We welcome you to The Foot and Ankle Clinic of Albuquerque, P.C. where we give you your best care because you matter.

PATIENT REGISTRATION

PATIENT INFORMATION

Last Name: ____________________ **First:** _______________________ **Middle Initial:** _____

0Mr. 0Mrs. 0Dr. 0Miss 0Ms. **Marital Status (Check One)** Single 0Mar 0Div 0Sep 0Wid

Nickname (Name I prefer to be called): ____________________________ **Spouse's Name:** _____________

Sex: 0M 0F 0NA **Birth Date:** __________________ **Primary Language:** __________

Street Address: ____ **City:** ____________________________

State: ______ **Zip Code:** _________ **Social Security #:** _____________________________

Home Phone #: _____________________ **Mobile Phone #:** ______________________________

E-mail: ____________________________ **Employer:** _________________________

Employer Address: ____ **Work Phone #:** ___________________

Pharmacy Name & Phone #:______________________________________ **Primary Care Physician (PCP):** _____

PERSON RESPONSIBLE FOR BILL (IF DIFFERENT FROM ABOVE)

Last Name: ____________________ **First:** _______________________ **Middle Initial:** _____

Sex: ⬯M ⬯F ⬯NA **Birth Date:** __________________

Relationship to Patient (Check One) ⬯Self ⬯Spouse ⬯Child ⬯Other

Street Address: ____ **City:** ____________________________

State: ______ **Zip Code:** _________ **Social Security #:** _____________________________

Home Phone #: _____________________ **Mobile Phone #:** ______________ **E-mail:** ____________________

Employer: _________________________ **Employer Address:** ___________________________

Work Phone #: ____________

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD AND PHOTO ID TO RECEPTIONIST)

Primary Insurance: _________________ **Subscriber Name:** ____

Insurance ID #: ____________________ **Group #:** _____________________ **Policy #:** ___________________

Effective Date: _____________________ **Expiration Date:** ______________ **Co-Payment: $** ______________

Secondary Insurance: ________________ **Subscriber Name:** ____

Insurance ID #: ____________________ **Group #:** ____________________ **Policy #:** ___________________

Effective Date: _____________________ **Expiration Date:** ______________ **Co-Payment: $** ______________

IN CASE OF EMERGENCY

Name of Nearest Friend or Relative: __________________________________ **Relationship to Patient:** ______

REFERRAL

How did learn about use? (Please check all that apply): ______________________________________

The above information is true to the best of my knowledge. I certify that I am insured with the insurance company disclosed and assign directly to The Foot and Ankle Clinic of Albuquerque, P.C. all insurance benefits, if any, otherwise payable to me for service(s) rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature below on all insurance submissions. The Foot and Ankle Clinic of Albuquerque, P.C. may use my healthcare information and may disclose such information to the disclosed insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

____ ____________________

PATIENT/GUARDIAN SIGNATURE DATE

PATIENT HISTORY

Patient Name: ________________________________ **Date of Birth:**____________ **Today's Date:** ________

Chief Complaint: ____

Any Associated Recent Injury? ⬯No ⬯Yes

Symptoms:____

Duration:____________ **Severity of Pain (rate 1-10; *10 being most severe*):** _____

PAST MEDICAL HISTORY

Diabetes: ⬯No ⬯Yes Hypertension: ⬯No ⬯Yes

Liver Disease: ⬯No ⬯Yes Kidney Disease: ⬯No ⬯Yes

Lung Disease: ⬯No ⬯Yes Circulation Problems: ⬯No ⬯Yes

Heart problems: ⬯No ⬯Yes High Cholesterol: ⬯No ⬯Yes

Other:____

PAST SURGICAL HISTORY

⬯Foot/Ankle ⬯Joint Replacement

⬯Joint Replacement ⬯C-Section

⬯Hysterectomy ⬯Tubal Ligation

⬯Appendix ⬯Gallbladder ⬯Tonsils/Add

⬯Other: _______________________

MEDICATIONS (include RX meds, OTC meds, and vitamins) ALLERGIES

Medication **Dosage** **Medication** **Reaction**

____

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REVIEW OF SYSTEMS

Please circle the ones that apply or explain any that may not be listed. In each area, if you are not having any difficulties, please check "No Problems." If you have any questions about this, please ask the doctor.

Const. (Health in General) ☐No Problems Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in the jaws when eating, scalp tenderness, prior diagnosis of cancer. Other: ________________________

C-V (Heart and Blood Vessels) ☐No Problems Irregular heartbeat, racing heart, chest pains, swelling of the feet or legs. Other: ________________________

Resp. (Lungs & Breathing) ▯ No Problems Shortness of breath, prolonged cough, wheezing, oxygen at home.
Other: ________________________

MS (Muscles, Bones, Joints) ▯ No Problems Joint pain, aching muscles, shoulder pain, swelling of joints, back pain. Other: ______________________________

Integ. (Skin & Hair) ▯ No Problems Persistent rash, itching, new skin lesion. Other: __________________

FAMILY HISTORY

Father: ▯ Living ▯ Deceased- age ______ Cause of Death: _______________

Mother: ▯ Living ▯ Deceased- age ______ Cause of Death: _______________

Sibling(s): ▯ Living ▯ Deceased- age ______ Cause of Death: ______________

Has any relative suffered the following? (Please indicate only to close relatives)

