THE FOOT AND ANKLE CLINICS

WELCOME TO OUR OFFICE!!

NEW PATIENT INFORMATION FORM

(PLEASE PRINT CLEARLY)

PATIENT NAME: _____ PREFERRED NAME: _____

LAST FIRST MI

SEX: M / F DATE OF BIRTH: ____/_____ /_____ SSN:_____-_____-_____

HOME ADDRESS: _____ CITY/STATE: _____ / _____ ZIP: _____

MARITAL STATUS: _____ HOME PHONE #: (_____)_____-_____

RACE: _____ CELL PHONE #: (_____)_____-_____

ETHNICITY: ☐ NOT HISPANIC OR LATINO ☐ HISPANIC/LATINO WORK PHONE #: (_____)_____-_____

☐ OTHER _____ E-MAIL: _____

EMPLOYER:_____

YOUR PREFERRED METHOD OF COMMUNICATION *(PLEASE CHECK ONE)*: ☐HOME ☐CELL ☐WORK ☐E-MAIL ☐ MAIL

MAY WE CALL AND LEAVE A MESSAGE?:☐YES ☐ NO MAY WE SEND TEXT MESSAGES TO YOUR CELL PHONE: : ☐YES ☐NO

EMERGENCY CONTACT: _____ RELATIONSHIP TO PATIENT: _____

HOME PHONE: (_____)_____-_____ CELL PHONE #: (_____)_____-_____

TWO PEOPLE WE MAY RELEASE MEDICAL RECORDS TO:

1. NAME: _____RELATIONSHIP TO PATIENT: _____ CONTACT PHONE:(_____)_____-_____

2. NAME: _____RELATIONSHIP TO PATIENT: _____ CONTACT PHONE:(_____)_____-_____

WHO IS RESPONSIBLE FOR PAYMENT? ☐SELF ☐OTHER: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____ PHONE #: (_____)_____-_____

DOES THE PATIENT HAVE A LEGAL GUARDIAN OR HEALTH-CARE POWER OF ATTORNEY? *(PLEASE CHECK ONE ONE)*: ☐YES ☐NO

IF YES, NAME: _____ RELATIONSHIP: _____ PHONE #: (_____)_____-_____

PRIMARY CARE DOCTOR: _____DATE LAST SEEN: _____ PHONE #: (_____)_____-_____

SPECIALISTS:_____ ☐ CARDIOLOGIST ☐ NEPHROLOGIST ☐RHEUMATOLOGIST

PHARMACY:_____ ADDRESS: _____ PHONE #: (_____)_____-_____

ARE YOU CURRENTLY UNDER A PAIN MANAGEMENT CONTRACT OR RECEIVING NARCOTICS OF ANY KIND FROM ANOTHER PHYSICIAN? *(PLEASE CHECK ONE ONE)*: ☐YES ☐NO ***IF YES, WHO?***_____

ARE YOU CURRENTLY UNDER THE CARE OF A HOSPICE?: ☐YES ☐NO ***IF YES, WHO?***_____

ARE YOU HERE TODAY FOR AN INJURY THAT OCCURRED WHILE AT WORK OR IS THIS ACCIDENT RELATED?: ☐YES ☐NO

DO YOU CURRENTLY RECEIVE HOME HEALTH? ☐YES ☐NO ***IF YES, WHO?***_____

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM AND THE FOLLOWING PAGES ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS. I HAVE READ THE HIPAA NOTICE OF PRIVACY PRACTICES. I UNDERSTAND THAT I MAY OBTAIN MY OWN COPY OF IT BY REQUESTING IT. I HAVE READ AND UNDERSTAND YOUR "IMPROVING YOUR OFFICE VISIT" STATEMENT. I HAVE READ, UNDERSTAND AND AGREE TO COMPLY WITH YOUR "PATIENT FINANCIAL POLICY".

