

SW FLORIDA ANKLE & FOOT CARE SPECIALISTS

Patient Last Name: _____ First: _____ Middle: _____

Mailing address _____

Street Address: (If different from above) _____

Type of Residence you live in: Private Home Assisted Living facility Nursing Home Group Home

Home Ph#: _____ Cell Ph#: _____

Ok To Leave a Message: YES NO Email: _____

Date of Birth: _____ Social Security#: _____ Marital Status: _____

Race: _____ Ethnicity: _____ Language Preference: _____

Emergency Contact: _____ Contact Ph#: _____ Rel: _____

Pharmacy Information:

Pharmacy Name: _____ Pharmacy Ph#: _____

Location: _____

Seasonal Residents:

Northern Address: _____

Ph #: _____ When do you go North: _____

Insurance Information:

Primary Insurance: _____ Phone Number: _____

Subscriber ID: _____ Group Number: _____

Subscriber Name: _____

Subscriber SS#: _____ Subscriber Date of Birth: _____

Secondary Insurance: _____ Phone Number: _____

Subscriber ID: _____ Group Number: _____

Subscriber Name: _____

Subscriber SS#: _____ Subscriber Date of Birth: _____

Employer Information:

Employer Name: _____

Address: _____

Phone Number: _____ OK to leave message: YES NO

SW FLORIDA ANKLE & FOOT CARE SPECIALISTS

AUTHORIZATION FOR COMMUNICATION WITH PHARMACY

I hereby authorize the physician and/or representative to communicate via electronic submission with the pharmacy of my choice. This can and may include electronic submission of new prescriptions, authorizations of refills, and inquiry as to current medications.

Signature of patient or authorized person

Date

PREGNANCY DISCLAIMER (FEMALE PATIENTS ONLY)

I understand that if I am pregnant, I should not have any diagnostic x-rays or elective surgery without first checking with my Obstetrician.

I am NOT pregnant. My last period was _____.

If during the course of my treatment I become pregnant, it is my responsibility to inform the doctor and avoid x-rays and elective surgery.

Signature of patient or authorized person

Date

Staff Witness

AUTHORIZATION FOR RELEASE OF INFORMATION

I request the services of the Doctors of Southwest Florida Ankle and Foot Care Specialists, duly licensed physicians in the State of Florida, and all personnel, the consent to examination, diagnostic procedures and treatment which may need to be performed on my behalf. Also, I authorize the release of any medical information, to any person or corporation, necessary to process my claim.

Signature of patient or authorized person

Date

ASSIGNMENT OF BENEFITS

I hereby authorize direct payment for all valid insurance benefits including all major medical benefits, be made on my behalf to Southwest Florida Ankle and Foot Care Specialists. I understand I will be financially and legally responsible for charge(s) not covered by assignment.

I certify that I have read the above authorizations and understand and agree to same, and also certify no guarantee or assurance has been made as to the results that may be obtained.

Signature of patient or authorized person

Date

Consent to Use and Disclose Health Information

Patient Name: _____

By signing this consent, you authorize us to use and/or disclose your health information for treatment, payment, or health care operations. You have the right not to sign this consent. However, if you refuse to sign the consent, we have the right to refuse to treat you.

Your Rights With Respect To This Consent:

- **Right to Review Notice of Privacy Practices** – You have the right to review a copy of our Notice of Privacy Practices before signing this consent. Our Notice of Privacy Practices details how we may use and disclose your health information. We may amend the Notice from time to time. A copy of the Notice is posted in our office. Any revisions made to the Notice will be posted as soon as feasible.
- **Right to Request Restrictions on Use/Disclosure** – You have the right to request that we restrict how we use and/or disclose your protected health information for the purpose of providing treatment, obtaining payment for our services, and/or conducting health care operations. Such requests must be made in writing. Please note that we are **not required** to agree to any restriction you may request. If, however, we decide to agree to a restriction you have requested, we must restrict use and disclosure of your health information in the manner described in your request. To obtain a restriction request form, please contact the administrator of this practice.
- **Right to Revoke Consent** – You have the right to revoke this consent at any time. Your revocation of this consent must be in writing. If you wish to revoke this consent, please contact the administrator of this practice to obtain a revocation form. Note that your revocation of this consent will not be effective for disclosures we have already made in reliance on your prior consent. We also have the right to refuse to provide further treatment if you revoke this consent.
- **Right to Receive a Copy of This Consent Form** – You have a right to receive a copy of this consent form after you sign it.
- **Effective Period** – This consent is effective unless and until you revoke it in writing.

