PATIENT INTAKE FORM

PLEASE PRINT AND COMPLETE ALL ENTRIES			
FIRST NAME	LAST NAME	DATE OF BIRTH _____/_____/_____	
SEX ❑ Male ❑ Female	SOCIAL SECURITY	PHONE NUMBER	EMAIL ADDRESS
ADDRESS			
CITY	STATE	ZIP CODE	
MARITAL STATUS ❑ SINGLE ❑ MARRIED	SPOUSES NAME	SPOUSE PHONE NUMBER	
EMERGENCY CONTACT	RELATIONSHIP	PHONE NUMBER	
HEIGHT	WEIGHT	SHOE SIZE	SHOE WIDTH

INSURANCE INFORMATION		
DO YOU HAVE INSURANCE? ❑ YES ❑ NO	PRIMARY CARD HOLDER ❑ SELF ❑ SPOUSE. ❑ PARENT OTHER _____	PRIMARY POLICY HOLDER NAME
PRIMARY INSURANCE COMPANY	PRIMARY ID NUMBER	PRIMARY GROUP NUMBER
DO YOU HAVE SECONDARY INSURANCE? ❑ YES ❑ NO	SECONDARY CARD HOLDER ❑ SELF ❑ SPOUSE. ❑ PARENT OTHER _____	SECONDARY POLICY HOLDER NAME
SECONDARY INSURANCE COMPANY	SECONDARY ID NUMBER	SECONDARY GROUP NUMBER

PHARMACY INFORMATION	
PHARMACY NAME	**PHARMACY PHONE NUMBER**

PATIENT INFORMATION

PRIMARY CARE DOCTOR	PHONE	LAST SEEN
		_____/_____/_____

EMPLOYED	EMPLOYER NAME	OCCUPATION	BUSINESS ADDRESS
❑ YES ❑ NO			

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.

PATIENT SIGNATURE	**DATE**
	_____/_____/_____

PATIENT MEDICAL HISTORY

ALLERGIES

❑ NONE/Known Allergies	❑ Adhesive Tape	❑ Anesthesia	❑ Aspirin	❑ Codeine
❑ Dairy Products	❑ Iodine/Shellfish/Contrast	❑ Latex	❑ Lidocaine	❑ Penicillin
❑ Acetaminophen/Tylenol	❑ Advil//Motrin/Aleve	❑ Cortisone	❑ Sulfa Drugs	❑ Other Antibiotics

OTHER:

FAMILY HISTORY – Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box.

	MOTHER	FATHER
Anesthesia Problems		
Arthritis		
Cancer		
Diabetes		
Heart Problems		
Hypertension		
Stroke		
Thyroid 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

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?

❑ NONE	❑ Chest pain	❑ Hypertension	❑ Osteoporosis
❑ Allergies	❑ Congestive heart failure	❑ Hypogonadism male	❑Pulmonary embolism
❑ Anemia	❑Chronic fatigue syndrome	❑Hypothyroidism	❑ Seizure disorders
❑ Arthritis	❑ Depression	❑ Infection problems	❑ Shortness of breath
❑ Asthma	❑ Diabetes	❑ Insomnia	❑ Sinus conditions
❑ Atrial fibrillation	❑ Drug/alcohol abuse	❑ Irritable bowel syndrome	❑ Stroke
❑ Bleeding problems	❑ Erectile dysfunction	❑ Kidney problems	❑ BPH
❑ Fibromyalgia	❑ Menopause	❑ Tremors	❑ GERD
❑ Cancer	❑ Migraines/headaches	❑ Wheat allergy	❑ DVT
❑ Heart disease	❑ Neuropathy	❑ Cardiac arrest	❑ Organ Injury
❑ Celiac disease	❑ Hyperlipidemia	❑ Organ injury	❑ Hyperinsulinemia

Have you ever been treated for (select all that applies):

❑ Corns/Calluses	❑ Warts	❑ Athlete's Foot	❑ Fungal Nails
❑ Ingrown Nails	❑ Neuroma	❑ Leg/Foot Ulcers	❑ Foot Numbness
❑ Bunions	❑ Broken Foot/Bone	❑ Broken Ankle	❑ Ankle Sprain
❑ Hammer/Mallet Toe	❑ Leg/Foot Cramp	❑ Flat Feet	❑ Arch pain
❑ High Arch Feet	❑ Knee Pain	❑ Lower Back Pain	❑ Heel Pain
❑ Rash	❑ In-Toeing	❑ Toe Walking	❑ Gait Problems
❑ Childhood Foot Problems			

Do you get leg cramps after activity? □ **Yes** □ **No**
Does foot pain limit your desired activities? □ **Yes** □ **No**
Do you have any difficulty walking? □ **Yes** □ **No**
Any pain in the calves or buttocks when walking? □ **Yes** □ **No**
Is the pain relieved by stopping & standing still? □ **Yes** □ **No**
List the sports and other actives in which you are involved:

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

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

MEDICATIONS:

List any medications you are currently taking (please include over the counter medications):
PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE

MEDICATION	DOSAGE	PRESCRIBING DOCTOR

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 Columbus Foot & Ankle Specialists, entity 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 Columbus Foot & Ankle Specialists, entity 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. Columbus Foot & Ankle Specialists is an entity of Westland Family Care and any reference to Westland Family Care in this agreement automatically includes Columbus Foot & Ankle Specialists.

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: _____