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FAMILY FOOT & ANKLE PHYSICIANS, PLLC

J. Scott Stancil, DPM Amy M. Pitzer, DPM Rick C. Chen, DPM Aaron J. Leshikar, DPM
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P (252) 439-1150 F (252) 439-1152

Welcome to our office. Please print your responses to the following questions. This is a part of your medical record.

Full Name _____ Today's Date _____

Home phone _____ Cell _____ Work phone _____

Address (Physical Location) _____

City/State/9-digit Zip_____ Email Address: _____

Mailing Address if different from above_____

City/State/Zip_____

Sex: F M Birth date _____ Age _____ Social Security # _____

Race/Ethnicity _____

Marital Status (Please circle one): Single Married Divorced Widowed

Employer Name: _____Occupation_____
Employer Address: _____

Emergency contact (other than someone living with you):
Name _____ Relationship _____ Phone _____

How did you find out about our office? _____

MEDICAL INFORMATION

Primary Care Physician's Name and Phone Number:_____
_____

Date of last visit with your PCP: _____/_____/_____ (month/day/year)

Are you currently under your doctor's care? Yes No
If so, for what reason? _____

Is there anything else we should know about your general health? _____
_____

What is your Height? _____Weight? _____ Shoe size? _____

Have you had previous treatment by a podiatrist? Yes No When? _____
For what reason? _____

What is the reason for your visit today? _____

Do you now have or have you ever had any of the following? Please check all that apply.

O Anemia	O Glaucoma	O Polio
O Arthritis	O Heart trouble	O Rheumatic/Scarlet fever
O Asthma	O High blood pressure	O Skin rashes
O Bleeding problems	O High Cholesterol	O Stomach/intestinal ulcers
O Blood disease	O Kidney disease	O Stroke
O Breathing/Lung problems	O Leg cramps	O Thyroid disease
O Cancer	O Liver disease	O Tuberculosis
O Diabetes	O Muscle disease	O Varicose veins
O Epilepsy	O Nervousness	O Other (please specify)
O Fainting spells	O Pacemaker	_____

Does any of your immediate family (father, mother, sister, brother, grandparents) have any of the above conditions? Please list:

_____

_____

Pharmacy Name and Location _____

Please list *all* medications you are taking including aspirin and birth control: _____

_____

_____

_____

ALLERGIES Are you allergic to . . .

_____ Novocaine _____ Codeine _____ Adhesive tape _____ Sulfa

_____ Foods _____ Penicillin _____ Iodine _____ Other

Do you smoke? _____ How many packs per day? _____
Do you use alcohol? _____ How much do you drink per week? _____
Do you use street drugs? _____ Please name _____
Have you been in contact with the AIDS virus? _____
Have you had the Flu Vaccine in the past 12 months? _____ Date _____
Have you had the Pneumonia Vaccine? _____Date _____

Please list and date any surgeries you've had since childhood.

_____

_____

I certify that the above information is true and correct to the best of my knowledge. I hereby give Dr. Stancil, Dr. Pitzer, Dr. Chen and/or Dr. Leshikar permission to administer and perform such procedures as may be deemed necessary to diagnose and/or treat my feet/ankles. Also, I understand that photographs and/or X-rays may be taken of my feet/ankles and are a part of my permanent medical record.

_____ _____

Signature Date

(Signature of Parent or Guardian if under 18 years of age)

Authorization for Release of Information

Name of Patient _____ Date of Birth _____

Family Foot & Ankle Physicians, PLLC is authorized to release protected health information about the above-named patient in the following manner and to identified persons.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Results of lab tests/x-rays ☐ Other_____
☐ Other person(s) (provide name and phone number) _____ _____ _____	☐ Financial ☐ Medical
☐ Email communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Medical ☐ Appointment reminders ☐ Breach notification
☐ Text communication – Provide number * _(____)_____ ☐ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder *You will receive automated reminder two business days prior. ☐ Other: _____
☐ *For email and/or text communication I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

_____Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

Revised Oct 2014

PATIENT ACKNOWLEDGMENT FORM

Patient Acknowledgment of Understanding of Family Foot & Ankle Physicians' Privacy Practices

Patient's Name: _____ Date of Birth: _____

SSN: _____ Previous Name: _____

I understand that the patient's health information is private and confidential. I understand that Family Foot & Ankle Physicians works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Family Foot & Ankle Physicians may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. [*In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.]