I hereby authorize Southwest Florida Ankle & Foot Care Specialists to use and/or disclose my health information for treatment, payment, or health care operations.

Patient Signature

Date

If patient is unable to sign, complete the following:

Patient is unable to sign because _____

Name of Personal Representative: _____

Relationship to Patient: _____

Authority of Personal Representative: (e.g. health care POA, guardian, other statutory authorization)

Address: _____

Home Telephone Number: _____

Work Telephone Number: _____

Signature of Personal Representative

Date

SWF ANKLE AND FOOT CARE SPECIALISTS
8851 BOARDROOM CIRCLE
FORT MYERS, FLORIDA 33919

New Policy Effective October, 2010

Please be aware that effective October 1, 2010, SWF Ankle and Foot Care Specialists will have a new billing and collection policy.

As a patient, it is your responsibility to verify that we are indeed a participating provider with your insurance company/network and what services are covered. _____ (patient initial)

Please be advised that you are ultimately responsible for any and all balances incurred, regardless of insurance coverage. As a courtesy to you, our valued patient, our office will file to your primary and secondary insurance, as well as call your insurance carrier for eligibility verification and procedure pre-certification, when necessary. However, it is the responsibility of the patient to be aware of their insurance benefits. **It is our office policy to collect any co-pays and deductibles at the time of check in** (Exception: Medicare deductible/Co-insurance if owed will be billed.) Please be aware that a \$10.00 processing fee may be charged for each co-pay not paid at the time of service and/or, your appointment rescheduled. _____ (patient initial)

Be advised that should you cancel your appointment with less than 24 hours notice or no-show for your appointment, it is up to the discretion of physician to reserve the right to assess a \$50.00 cancellation fee. _____ (patient initial)

Please be aware that although your insurance carrier might state that some procedures are "eligible" for payment, or are a "covered benefit" that does not mean that there will be no financial obligation by you, the patient. Many times a deductible is withheld, or there may be a separate co-payment withheld, depending on your specific carrier. Again, it is ultimately the responsibility of the patient, to know and understand their individual policy. _____ (patient initial)

All insurance companies state a disclaimer: There is no guarantee of payment. Every claim is subject to medical necessity and the terms of your contract at the time services are rendered. Once we receive the "explanation of benefits" (EOB) we must abide by their payment and/or denial; therefore any remaining balance will be billed to you. Any disputes of the benefits should be addressed to your insurance company. Your account will be considered delinquent if payment is not made in a timely manner. _____ (patient initial)

In addition any co-insurance that is owed by you will be collected by the receptionist at subsequent appointments once your insurance carrier has processed the claim, or you will be sent a statement. _____ (patient initial)

By my signature below, the undersigned patient assigns the rights and benefits of insurance under the applicable insurance policy for any service and/or charges provided by the physicians of the SWF Ankle and Foot Care Specialists. I hereby direct the benefits be paid directly to the physicians on my behalf for any services furnished to me by the physicians of SWF Ankle and Foot Care Specialists. By my signature below I hereby certify that I have read and fully understand all the words and information contained in this form and reaffirm my consent to the examination, diagnostic procedure and/or care, treatment, therapy or remedy proposed.

By my signature below, I permit a copy/fax of this form to serve as an original signature of authorization.

Please feel free at any time to discuss any concerns or questions you may have with our Billing Specialists.

