Advanced Foot & Ankle
CARE CENTERS

Patient Information

Full Name: _____ Today's Date: _____/_____/_____

Address: _____ City: _____ State: _____ Zip: _____

SS#: _____- _____- _____ DOB: _____/_____/_____ Age: _____ Gender: ☐ Male ☐ Female

E-mail Address: _____

Home Phone: _____ Work Phone: _____Cell: _____

***Circle preferred phone number**: ···Home / Work / Cell

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race: ☐ Asian ☐ American Indian or Alaska Native ☐ Black or African American
☐ White ☐ Native Hawaiian or Other Pacific Islander ☐ Hispanic ☐ Other

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employer: _____ Employer Phone: _____

Responsible Party

Spouse/Guardian Name: _____DOB: ___/___/___SS#: _____

Address: _____ PHONE#: _____

Additional Information:

Emergency Contact: _____Relationship_____ Phone: _____

Do you have a Power of Attorney? ☐ Yes ☐ No Do you have a **Living Will?** ☐ Yes ☐ No

Primary Care Physician: _____Phone: _____Date Last Seen: ___/___/___

Pharmacy Name: _____Street: _____City_____

***** How were you referred to us?** ☐ Physician: _____ ☐ Friend/Family ☐ Google
☐ AFACC website ☐ Insurance ☐ Urgent Care ☐ Hospital/ER ☐ Health Fair ☐ Walk-In

Insurance Information ***We MUST have a copy of your insurance card(s) in order to file your insurance. Please provide to the front desk. ALL fields must be filled out in order for us to file your insurance.***

Primary Insurance: _____ Are you the insured: ☐ Yes ☐ No

Policy ID#: _____ Group#: _____ Insurance Phone #: _____

Subscriber Name: _____ DOB: ___/___/_____

SS#: _____- _____- _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Secondary Insurance: _____ Are you the insured: ☐ Yes ☐ No

Policy ID#: _____ Group #: _____ Insurance Phone #: _____

Subscriber Name: _____ DOB: ___/___/_____

SS#: _____- _____- _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

To the best of my knowledge, I have answered questions on this form accurately. I authorize Dr. Frankfather, Dr. Brace, Dr. Cartman, Dr. Reva Bork, Dr. Rhennetta Bork, Dr. Khalil, Isabella Balzola, or their extenders to examine and treat me medically, surgically, or biomechanically and take before and after photos for my medical record. I assign my insurance benefits to be paid directly to AFACC. I authorize release of medical information necessary to process all claims.

Patient Signature: _____ **Date:** _____/_____/_____

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Name: _____

DOB: _____

Please describe the type of problem that you are having: _____

_____

Is this a result of an accident or work injury? ☐ Yes ☐ No Date of Injury: _____

Medical History –Please choose any condition that apply

☐ AIDS/HIV	☐ Arthritis	☐ Asthma	☐ Bleeding Problems	☐ High Blood Pressure
☐ Diabetes	☐ Fibromyalgia	☐ Gout	☐ Hepatitis	☐ Heart Disease
☐ Cancer	☐ Stomach Ulcer	☐ Seizures	☐ Kidney Disorders	☐ Lung Disorders
☐ Slow Healing	☐ Liver Disorder	☐ Knee, Hip, Low Back Pain		☐ Poor Circulation

Additional Medical Disorders: _____

Previous Surgeries or Hospitalizations: _____

_____

Are you currently taking any medications? Yes No If Yes, Please List: _____

_____

_____

Allergies: ☐ Known Drug Allergies: (List) _____ ☐ No Known Allergies

Date of Last Flu Shot: _____ **Did You Get A Pneumococcal Vaccination?** Yes No

Family Health History: (If Immediate Family Has or Had One of the Following, Please Check)

☐ Arthritis ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Mental Issues ☐ Stroke

DO YOU SMOKE: Yes No **DO YOU DRINK ALCOHOL DAILY OR EXCESSIVELY?** Yes No

Height: _____ **Weight:** _____ **Shoe Size:** _____

Review of Systems- Check if you have any of these symptoms:

Cardiovascular: ☐Leg pain when walking ☐ Palpitations ☐ Chest pain/pressure ☐ Valve Problems ☐ Cold hands/feet ☐Fainting ☐Fever ☐Vascular Disease ☐ Leg swelling ☐**NONE**

Genitourinary: ☐Blood in urine ☐ Excessive Urination ☐Increased Urgency ☐Decreased Frequency ☐ Incontinence ☐Hesitancy ☐Kidney disease ☐ Kidney stones ☐ **NONE**

Integumentary: ☐ Athletes Foot ☐ Nail Abnormalities ☐ Keloids ☐ Itchiness ☐ Dry, scaly skin ☐**NONE**