_____ _____

PRINT NAME OF PATIENT, PARENT OR GUARDIAN **RELATIONSHIP TO PATIENT**

_____ _____

SIGNATURE **TODAY'S DATE**

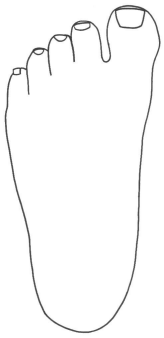
THE FOOT AND ANKLE CLINICS

CURRENT FOOT OR ANKLE PROBLEM:

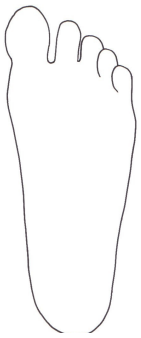
WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

WHERE IS THE PAIN/PROBLEM LOCATED? ***(PLEASE MARK ON THE PICTURES BELOW):***

LEFT FOOT



TOP OF FOOT

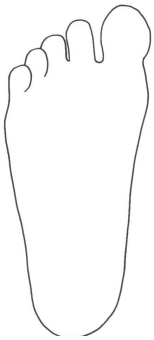


BOTTOM OF FOOT

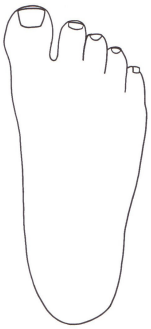
INSIDE OF FOOT

OUTSIDE OF FOOT

RIGHT FOOT



BOTTOM OF FOOT



TOP OF FOOT

OUTSIDE OF FOOT

INSIDE OF FOOT

PAIN AT WORST *(PLEASE CIRCLE ONE):* 0 1 2 3 4 5 6 7 8 9 10

TYPE OF PAIN *(CHECK ALL THAT APPLY):* ☐SHARP ☐DULL ☐BURNING ☐TINGLING ☐NUMBNESS ☐ACHING ☐OTHER_____

_____

WAS THIS CAUSED BY AN INJURY? ☐YES ☐NO IF YES, PLEASE SPECIFY: _____

HAVE YOU BEEN TREATED FOR THIS CONDITION IN THE PAST? ☐YES ☐NO IF YES, PLEASE SPECIFY: _____

_____

ALLERGIES: ☐ NONE KNOWN ☐ MEDICATIONS _____

☐ SULFA ☐ TAPE/ADHESIVES ☐ LATEX ☐ SHELLFISH/IODINE ☐ FOODS _____

☐ BEES ☐ METAL ☐ OTHER _____

PLEASE LIST ALL MEDICATIONS YOU TAKE OR PROVIDE US WITH A MEDICATION LIST (INCLUDING OVER THE COUNTER):

MEDICATION	**DOSE**	**MEDICATION**	**DOSE**

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HAVE YOU EVER HAD ANY OF THE FOLLOWING?:

ABNORMAL BLEEDING	Y	N	GOUT	Y	N	PULMONARY EMBOLISM	Y	N
ANEMIA	Y	N	HEART ATTACK	Y	N	RAYNAUD'S DISEASE	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	RHEUMATOID ARTHRITIS	Y	N
BACK/NECK TROUBLE	Y	N	HEPATITIS	Y	N	SICKLE CELL DISEASE	Y	N
BACK/NECK SURGERY	Y	N	HIV+/AIDS	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS/DVT	Y	N	HIGH BLOOD PRESSURE	Y	N	SLEEP APNEA	Y	N
CANCER	Y	N	KIDNEY DISEASE	Y	N	STENTED ARTERIES	Y	N
CAD	Y	N	LEG OR FOOT ULCERS	Y	N	STOMACH ULCERS	Y	N
CLAUSTROPHOBIA	Y	N	LIVER DISEASE	Y	N	STROKE	Y	N
COPD	Y	N	LUPUS	Y	N	SUBSTANCE ABUSE	Y	N
DIABETES	Y	N	LYMPHEDEMA	Y	N	THYROID DISEASE	Y	N
DIALYSIS	Y	N	NEUROPATHY	Y	N	TOENAIL FUNGUS	Y	N
EDEMA/SWELLING	Y	N	OSTEOARTHRITIS	Y	N	VARICOSE VEINS	Y	N
EPILEPSY/SEIZURES	Y	N	PACEMAKER	Y	N	WARTS	Y	N
FIBROMYALGIA	Y	N	PAD/PVD	Y	N	WOUNDS	Y	N
OTHER:											

SOCIAL HISTORY

USE OF TOBACCO: ☐ YES ☐ NO : ☐ SMOKE / ☐ DIP _____PACKS/DAY FOR _____YEARS ☐ QUIT – HOW LONG AGO?____

USE OF ALCOHOL: ☐ NEVER/NO LONGER USE ☐ CURRENT USE - TYPE _____

FREQUENCY: ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY ☐ HISTORY OF ALCOHOL ABUSE