Dr. Charara, Tribuiani, Barbounis, and Cumberbatch, Kanuck, Mina

Call Angela at 239-689-8910

Dr. Nathanson, Lawlor, Zafar, and Maribona, Lerman, Kleinpell

Call Ami at 239-689-8918

Patient Signature

Date

Witness Signature

Date

Southwest Florida Ankle and Foot Care Specialists

1. What is the foot/ankle/leg problem/condition you are having? _____

 2. Is your problem/condition a result of an injury? YES NO If YES, is this work related? YES NO
Describe the injury: _____
How long have you been having this problem/condition? _____
 3. As a result of your condition, what activities are you unable to perform at this time? _____

 4. Are You Diabetic: YES NO If so, name of physician monitoring diabetes: _____
Controlled by: DIET ORAL MEDICATION INSULIN Last Blood Sugar: _____
 5. Do you experience any burning, numbness or tingling in your feet or legs? YES NO
 6. Do you experience any cramping in your feet or legs? YES NO
 7. Have you seen a physician for your foot/ankle condition? YES NO If so, when? _____
 8. Any prior treatment by a Podiatrist? _____
 9. Current Medications:

 10. Medication Allergies: _____
 11. Surgical History: _____

 12. Prior Hospitalizations: _____

- Name of Primary care Physician: _____ Phone: _____
- Shoe Size: _____
- Do you have a PACEMAKER or DIFIBRILLATOR? YES NO If yes, when placed? _____
- PATIENT NAME: _____ DATE: _____

Do you have, or have had in the past, any of the following?

- | | | | | | |
|----------------------|---------------------------|--------------------------|---------------------------|---------------------------|--------------------------|
| Fever/Chills | <input type="radio"/> Yes | <input type="radio"/> No | Burning/Tingling/Numbness | <input type="radio"/> Yes | <input type="radio"/> No |
| Hearing Loss | <input type="radio"/> Yes | <input type="radio"/> No | Blurred Vision | <input type="radio"/> Yes | <input type="radio"/> No |
| Frequent Sore Throat | <input type="radio"/> Yes | <input type="radio"/> No | Infection | <input type="radio"/> Yes | <input type="radio"/> No |
| Ringing in Ears | <input type="radio"/> Yes | <input type="radio"/> No | Callous | <input type="radio"/> Yes | <input type="radio"/> No |
| Chest Pain | <input type="radio"/> Yes | <input type="radio"/> No | Wound | <input type="radio"/> Yes | <input type="radio"/> No |
| Foot/Ankle Swelling | <input type="radio"/> Yes | <input type="radio"/> No | Rash/Itching | <input type="radio"/> Yes | <input type="radio"/> No |
| Heart Valve Problems | <input type="radio"/> Yes | <input type="radio"/> No | Change in Mole | <input type="radio"/> Yes | <input type="radio"/> No |
| Diarrhea | <input type="radio"/> Yes | <input type="radio"/> No | Deformed Nails | <input type="radio"/> Yes | <input type="radio"/> No |
| Loss of Appetite | <input type="radio"/> Yes | <input type="radio"/> No | Balance Problems | <input type="radio"/> Yes | <input type="radio"/> No |
| Nausea/Vomiting | <input type="radio"/> Yes | <input type="radio"/> No | Headaches | <input type="radio"/> Yes | <input type="radio"/> No |
| Weight Gain/Loss | <input type="radio"/> Yes | <input type="radio"/> No | Joint Stiffness | <input type="radio"/> Yes | <input type="radio"/> No |
| Shortness of Breath | <input type="radio"/> Yes | <input type="radio"/> No | Joint Pain | <input type="radio"/> Yes | <input type="radio"/> No |
| Chronic Cough | <input type="radio"/> Yes | <input type="radio"/> No | Muscle Weakness | <input type="radio"/> Yes | <input type="radio"/> No |
| Menopausal | <input type="radio"/> Yes | <input type="radio"/> No | | | |

Social History:

