

# WESTLAND FAMILY CARE PATIENT INTAKE FORM

**PLEASE PRINT AND COMPLETE ALL ENTRIES**

FIRST NAME		LAST NAME		DATE OF BIRTH ____/____/____
SEX  <input type="checkbox"/> Male <input type="checkbox"/> Female	SOCIAL SECURITY	PHONE NUMBER	EMAIL ADDRESS	
ADDRESS				
CITY			STATE	ZIP CODE
MARITAL STATUS  <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED	SPOUSES NAME		SPOUSE PHONE NUMBER	
EMERGENCY CONTACT	RELATIONSHIP		PHONE NUMBER	

**INSURANCE INFORMATION**

DO YOU HAVE INSURANCE?  <input type="checkbox"/> YES <input type="checkbox"/> NO	PRIMARY CARD HOLDER  <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT OTHER _____	PRIMARY POLICY HOLDER NAME
PRIMARY INSURANCE COMPANY	PRIMARY ID NUMBER	PRIMARY GROUP NUMBER
DO YOU HAVE SECONDARY INSURANCE?  <input type="checkbox"/> YES <input type="checkbox"/> NO	SECONDARY CARD HOLDER  <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE. <input type="checkbox"/> PARENT OTHER _____	SECONDARY POLICY HOLDER NAME
SECONDARY INSURANCE COMPANY	SECONDARY ID NUMBER	SECONDARY GROUP NUMBER

**PHARMACY INFORMATION**

PHARMACY NAME: \_\_\_\_\_ PHARMACY PHONE NUMBER: \_\_\_\_\_

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**PATIENT INFORMATION**

PRIMARY CARE DOCTOR		PHONE	LAST SEEN ____/____/____
EMPLOYED <input type="checkbox"/> YES <input type="checkbox"/> NO	EMPLOYER NAME	OCCUPATION	BUSINESS ADDRESS
ANY RECENT HOSPITAL ADMISSIONS	REASON	DISCHARGE DATE ____/____/____	

**PAYMENT POLICIES**

- I hereby authorize Columbus Foot & Ankle Specialists, entity of Westland Family Care LLC, to release any information in connection with my claim to the above named insurance carriers, the social security administration or their intermediaries or carriers. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits be made directly to Westland Family Care LLC.
- In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trying to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable copayments and deductibles will be collected at the time of check-in
- We accept payment in the form of cash, check and credit card. Return checks will be subject to a \$30 return fee. It is your responsibility to verify our participation with your plan and any ancillary providers prior to your visit. You must give at least 24-hour notice if you are unable to keep an appointment. You may be charged a \$50 fee for missed appointments.
- You are financially responsible for anything insurance does not cover. All copays are due and payable at each visit. The amount your insurance will allow and pay for and your financial responsibility is determined by your insurance company and the policy you have chosen. Your claim will be processed according to the benefits of your insurance plan. The deductible, co-insurance and co-pay are your financial responsibility. It is your responsibility to understand your insurance plan.
- \$50 No Show Fee for any Missed Appointment that was not canceled or rescheduled 24 hours prior to the appointment. Please be considerate and call at least 24 hours before your appointment if you cannot come in.
- \$30 charge for any returned check from the bank. If there is a history of 2 returned checks, our office will only accept cash or credit card payments
- If you are a private patient without insurance, all charges are due at the time of the visit. We do not send a statement to private pay patients.
- I expressly consent to receiving telephone calls from an automatic telephone dialing system, artificial and/pr pre recorded messages, emails, text messages, or other electronic communication from Columbus Foot & Ankle Specialists, entity of Westland Family Care, and/or their contractors, servicers, debt collection agencies, or agents for any reason by using any telephone number, email address, and/or mailing address associated with my account or obtained by such entities. I agree that my consent may only be revoked by sending a written notice to Columbus Foot & Ankle Specialists, an entity of Westland Family Care or their agents. I agree to arbitrate any claims under the Telephone Consumer Protection Act, and I waive any right/ability to bring a class action against claims, against Columbus Foot & Ankle Specialists, Westland Family Care and/or their contractors, servicers, debt collection agencies or agents.

