGIES	<input type="checkbox"/>
Adhesive Tape	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>
Codeine	<input type="checkbox"/>
Iodine	<input type="checkbox"/>
Demerol	<input type="checkbox"/>
Latex	<input type="checkbox"/>
Novocaine	<input type="checkbox"/>
Lidocaine	<input type="checkbox"/>
Penicillin	<input type="checkbox"/>
Seafood	<input type="checkbox"/>
Sulfa Drugs	<input type="checkbox"/>
Local Anesthetics	<input type="checkbox"/>

Other: _____

Other: _____

Other: _____

Reactions: _____

Medications (List all or give list to receptionist to copy)

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	YES	NO		YES	NO
Aids/HIV	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Hip Replacement	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots in Lungs	<input type="checkbox"/>	<input type="checkbox"/>	Knee Replacement	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots in Legs	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapses	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal Issues	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Neuropathy	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Gallstones	<input type="checkbox"/>	<input type="checkbox"/>	Seizure	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis A, B, C	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>

Social History

Do you drink alcohol? Yes No Drinks per week? _____

Do you smoke? Yes No Packs per day? _____

Height: _____ Weight: _____ Shoe Size: _____

Pharmacy Name, Phone # and Zip Code:

Surgeries in the last 5 years: _____

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Family History

Diabetes	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Other: _____	

Podiatric History

Have you seen a podiatrist before? Yes No

If yes, please complete the following information.

Doctor's Name: _____ Date of last visit: _____

Condition for which you were treated: _____

Describe the specific problem that brings you to our office today: _____

How would you describe your pain? No Pain Sharp Dull Aching Burning
 Radiating Itching Stabbing Other: _____

How would you rate your pain on a scale from 0 to 10? (Please Circle)

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Pain)

What makes your pain or problem feel worse? Walking Standing Resting

Daily Activities Dress Shoes High Heels Flat Shoes

Closed Toe Shoes Running Other: _____

Occupation: _____

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I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer such procedures as may be deemed necessary in the diagnosis and/or treatment of podiatric condition, which may include and any outside testing facilities or laboratories that are deemed necessary.

Date: _____

Signature of Patient OR Authorized Representative

Patient HIPAA Privacy Regulations with electronic access to prescriptions

Please provide NextStep Foot & Ankle Centers access to your **online prescriptions**

_____ Patient/Guardian consents to prescriptions by any provider. **(Full access)**
(Select this if you want NextStep Foot and Ankle Centers to send and receive electronic prescriptions)

_____ Patient/Guardian **limits** consent to prescriptions by current provider only.
(Select this if you want NextStep Foot and Ankle Centers to only write prescriptions)

Date: _____

Signature of Patient OR Authorized Representative

Relationship to patient:

_____ Self

_____ Parent

_____ Guardian

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Patient Consent

Patient Consent to the Use and disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, NEXTSTEP FOOT AND ANKLE CENTERS originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that NEXT STEPFOOT AND ANKLE CENTERS is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treatment as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that NEXTSTEP FOOT AND ANKLE CENTERS reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should NEXTSTEP FOOT AND ANKLE CENTERS change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I hereby give NEXTSTEP FOOT AND ANKLE CENTERS my permission to release my medical information to the individuals specified below: **(FAMILY MEMEBERS ONLY)**

Name	Relationship to Patient	Daytime/Cell Phone Number
_____	_____	_____
_____	_____	_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I fully understand and accept/decline the terms of this consent.

_____ Date: _____

Signature of Patient OR Authorized Representative

NextStep Foot and Ankle Centers

Agreement of Financial Responsibility

Thank you for choosing Next Step Foot and Ankle Centers as your health care provider. We are committed to providing quality care to all our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- *Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and pre-approved insurance for which we are a contracted provider.*
- *It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.*
- *We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.*
- *If we have a contract with your insurance company, we will bill your insurance company first, and then bill you for any amount determined to be your responsibility, less any copayment(s) or deductible(s). This process generally takes 45-60 days from the time the claim is received by the insurance company.*
- *Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.*
- *Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In-Network rate.*

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

Signature of Patient /Responsible Party

Date

Name of Patient/Responsible Party (please print)

Relationship to Patient