



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: _____
 Address: _____ SS#: ____-____-____ DOB: ____/____/____

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. Retief, Dr. Henderson, Dr. Delaney, Dr. Brace and Dr. Davis 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

- | | | | | |
|---------------------------------------|---|---|--|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Gout | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Stomach Ulcer | <input type="checkbox"/> Seizures | <input type="checkbox"/> Kidney Disorders | <input type="checkbox"/> Lung Disorders |
| <input type="checkbox"/> Slow Healing | <input type="checkbox"/> Liver Disorder | <input type="checkbox"/> Knee, Hip, Low Back Pain | <input type="checkbox"/> 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:

- | |
|--|
| <p>Cardiovascular: <input type="checkbox"/> Leg pain when walking <input type="checkbox"/> Palpitations <input type="checkbox"/> Chest pain/pressure <input type="checkbox"/> Valve Problems <input type="checkbox"/> Cold hands/feet
 <input type="checkbox"/> Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Vascular Disease <input type="checkbox"/> Leg swelling <input type="checkbox"/> NONE</p> |
| <p>Genitourinary: <input type="checkbox"/> Blood in urine <input type="checkbox"/> Excessive Urination <input type="checkbox"/> Increased Urgency <input type="checkbox"/> Decreased Frequency
 <input type="checkbox"/> Incontinence <input type="checkbox"/> Hesitancy <input type="checkbox"/> Kidney disease <input type="checkbox"/> Kidney stones <input type="checkbox"/> NONE</p> |
| <p>Integumentary: <input type="checkbox"/> Athletes Foot <input type="checkbox"/> Nail Abnormalities <input type="checkbox"/> Keloids <input type="checkbox"/> Itchiness <input type="checkbox"/> Dry, scaly skin <input type="checkbox"/> NONE</p> |
| <p>Hematologic: <input type="checkbox"/> Lower leg ulcers <input type="checkbox"/> Sickle Cell <input type="checkbox"/> Anemia <input type="checkbox"/> Blood Thinner <input type="checkbox"/> Clotting Disorder <input type="checkbox"/> NONE</p> |
| <p>Neurologic: <input type="checkbox"/> Tingling <input type="checkbox"/> Weakness <input type="checkbox"/> Seizures <input type="checkbox"/> Numbness <input type="checkbox"/> Headaches <input type="checkbox"/> Tremors <input type="checkbox"/> Paralysis <input type="checkbox"/> NONE</p> |
| <p>Musculoskeletal: <input type="checkbox"/> Back Pain <input type="checkbox"/> Joint Swelling <input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Muscle Pain <input type="checkbox"/> Joint Stiffness/Pain <input type="checkbox"/> Arthritis
 <input type="checkbox"/> Joint Instability <input type="checkbox"/> NONE</p> |
| <p>Respiratory: <input type="checkbox"/> Chest pain <input type="checkbox"/> Wheezing <input type="checkbox"/> COPD <input type="checkbox"/> Coughing <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Emphysema <input type="checkbox"/> Snoring <input type="checkbox"/> NONE</p> |



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CARE CENTERS

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.

ALL patients must complete and/or update our Registration and History forms before seeing the doctor.

PLEASE INITIAL EACH POLICY, SIGN AND DATE.

_____ **Insurance.** Payment is due at the time services are rendered, including co-pays, deductibles, co-insurances, and previous balances. We do bill to your insurance as a courtesy, on your behalf, but is not a guarantee of payment. In the event that 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 or not 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.

_____ **Returned Checks.** A \$29.00 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 Appointments.** Our automated system will contact you five days prior to your appointment as a reminder. We ask that you notify our office within 24 hours prior to cancellation or change to your appointment. Missed appointments will result in a \$20.00 fee. Multiple late cancellations or no shows may result in discharge from our practice.

_____ **Surgeries.** Prior to scheduling, you will be given an estimate of the amount you will be responsible to pay. 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 \$20 fee per packet.

_____ **Medical Records.** We gladly send your medical records to other physicians at no charge. They will also be available to you on your patient portal. A copy of your medical records will cost you 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



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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

I understand the physicians may choose to photograph, televise, film or otherwise record all or any portion of my care for medical, scientific, promotional or educational purposes. I consent to the aforementioned, provided my identity is not revealed. I understand and agree that any photographs, films or other recordings created will be the sole property of AFACC and are not a part of my medical record, therefore I cannot obtain a copy.

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:

Erin Schroeder
 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: _____