PATIENT SIGNATURE	DATE ____/____/____
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# PATIENT MEDICAL HISTORY

## ALLERGIES

- |   |  |  |                                    |
|---|--|--|------------------------------------|
| <input type="checkbox"/> NONE/Known Allergies | <input type="checkbox"/> Adhesive Tape             | <input type="checkbox"/> Anesthesia          | <input type="checkbox"/> Aspirin   |
| <input type="checkbox"/> Dairy Products       | <input type="checkbox"/> Iodine/Shellfish/Contrast | <input type="checkbox"/> Latex               | <input type="checkbox"/> Lidocaine |
| <input type="checkbox"/> Penicillin           | <input type="checkbox"/> Acetaminophen/Tylenol     | <input type="checkbox"/> Advil//Motrin/Aleve | <input type="checkbox"/> Cortisone |
| <input type="checkbox"/> Sulfa Drugs          | <input type="checkbox"/> Other Antibiotics         | <input type="checkbox"/> Codeine             |                                    |

OTHER: \_\_\_\_\_

## FAMILY HISTORY

If you have a family history of any of the following conditions, please check where appropriate and indicate the person afflicted. includes parents, grandparents, siblings.

Number of Sisters \_\_\_\_\_ Number of Brothers \_\_\_\_\_

- Emphysema
- Arthritis
- Cancer
- Diabetes
- Heart Disease
- Hypertension
- Epilepsy
- Blood Disease
- Tuberculosis
- Nervous Disorder

## SOCIAL HISTORY

- Yes**  **No** - Do you drink alcohol?     Daily  Weekly  Infrequently  Recovering Alcoholic
- Yes**  **No** - Do you smoke?     Smoke ( \_\_\_ packs per day)  Chew
- Yes**  **No** - Do you drink caffeine?     Daily  Weekly  Infrequently
- Yes**  **No** - Do you use illicit drugs?     Daily  Weekly  Infrequently    What kind? \_\_\_\_\_

## MENSTRUAL HISTORY

Onset \_\_\_\_\_ Last Menstrual Period \_\_\_\_\_ Number of Pregnancies \_\_\_\_\_

Regular Periods  **Yes**  **No**

Number of Pregnancies \_\_\_\_\_ Number of Children \_\_\_\_\_ Miscarriages \_\_\_\_\_

## SURGICAL HISTORY

Please list any hospitalizations, surgeries, fractures or major illnesses you have had.

TYPE OF SURGERY	YEAR or DATE	DOCTOR	LOCATION

**MEDICAL HISTORY:** Have you ever had any of the following?

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> NONE                     | <input type="checkbox"/> Diphtheria           | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Skin disease        |
| <input type="checkbox"/> Allergies                | <input type="checkbox"/> Drug/alcohol abuse   | <input type="checkbox"/> Jaundice                 | <input type="checkbox"/> Stuttering          |
| <input type="checkbox"/> Anemia                   | <input type="checkbox"/> Depression           | <input type="checkbox"/> Seizure disorders        | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Arthritis                | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Kidney Problems          | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Erectile dysfunction | <input type="checkbox"/> Liver Problems           | <input type="checkbox"/> Thyroid problems    |
| <input type="checkbox"/> Atrial fibrillation      | <input type="checkbox"/> Frequent Headache    | <input type="checkbox"/> Malaria                  | <input type="checkbox"/> Tremors             |
| <input type="checkbox"/> Anxiety                  | <input type="checkbox"/> Fibromyalgia         | <input type="checkbox"/> Measles                  | <input type="checkbox"/> Tonsillitis         |
| <input type="checkbox"/> Bed Wetting              | <input type="checkbox"/> Fainting spells      | <input type="checkbox"/> Menopause                | <input type="checkbox"/> Tuberculosis        |
| <input type="checkbox"/> Bloody Urine             | <input type="checkbox"/> GERD                 | <input type="checkbox"/> Mumps                    | <input type="checkbox"/> Typhoid fever       |
| <input type="checkbox"/> Broken Bones             | <input type="checkbox"/> Gout                 | <input type="checkbox"/> Menstrual disorders      | <input type="checkbox"/> Ulcers              |
| <input type="checkbox"/> Cancer                   | <input type="checkbox"/> Hemophilia           | <input type="checkbox"/> Neuropathy               | <input type="checkbox"/> Urinary frequency   |
| <input type="checkbox"/> Chest Pain               | <input type="checkbox"/> Hypothyroidism       | <input type="checkbox"/> Organ Injury             | <input type="checkbox"/> Venereal disease    |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Hypogonadism Male    | <input type="checkbox"/> Poliomyelitis            | <input type="checkbox"/> Wheat allergy       |
| <input type="checkbox"/> Convulsions              | <input type="checkbox"/> Hyperinsulinemia     | <input type="checkbox"/> Pulmonary embolism       |  |
| <input type="checkbox"/> Chicken pox              | <input type="checkbox"/> Hyperlipidemia       | <input type="checkbox"/> Pneumonia                |  |
| <input type="checkbox"/> Colitis                  | <input type="checkbox"/> Hypertension         | <input type="checkbox"/> Pleurisy                 |  |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Hay Fever            | <input type="checkbox"/> Rheumatic fever          |  |
| <input type="checkbox"/> Chronic Fatigue Syndrome | <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> Scarlet fever            |  |
| <input type="checkbox"/> Celiac Disease           | <input type="checkbox"/> Infection Problems   | <input type="checkbox"/> Sinus trouble            |  |
| <input type="checkbox"/> Cardiac Arrest           | <input type="checkbox"/> Insomnia             | <input type="checkbox"/> Swollen Joints           |  |