- Do you use recreational Drugs? YES NO
- Do you exercise routinely? YES NO
- Do you intake caffeine? YES NO If yes, how much daily? _____
- HIV/AIDS YES NO
- Do you use Tobacco? YES NO Former If YES, how long? _____
- If Former, how long ago did you quit? _____ How long did you use? _____
- Type of Tobacco: Pipe Cigar Cigarettes Chew
- Amount: less than one pack per day one pack per day more than one pack per day
- Do you use Alcohol? YES NO Socially Daily # drinks per day: _____ # drinks per week: _____

Family History:

- | | <input type="radio"/> Living | <input type="radio"/> Deceased | Age now/of death | Illness/Cause of death |
|----------|------------------------------|--------------------------------|------------------|------------------------|
| Mother | <input type="radio"/> Living | <input type="radio"/> Deceased | _____ | _____ |
| Father | <input type="radio"/> Living | <input type="radio"/> Deceased | _____ | _____ |
| Siblings | <input type="radio"/> Living | <input type="radio"/> Deceased | _____ | _____ |
| Children | <input type="radio"/> Living | <input type="radio"/> Deceased | _____ | _____ |

PATIENT NAME: _____ DATE: _____

Past Medical History

Diabetic	<input type="radio"/> Yes	<input type="radio"/> No	Crohn's Disease	<input type="radio"/> Yes	<input type="radio"/> No
Heart Disease	<input type="radio"/> Yes	<input type="radio"/> No	Hiatal Hernia	<input type="radio"/> Yes	<input type="radio"/> No
Heart Murmur	<input type="radio"/> Yes	<input type="radio"/> No	Colitis	<input type="radio"/> Yes	<input type="radio"/> No
Mitral Valve Prolapse	<input type="radio"/> Yes	<input type="radio"/> No	Cirrhosis	<input type="radio"/> Yes	<input type="radio"/> No
Hypertension	<input type="radio"/> Yes	<input type="radio"/> No	Thyroid Problems	<input type="radio"/> Yes	<input type="radio"/> No
Peripheral Vascular Disease	<input type="radio"/> Yes	<input type="radio"/> No	Liver Disease	<input type="radio"/> Yes	<input type="radio"/> No
Stroke	<input type="radio"/> Yes	<input type="radio"/> No	Carpal Tunnel	<input type="radio"/> Yes	<input type="radio"/> No
Raynauds Syndrome	<input type="radio"/> Yes	<input type="radio"/> No	Neuropathy	<input type="radio"/> Yes	<input type="radio"/> No
Menieres Disease	<input type="radio"/> Yes	<input type="radio"/> No	Cancer	<input type="radio"/> Yes	<input type="radio"/> No
Dialysis	<input type="radio"/> Yes	<input type="radio"/> No	Pancreatitis	<input type="radio"/> Yes	<input type="radio"/> No
Phlebitis	<input type="radio"/> Yes	<input type="radio"/> No	Multiple Sclerosis	<input type="radio"/> Yes	<input type="radio"/> No
Venous Insufficiency	<input type="radio"/> Yes	<input type="radio"/> No	Hypercholesterolemia	<input type="radio"/> Yes	<input type="radio"/> No
Respiratory Disease	<input type="radio"/> Yes	<input type="radio"/> No	Osteomyelitis	<input type="radio"/> Yes	<input type="radio"/> No
Alzheimers Disease	<input type="radio"/> Yes	<input type="radio"/> No	Sciatica	<input type="radio"/> Yes	<input type="radio"/> No
Parkinsons Disease	<input type="radio"/> Yes	<input type="radio"/> No	Arthritis	<input type="radio"/> Yes	<input type="radio"/> No
Hepatitis	<input type="radio"/> Yes	<input type="radio"/> No	Fractures	<input type="radio"/> Yes	<input type="radio"/> No
Fibromyalgia	<input type="radio"/> Yes	<input type="radio"/> No	Hip Replacement	<input type="radio"/> Yes	<input type="radio"/> No
RSD	<input type="radio"/> Yes	<input type="radio"/> No	Knee Replacement	<input type="radio"/> Yes	<input type="radio"/> No

PATIENT NAME: _____ DATE: _____