FOOT ANKLE EAST
WILLIAM D. RESPESS, DPM

Off: 252.695.6000 Fax: 252.695.6059 1020 Red Banks Road, Greenville, NC 27858

PATIENT FORM

New Patient Information

We Need Your Help With The Following Important Information. Please Be As Complete And Thorough As Possible. Keep Moving And Don't Get Stuck! ***We Will Help You If You Need Assistance.***

HAVE YOU BEEN SEEN BY ANOTHER PHYSICIAN FOR YOUR FOOT PROBLEM?

☐ YES ☐ NO

WAS THAT PHYSICIAN A PODIATRIST?

☐ YES ☐ NO

MAY WE HAVE THE NAME OF YOUR PREVIOUS TREATING PHYSICIAN?

_____

WHAT IS YOUR FOOT PROBLEM TODAY?

_____

_____

_____

HOW LONG HAVE YOU EXPERIENCED THIS PROBLEM?

_____

WHAT TREATMENT IF ANY HAS BEEN PERFORMED FOR YOUR PROBLEM?

_____

_____

_____

WHAT SIZE SHOE DO YOU WEAR?

_____

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PATIENT FORM

New Patient Information - Personal Information

NAME: _____
First Middle Last

Date of Birth: _____ Social Security: _____

Sex: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ D

Address: _____
Number / Street Name City, State Zip

Mailing Address: _____
P.O.Box / Street Name City, State Zip

Telephone: Home: (_____)_____ Mobile:(_____)_____

Email Address: _____

Employer Name: _____ Telephone: (_____)_____
Complete Name

Employer Address: _____
Number / Street Name City, State Zip

Responsible Party (If other than Patient)

Name: _____ Relationship to Patient: _____

Emergency Contact:

Name: _____ Telephone: (____)_____

Address: _____
Number / Street Name City, State Zip

Referring Physician

Name: _____ Telephone: (____)_____

Address: _____
Number / Street Name City, State Zip

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PATIENT FORM

New Patient Information - Medical History

Family Physician:_____ Last Visit:_____

REVIEW OF SYSTEMS (ROS)
****CHECK ALL THAT APPLY****

EAR, NOSE, THROAT & EYES

- ☐ Impaired Vision
- ☐ Glaucoma
- ☐ Sinus
- ☐ Nose Bleed
- ☐ Ear Infections
- ☐ Dentures
- ☐ Hearing Loss
- ☐ Dizzy Spells
- ☐ Fainting
- ☐ Ringing Ears

GASTROINTESTINAL/UROGENITAL

- ☐ Diabetes
- ☐ Excessive Thirst
- ☐ Excessive Hunger
- ☐ Frequent Urination
- ☐ Ulcer
- ☐ Renal Disease / Failure
- ☐ Hepatitis
- ☐ Loss Appetite
- ☐ Other

CONSTITUTIONAL / GENERAL

- ☐ Weight Loss / Gain (more than 15 lbs.)
- ☐ Fever
- ☐ Chills
- ☐ Nausea / Vomiting
- ☐ Fatigue

RESPIRATORY

- ☐ Pneumonia/Pleurisy
- ☐ Asthma
- ☐ Shortness of Breath
- ☐ C.O.P.D.
- ☐ Tuberculosis
- ☐ Emphysema
- ☐ Seasonal Allergies
- ☐ Other _____

NEUROLOGICAL

- ☐ Headaches
- ☐ Seizures
- ☐ Stroke
- ☐ Numbness
- ☐ Polio
- ☐ Mental Status Changes
- ☐ Trouble with Balance
- ☐ Other _____

CARDIOVASCULAR

- ☐ High Blood Pressure
- ☐ Chest Pain
- ☐ Heart Attack
- ☐ High Cholesterol
- ☐ Heart Murmur
- ☐ Irregular Pulse
- ☐ Circulation Disorder
- ☐ Varicose Veins
- ☐ Phlebitis
- ☐ Swelling Ankles/Legs
- ☐ "Tired" Legs
- ☐ Other _____

HEMATOLOGIC

- ☐ Anemia
- ☐ Sickle Cell
- ☐ Transfusions
- ☐ HIV
- ☐ Other _____

BONE & JOINT

- ☐ Gout
- ☐ Osteoporosis
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Painful Joints
- ☐ Other _____

contd.