**REVIEW OF SYSTEMS:** Are you currently experiencing any of the following:

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> NONE              | <input type="checkbox"/> Fever/Chills        | <input type="checkbox"/> Weight change              | <input type="checkbox"/> Decreased Strength |
| <input type="checkbox"/> Headaches         | <input type="checkbox"/> Vertigo             | <input type="checkbox"/> Injury                     | <input type="checkbox"/> Abnormal vision    |
| <input type="checkbox"/> Heartburn         | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Fatigue                    | <input type="checkbox"/> Chest Pain         |
| <input type="checkbox"/> Cold Feet         | <input type="checkbox"/> Leg Cramps          | <input type="checkbox"/> Blood in urine             | <input type="checkbox"/> Painful Urinations |
| <input type="checkbox"/> Extremity burning | <input type="checkbox"/> Extremity weakness  | <input type="checkbox"/> Swelling lower extremities | <input type="checkbox"/> Extremity weakness |
| <input type="checkbox"/> Low back pain     | <input type="checkbox"/> Foot/Ankle pain     | <input type="checkbox"/> Knee pain                  | <input type="checkbox"/> Extremity numbness |
| <input type="checkbox"/> Hip pain          | <input type="checkbox"/> Easy bruising       | <input type="checkbox"/> Poor wound healing         | <input type="checkbox"/> Bloody stool       |
| <input type="checkbox"/> Vomiting          | <input type="checkbox"/> Fainting            | <input type="checkbox"/> Cough                      | <input type="checkbox"/> COVID              |
| <input type="checkbox"/> Pregnant          | <input type="checkbox"/> Breast feeding      | <input type="checkbox"/> High blood pressure        | <input type="checkbox"/> Influenza          |



## HIPAA Compliance Patient Consent Form

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Social Security Number \_\_\_\_\_

Contact Number: \_\_\_\_\_

**IF ANY OF THE ABOVE INFORMATION CHANGES IT IS THE PATIENT/PARENT/LEGAL GUARDIANS' RESPONSIBILITY TO CONTACT OUR OFFICE AND NOTIFY US OF THE CHANGES**

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. As a client of Westland Family Care LLC, you ascertain by your signature that you have access and have reviewed our notice of privacy practices before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

As a client of Westland Family Care, I have read and understand the operating procedures, and hereby give permission to the professional staff at the agency to provide diagnostic and/or therapeutic services. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? **YES NO**

May we contact you at work to confirm appointments? **YES NO**

May we leave a message on your answering machine at home or on your cell phone? **YES NO**

May we discuss your medical condition with any member of your family? **YES NO**

If **YES**, please name the members allowed:

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

This consent was signed by: \_\_\_\_\_ (PRINT NAME )

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## MEDICAL SERVICES AGREEMENT

**Medical Consent:** I consent to any treatments or procedures which may be performed on an outpatient basis (including emergency treatment or services), which may include but are not limited to medications, injections, taking of medical photographs, laboratory procedures, and/or x-ray examinations provided to me under the general and special instructions of the physicians, staff, or other health care providers of Westland Family Care assisting my care.