Family Foot & Ankle Physicians has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy and is attached to this Acknowledgment. I understand that I have the right to read the "Notice" before signing this Acknowledgment.

Family Foot & Ankle Physicians may update this Acknowledgment and "Notice of Privacy Practices". If I ask, Family Foot & Ankle Physicians will provide me with the most current "Notice of Privacy Practices".

Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include but aren't limited to: access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication be by specified methods of communications or alternative location.

Family Foot & Ankle Physicians has established procedures which help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgments, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs, etc. I will assist Family Foot & Ankle Physicians by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

My signature below indicates that I have been given the chance to review a current copy of Family Foot & Ankle Physicians' "Notice of Privacy Practices".

_____ _____ _____

Patient or legally authorized individual signature Date Time

If signed by other than patient, please state relationship _____

(parent, legal guardian, personal representative, etc.)

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Thank you for choosing Family Foot and Ankle Physicians, PLLC. We would like to welcome you to our practice and we appreciate the opportunity to take care of your podiatric needs. Our office policies are as follows:

OFFICE POLICIES

We accept payment by cash, check, money order, VISA, Mastercard, American Express and Discover.

You must present a photo ID and all insurance cards upon every visit to our office. If you do not have your insurance card(s), you may be asked to sign a waiver and may be required to pay in full at the time services are rendered.

Your insurance policy is a contract between you and your insurance company. Your co-payment, co-insurance and/or deductible is due at the time services are rendered and it is your responsibility to have proof of insurance: name, address and member number.

You recognize and accept personal responsibility for any referral needed from your primary care physician, which is required by your health insurance provider. If this information has not been obtained in accordance to your policy, you will be fully responsible for getting the referral. Failure to obtain the required information may result in rescheduling your appointment,

We participate with Medicare Part B and most insurance companies. Ask one of our staff members if we participate with your insurance company.

Medicare Part B patients have an annual deductible and then are responsible for 20% after the deductible has been met. If you have a second or tertiary insurance, we will file that for you as a courtesy. However, you will be responsible for any monies your insurance carrier has left you responsible for.

If it has been more than 1 year since your last visit, or if it is your first visit of a new year, you will be asked to complete a new patient registration sheet and office policies. This must be updated each year.

Patients who would like a copy of their records provided to them must do so in writing and must present photo identification when picking up the records. All requests for medical records require a minimum of five (5) day notice to process. We will be glad to send your records to your primary care physician with written request.

Prescription refills and authorization requests require at least 72 hour notice for processing. Please note that if prior authorization is needed, it may take longer due to your insurance prescription plan.

If for some reason you need time to pay your balance off, we will be glad to place you on a payment plan. That is a separate contract between you and Family Foot and Ankle Physicians, PLLC. You agree to abide by all the rules and conditions set forth in that payment plan. If you do not make a payment or are late making a payment, you have breached your contract and we have the right to terminate you from our practice.

You authorize Family Foot and Ankle Physicians, PLLC to release pertinent medical information to your insurance company when requested, or to facilitate payment of a claim. You also request payment of insurance benefits be made directly to Family Foot & Ankle Physicians, PLLC.

If for some reason you need blood drawn by our staff during your visit, we use Vidant Medical Center Lab and LabCorp as our reference laboratories. If your insurance requires any other lab, you must indicate this at check in so arrangements can be made.

We ask you to notify us at least 24 hours in advance if you are unable to keep your appointment. If you do not notify us in advance there will be a $75.00 fee for missed appointments.

You have read and understand the above information. You understand once you sign this agreement, all terms and conditions will be in full force and in effect. Further, you understand and agree to the terms outlined in this office agreement. You have been given a copy of this policy for future reference.

Patient Printed Name: _____

Patient or Authorized Guardian Signature: _____

Date: _____