Hematologic: ☐Lower leg ulcers ☐Sickle Cell ☐Anemia ☐Blood Thinner ☐Clotting Disorder ☐ **NONE**

Neurologic: ☐ Tingling ☐Weakness ☐Seizures ☐Numbness ☐Headaches ☐Tremors ☐Paralysis ☐**NONE**

Musculoskeletal: ☐Back Pain ☐Joint Swelling ☐Muscle Weakness ☐Muscle Pain ☐Joint Stiffness/Pain ☐Arthritis ☐Joint Instability ☐ **NONE**

Respiratory: ☐Chest pain ☐Wheezing ☐COPD ☐Coughing ☐Shortness of breath ☐Emphysema ☐Snoring ☐**NONE**

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Financial Policy

Thank you for choosing us for all your podiatric needs. The following is our financial policy. It is vital to your care for you to have a clear understanding of our expectations regarding your billing and payment for our services.

PLEASE *INITIAL* EACH POLICY AND SIGN AND DATE AT THE BOTTOM.

_____ **Insurance.** Payment is due at the time services are rendered, including co-pays, deductibles, co-insurances, and previous balances. We bill your insurance as a courtesy, on your behalf, but is not a guarantee of payment. If insurance denies payment of services rendered, you are responsible for all medical charges left unpaid. Patients who do not have insurance will pay in advance for all services rendered at the time of service.

_____**Referral.** You are required to know whether your insurance plan requires a referral, and to obtain one before you are scheduled to be seen. You will not be seen without a referral if it is required. However, the referral is NOT a guarantee of coverage.

_____**Credit Card Fee.** Effective 1/15/2025, your receipt now includes a 3% service fee to cover the rising cost of credit card acceptance, which is no greater than what is charged to the business to accept credit cards. For your convenience, you may avoid this extra fee by paying with CASH or DEBIT CARD.

_____**Returned Checks.** A $35.00 fee will be charged for any returned checks. You will not be able to pay the fee and cover the returned check with another check, only with cash or VISA/Master/Discover card.

_____**Past Due Accounts.** Patients who fail to make payment on delinquent accounts will be turned over to a collection agency within 120 days. You will receive four statements in the mail alerting you of your account balance. Patients with accounts in collections will be required to satisfy their financial obligation to us prior to being seen by our doctors.

_____**Missed/Canceled Appointments**. We enforce a $40 fee for missed or canceled appointments without 24-hour notice. As a courtesy to our patients, we make every effort to confirm all appointments by text/email well in advance.

_____**Surgeries.** Prior to scheduling, you will be given an estimate of the amount you will be responsible for paying. This amount is collected before the surgery is performed. Additional payments/refunds may be required after the insurance has processed your claim.

_____**FMLA forms.** FMLA (leave from work) forms take 3-5 business days to process. There is a $25 fee per packet.

_____**Medical Records.** We gladly send your medical records to other physicians at no charge. If you would like a paper copy of your medical records, there will be a $20.00 fee.

I HAVE READ THE ABOVE AGREEMENT AND I AGREE TO THE TERMS AND CONDITIONS SET FORTH BY AFACC, PC.

_____	_____	_____
Patient or Patient's Representative Signature	Relationship to Patient	Date

Advanced Foot & Ankle
CARE CENTERS

Summary of Notice of Privacy Practices

Advanced Foot and Ankle Care Centers understands that medical information about you and your health is personal and we are committed to protecting that information. We will use and disclose your health information to treat you or to assist other health care providers in treating you. We will also use and disclose your health information to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students. We will not use or disclose your health information without your written authorization.

I hereby specifically authorize disclosure of my protected health care information to the person(s) indicated below.

PLEASE CIRCLE ALL THAT APPLY AND SPECIFY THEIR NAME(S):

ANY MEMBER OF MY IMMEDIATE FAMILY (NAME) _____ YES NO
MY SPOUSE ONLY (NAME) _____ YES NO
OTHER PERSONS (NAME) _____ YES NO

Your Rights Regarding Your Health Information

As our patient, you have the following rights:

- To have access to and/or a copy of your health information
- To request an accounting of certain disclosures we have made of your health information
- To request restrictions as to how your health information is used or disclosed
- To request that we communicate with you in confidence
- To request that we amend your health information
- To receive notice of our privacy practices

If you believe that your privacy rights have been violated, you may file a complaint in writing directly to the Secretary of the Department of Health and Human Services or with us by notifying our office Privacy Officer:

Kristie Smith
397 Wallace Road, Suite C411
Nashville, Tennessee 37211
(615) 332-0330

There will be no retaliatory action made against any individual who submits a complaint.

I have read the above Advanced Foot and Ankle Care Centers' Notice of Privacy Practices.

Patient's Name: _____ DOB: _____/_____/_____
Signature: _____ Date: _____/_____/_____
Representative/Guardian Signature: _____