USE OF RECREATIONAL DRUGS: *(PLEASE NOTIFY DOCTOR IN ROOM)*

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? ☐ CHILDREN–AGE(S) _____ ☐ ELDERLY OR DISABLED FAMILY MEMBER

☐ PET(S)–WHAT KIND?_____ ☐ OTHER _____

FAMILY HISTORY:

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES ☐ CANCER ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE

☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE ☐ RHEUMATOID ARTHRITIS

☐ OTHER _____

RELATIONSHIP TO PATIENT: _____

SURGICAL HISTORY	**DATE**	**SURGICAL HISTORY**	**DATE**
_____		_____	
_____		_____	
_____		_____	

PRIOR HOSPITALIZATIONS *(OTHER THAN SURGERIES)*: PLEASE INCLUDE REASON AND DATE

_____

_____

IF YOU ARE 65 YEARS OR OLDER:

DO YOU FEEL AS THOUGH YOU ARE UNSTEADY ON YOUR FEET WHILE WALKING?? ☐ YES ☐ NO

HAVE YOU HAD A HISTORY OF TWO OR MORE FALLS IN THE PAST YEAR? ☐ YES ☐ NO

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FINANCIAL POLICY

Effective: January 2022

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff prior to signing.

As our patient, you are responsible for all Triwest, VA Choice, motor vehicle accidents, conditions with active lawsuit referrals needed to seek treatment in this office. The only plans that have come across are some of the Compass plans purchased on the Healthcare.Gov website (Obamacare). Most other insurances usually don't need referrals.

Unless other arrangements have been made in advance by YOU, YOUR health insurance carrier, workman's comp or an attorney, payment for all estimated services are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check.

Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. The first file is free, but if you give us an expired or wrong insurance policy that causes significant extra administrative work, there is a $20 refiling fee.

We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the estimated co-pay/co-insurance/deductible at the time of service.

If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.

All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some services, durable medical equipment (DME) or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to their appointments.

You must inform the office of all insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.

There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.

Past due accounts are subject to collection proceedings. We offer payment plans for all costs incurred including, but not limited to, administrative fees, collection fees, attorney fees and court costs shall be your responsibility in addition to the balance due this office. A $200.00 collection fee will be added to your statement balance when your account is transferred to collections.

FEES:

-There is a service fee of $35.00 for all returned checks. Your insurance company does not cover this fee.
-There is a $5 late payment fee monthly for past due accounts. After 3 months accounts are past due. Fee is applied retroactively and for each month afterwards.
-The first 3 statements are sent free of charge. Any additional copies requested have a $3 postage fee .
-For the third missed appointments not canceled within 48 hours there is an administrative fee of $50 to be paid prior to being put on the schedule for any other appointments.

_____ _____

SIGNATURE TODAY'S DATE

THE FOOT AND ANKLE CLINICS

Release to Obtain Health Information

(including paper, oral and electronic information)

Name:	**Date:**
Address:	**Date of Birth:**
City/State/Zip	**Social Security #:**

I authorize:

Name: The Foot And Ankle Clinic Of West Monroe Provider: Dr. Luke Hunter/ Dr. Gentry Haughton

Mailing Address: 2269 Arkansas Rd. West Monroe LA, 71291 Ph: 318-397-1574 Fax: 318-397-1672

To obtain medical records from:

Facility: _____

Ph: _____ **Fax:** _____

FOR OFFICE USE ONLY:

The Purpose of this Authorization is indicated in the box(es) below. (Place an "X" in the box(es) that apply.)

☐ Further Medical Care ☐ Personal ☐ Legal Investigation or Action ☐ Changing Physicians ☐ Research related treatment ☐ Creating health information for disclosure to a third party

☐ Other (please specify)_____

I authorize the release of the following protected health information. (Place an "X"in the box(es) that apply to the information you want released or you want to obtain.)

☐ Entire Record ☐ Medical History, Examination, Reports ☐ Surgical Reports ☐ Prescriptions ☐ CONSULTS

☐ Hospital Records including Reports ☐ Laboratory Reports ☐ X-ray Reports ☐ MRI RESULTS ☐ CT RESULTS

☐ NCV EMG RESULTS ☐ Other: _____

I understand that if I do not specify an expiration date, this authorization will expire six (6) months from the date on which it was signed.

_____ _____

PRINT NAME OF PATIENT, PARENT OR GUARDIAN RELATIONSHIP TO PATIENT

_____ _____

SIGNATURE TODAY'S DATE