**Appointments:** Westland Family Care requires 24 business hours (Monday - Friday) notice for appointment cancellations. Otherwise the patient may be charged up to the full fee of the appointment. For example: if the patients' appointment is Monday at 9:00 am, Westland Family Care must receive a call by 9:00 am the previous Friday to have given proper 24 business hour notice. First appointments with Westland Family care require 48 business hour notice for appointment cancellation/rescheduling. If Westland Family Care is not provided 48 business hour notice, the appointment may not be rescheduled. It is the patients' responsibility to know the date and time of his/her appointment. Appointment reminder calls as a courtesy will be made a day prior to the appointment.

**Financial Agreement: I understand that all charges are due at the time of service.** I agree to pay Westland Family Care for all charges for healthcare services and professional services provided to me by physicians and other healthcare professionals. Acceptable forms of payment include Cash, Visa, MasterCard, Discover, and American Express. If I am a non-insured patient, I agree to pay for my visit in full at the time of service. If Westland Family Care is a participating provider with my insurance company, I understand that my co-pay, coinsurance, deductible, and/or any outstanding balances are due at the time of service. I understand that my insurance policy is a contract between myself and my insurance company, Westland Family Care is not involved. In order for Westland Family Care to file claims and accept payments from my insurance carrier, I understand that I must present current insurance information at each visit and that Westland Family Care will need to verify my health insurance coverage. In the event that Westland Family Care is not able to verify my insurance eligibility and benefits before my visit, I agree to pay for my visit in full at the time of service. A refund will be issued if my insurance pays for the visit. I also understand that I am financially responsible for any services not covered by my insurance company. When my spouse or a financial guarantor signs this agreement, the spouse or the financial guarantor shall be jointly and individually liable with me. Should my account(s) be referred to an attorney or a collection agency for the collection, the undersigned shall pay the actual attorney's fees (including costs) and collections expenses incurred in addition to the other amounts due. Unpaid accounts referred to outside agencies for collection shall bear interest at the current rate per year from the date of referral.

**Insurance Authorization and Release:** I request the payment of authorized benefits, including Medicare, and any other government sponsored program, private insurance, and any other health plans to be made to Westland Family Care for any services furnished by that provider. Westland Family Care will only submit claims to insurance companies that we are contracted with. Westland Family Care will not submit claims to secondary insurances with the exception of Medicare supplemental plans. To the extent necessary to coordinate my health care or determine liability for payment and to obtain reimbursement for services rendered, I authorize Westland Family Care to disclose portions of or all of my records, including my medical records to any person or corporation which is or may be liable for all or any portion of Westland Family Care charges, including but not limited to insurance companies, health care service plans, governmental agencies, or worker's compensation carriers. I authorize Westland Family Care to act as my agent to help me obtain any required pre-certification as well as acting as my agent to help me obtain payment from my insurance companies. I authorize my insurance companies to give Westland Family Care any information required to fulfill this function. This will remain in effect until revoked in writing. A photocopy of this assignment and release is to be considered as valid as the original. Please notify Westland Family Care in a timely manner of any changes including insurance coverage, address and telephone number. Delay in providing Westland Family Care with accurate information may prevent insurance reimbursement, and the patient will be responsible for the fees.

**Release of Medical Information:** I hereby authorize Westland Family Care to release any information in my chart to any practitioner, doctor, hospital, or medical institution to which I may be referred to assist in my care. Additionally, I authorize Westland Family Care to provide a copy of my medical records to my Primary Care Physician (PCP) to allow for continuity of care.

**Personal Valuables:** Westland Family Care shall not be liable for the loss of or damage to any money, documents, jewelry, glasses, dentures, furs, or other articles of unusual value and shall not be liable for loss or damage to any personal property. Westland Family Care, A medical corporation and the patient or the patient's representative, hereby enters into this agreement. The undersigned certifies that he/she has read and agrees to the foregoing, and is the patient, the patient's representative or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_