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PATIENT FORM

New Patient Information - Medical History (contd.)

WHAT PHARMACY DO YOU CURRENTLY USE FOR MEDICATIONS?

PHARMACY: _____

ADDRESS / LOCATION: _____

MEDICATIONS

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____

ALLERGIES

Please List ALL Allergies

_____

_____

_____

_____

PAST SURGERIES & HOSPITALIZATIONS

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

SOCIAL HISTORY

Do You Smoke? ☐ Yes ☐ No Packs Per Day _____ How Long _____

Previously Smoked ☐ Yes ☐ No How Long _____

Do You Drink Alcohol? ☐ Yes ☐ No If Yes, How Often? _____

FEMALES:

Number of Children? _____ Are You Pregnant? _____

Patient Signature:_____ Date:_____

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PATIENT FORM

Patient Acknowledgement Form

CONSENT FOR THE USE OR DISCLOSURE OF INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

I, _____, hereby referred to as the (patient, his or her) hereby consents to the use or disclosure of his/her individually identifiable health information ("protected health information") by Foot & Ankle East, P.C. ("Facility") in order to carry out treatment, payment, or health care operations. The Patient should review the Facility's Notice of Privacy Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information, and the Patient has the right to review such Notice prior to signing this consent form.

Facility reserves for itself the right to change the terms of its Notice of Privacy Practices for Protected Health Information at any time. If the Facility does change the terms of its Notice of Privacy Practices, Patient may obtain a copy of the revised Notice by notifying Foot & Ankle East, P.C. in writing.

Patient retains the right to request that the Facility further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Facility is not required to agree to such requested restrictions; however, if the Facility does agree to Patient's requested restriction(s), such restrictions are then binding on the Facility.

At all times, Patient retains the right to revoke this Consent. Such revocation must be submitted to the Facility in writing. The revocation shall be effective except to the extent that the Facility has already taken action in reliance on the Consent.

The Facility may refuse to treat Patient if he/she (or an authorized representative) does not sign this Consent Form (except to the extent that the Facility is required by law to treat individuals). If Patient (or authorized representative) signs this Consent Form and then revokes Consent, the Facility has the right to refuse to provide further treatment to Patient as of the time of revocation (except to the extent that the Facility is required by law to treat individuals).

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED/ READ OR HAVE BEEN GIVEN THE OPPORTUNITY TO READ AND HAVE WAIVED MY RIGHT TO RECEIVE A COPY OF FOOT & ANKLE EAST, P.C. NOTICE OF PRIVACY PRACTICES AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

Date:_____ Time _____AM/PM

_____
Signature of Patient

_____
Please print name

_____
Signature of Witness

_____
Person Signing on behalf of Patient

_____
Please print name

_____
Please print name

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PATIENT FORM

Insurance Information

(Please Submit ALL Insurance Cards)

Primary Insurance

Company	Subscriber Name	Policy / Group Number	Relationship

Secondary Insurance

Company	Subscriber Name	Policy / Group Number	Relationship

Authorization for Release of Information / Payment of Benefits

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO FOOT & ANKLE EAST P.C. / WILLIAM D. RESPESS, DPM FOR ANY MEDICAL AND/OR SURGICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME UNDER THE TERMS AND CONDITIONS OF MY CONTRACT WITH THE INSURANCE COMPANY.

I ALSO AUTHORIZE THE RELEASE OF INFORMATION UPON REQUEST BY MY INSURANCE COMPANY OR OTHER MEDICAL FACILITY.

PHOTOCOPIES OF AUTHORIZATION TO BE AS VALID AS THE ORIGINAL.

I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

Patient / Guardian Signature:_____ Date:_____

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Payment Policy

Thank you for choosing us as your care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. I f your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
7. **Nonpayment.** If your account is over 60 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.
8. **Missed appointments.** Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Payment Policy
Cont'd

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party/Date