Family Foot & Ankle Physicians, PLLC

J. Scott Stancil, DPM | Amy M. Pitzer, DPM | Rick C. Chen, DPM | Brian L. Jones, DPM | Anne S. Cossoguë, DPM

1432 East Fire Tower Road; Greenville, North Carolina 27858

Phone: (252) 439-1150 Fax: (252) 439-1152

MEDICAL HISTORY

Full Name: _____ Today's Date: _____

Date of Birth: _____

Primary Care Physician's Name: _____

Phone Number: _____

Date of last visit: _____

Are you currently under your doctor's care? Yes No

If so, for what reason? _____

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

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

Please list: -_____

_____

What pharmacy do you prefer? Please list location and/or phone number of pharmacy.

_____

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

_____

_____

_____

ALLERGIES Select all known allergies below ☐ No known allergies

☐ Novocain ☐ Codeine ☐ Adhesive tape ☐ Sulfa ☐ Foods
☐ Penicillin ☐ Iodine ☐ Other _____

Do you smoke? YES NO If Yes, how many packs per day? _____
Do you use alcohol? YES NO If yes, how much do you drink per week? _____
Do you use street drugs? YES NO If yes, please list: _____

Have you been in contact with the AIDS virus? YES NO
Have you had a Flu Vaccine in the last 12 months? YES NO
Have you had the COVID Vaccine in the last 12 months? YES NO
Have you had a Pneumonia Vaccine in the last 5 years? YES NO
Please list and date any surgeries you've had since childhood.

_____
_____
_____

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

_____
_____
_____

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

_____
_____

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, Dr. Jones and/or Dr. Cossogue 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**

Family Foot & Ankle Physicians, PLLC

J. Scott Stancil, DPM | Amy M. Pitzer, DPM | Rick C. Chen, DPM | Brian L. Jones, DPM | Anne S. Cossoguë, DPM
1432 East Fire Tower Road; Greenville, North Carolina 27858
Phone: (252) 439-1150 Fax: (252) 439-1152

DEMOGRAPHICS & AUTHORIZATIONS FOR RELEASE

Patient Name: _____ Date of Birth: _____ SS#_____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Mailing Address: _____

City: _____ St: ___ Zip: _____ Email:_____

Billing Address: _____

City: _____ St: ___ Zip: _____

Gender: M F Ethnicity: _____ Marital Status: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Insurance Carrier(s): _____

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

Allow our office to release information to you through the following communication preferences:

☐ Leave me a voicemail on the numbers provided above

☐ Send me an *email that is posted above ☐ Send me a *text on my mobile device

☐ *For **email and/or text communication** I understand that if information is *not* sent in an encrypted (secure) manner, there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.

Allow our office to send you the following information through the communication preferences you have selected above: ☐ Financial ☐ Medical Records and Results ☐ Appointment Reminders ☐ Legal/Insurance

Allow the following persons/entity to receive protected health information (PHI) regarding my health care. *This section can be left incomplete & changed if you decide to allow someone to receive your records in future.*

Person or Entity	Person Date of Birth	Phone	Email

Patient's Rights:

- I have the right to revoke this authorization at any time by contacting this office.
- 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 because 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 document

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

Signature of Patient or Personal Representative: _____Date: _____

Family Foot & Ankle Physicians, PLLC

J. Scott Stancil, DPM | Amy M. Pitzer, DPM | Rick C. Chen, DPM | Brian L. Jones, DPM | Anne S. Cossoguë, DPM
1432 East Fire Tower Road; Greenville, North Carolina 27858
Phone: (252) 439-1150 Fax: (252) 439-1152

OFFICE POLICIES

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. The following is an outline of our office policies.

We accept payment by cash, check, credit card, and care credit.

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 and or deductible are due at the time services are rendered. 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.

Medicare 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) days' notice to process. We will be glad to send your records to your primary care physician with written request.

Prescription refill and authorization requests require at least 72 hours 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 the release of any medical information to the proper agency to determine insurance benefits if necessary.

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.

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.

In order for our physicians and staff to maintain therapeutic and productive relationships with our patients, they must be treated respectfully. Disruptive or threatening behavior, such as abusive, vulgar, discriminatory, or indecent language is not acceptable. In addition, behavior that presents a threat to public safety, causing disruption or use of unlawful force, illegal drugs, firearms or intentional damage to property or theft is not tolerated.

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 financial agreement. You have been given a copy of this policy for future reference.

Patient Name (Please print):_____

Patient Signature:_____ Date:_____
(Or authorized Guardian)

Family Foot & Ankle Physicians, PLLC

J. Scott Stancil, DPM | Amy M. Pitzer, DPM | Rick C. Chen, DPM | Brian L. Jones, DPM | Anne S. Cossoguë, DPM

1432 East Fire Tower Road; Greenville, North Carolina 27858

Phone: (252) 439-1150 Fax: (252) 439-1152

PATIENT ACKNOWLEDGMENT

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

Patient's Name:_____ Date of Birth:_____

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 use, 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, authorizations, reasonable time frames for requesting information, charges for copies and non-routine information needs etcetera. 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.)