Arthritis: ▯No ▯Yes Liver Disease: ▯No ▯Yes

Asthma: ▯No ▯Yes Lung Disease: ▯No ▯Yes

Cancer: ▯No ▯Yes Migraine: ▯No ▯Yes

Diabetes: ▯No ▯Yes Obesity: ▯No ▯Yes

Heart Disease: ⬯No ⬯Yes

Stroke: ⬯No ⬯Yes

High Blood Pressure: ⬯No ⬯Yes

Tuberculosis: ⬯No ⬯Yes

High Cholesterol: ⬯No ⬯Yes

Thyroid Disease: ⬯No ⬯Yes

Kidney Disease: ⬯No ⬯Yes

Premature family history of heart attack (Before age 55): ⬯No ⬯Yes

Other: ____

SOCIAL AND ENVIRONMENTAL HISTORY

Pregnant: ⬯Yes ⬯No

Number of Children? _________

How many years? ___________

Tobacco Smoker: ⬯Yes ⬯No

When did you quit? ________

Sedentary life style (no exercise at all) ⬯Yes ⬯No

Drink Alcohol ⬯Yes ⬯No

How much per week? ________

Drink Caffeine ⬯Yes ⬯No

How much per week? ________

Other: _________________________

CONSENT TO TREATMENT

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of The Foot and Ankle Clinic of Albuquerque, P.C Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice. **Patient Initials:** __

ACKNOWLEDGMENT REGARDING PRIVACY POLICY

Due to the recent implementation of the Patient Privacy Act (HIPPA), I hereby authorize The Foot and Ankle Clinic of Albuquerque, P.C to leave messages at my home with family members and/or answering machines regarding the following: (1) Confirm Appointment, (2) Results of testing ordered by the physician, and/or (3) Any pertinent information that may be relative to my care. **Patient Initials:** __

ACKNOWLEDGMENT OF RECEIPT OF FINANCIAL POLICY

I acknowledge that I was provided a copy of The Foot and Ankle Clinic of Albuquerque, P.C Financial Policy and that I have read (or had the opportunity to read if I so chose) and understand and will comply by the policies stated.

Patient Initials: __

CONSENT TO VIEW EXTERNAL PRESCRIPTION HISTORY

I authorize the The Foot and Ankle Clinic of Albuquerque, P.C to view my external prescription history via electronic prescribing services. I understand that prescription history from multiple other unaffiliated medical providers, insurance

companies, pharmacies, and pharmacy benefit managers, may be viewable by my provider and staff at The Foot and Ankle Clinic of Albuquerque, P.C and it may include prescriptions back in time for several years. **Patient Initials:** __

PATIENT CONSENT

I hereby voluntarily consent to outpatient care by The Foot and Ankle Clinic of Albuquerque, P.C, encompassing routine care, diagnostic procedures, examination and medical treatment including but not limited to: minor surgical procedures, routine laboratory work, x-rays, ultrasound, photographs, and administration of medications and injections prescribed by their Doctor. I also provide consent for video recording of procedures limited only to the foot and ankle without any facial shots. I authorize the placement of these videos on The Foot and Ankle Clinic of Albuquerque, P.C website for patient educational purposes. I agree to ask questions to clarify treatment should I not understand the treatment plan.

Patient Initials: __

INSURANCE ASSIGNMENT AND RELEASE

I certify that I am insured with the insurance company disclosed and assign directly to The Foot and Ankle Clinic of Albuquerque, P.C and it's Doctor(s) all insurance benefits, if any, otherwise payable to me for service(s) rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I agree that should my account become delinquent and is referred to an attorney or collection agency for collection, I will be charged an additional 33.3% of any unpaid balance at the time of referral for all costs of collection an attorney's fees. I authorize the use of my signature below o all insurance submissions.

The Foot and Ankle Clinic of Albuquerque, P.C. may use my healthcare information and may disclose such information to the disclosed insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. **Patient Initials:** __

I have read and fully understand this Consent to Treatment. I agree to all of it contents. This authorization is valid as of the date I have signed below and will remain in effect as long as I am a patient at The Foot and Ankle Clinic of Albuquerque, P.C.

______________________________	______________________________	______________
Name of Individual/Legal Representative (Print)	Signature of Individual/Legal Representative	Date

Doctor Initials: __

HIPAA NOTICE OF PRIVACY PRACTICES

Written Acknowledgement Form

This is a brief summary of your rights and protections under the ***Federal Health Information Privacy Law****. A complete* ***Notice of Privacy Practices*** *available upon request.*

Your health Information is protected by Federal Law

•Most doctors, nurses, pharmacies, hospitals, clinics, many other health care providers, health insurance companies, HMOs, most employer group health plans and certain government programs, such as Medicare and Medicaid must follow this law.

•The information protected by this law includes information your doctors, nurses and other health care providers put in your medical record, conversations you doctor has about your care or treatment with nurses and others, you and your health insurer's computer system, billing information about you at your clinic and most other health information about you held those who must follow this law.

Providers and Health Insurers who are required to follow this law must comply with your right to

•Ask to see and get a copy of your health records

•Have corrections added to your health information

•Receive a notice that tells you how your health information may be used and shared

•Decide if you want to give your permission before your health information can be used or shared for certain purposes, such as for marketing

•Get a report on when and why your health information was shared for certain purposes

•If you believe your rights are being denied or your health information isn't being protected, you can

- File a complaint with your provider or health insurer
- File a complaint with the U.S. Government

The Law Sets Rules and Limits on Who Can Look at and Receive Your Information

•To make sure that your information is protected in a way that does not interfere with your health care, your information can be used and shared for your treatment and care coordination

•To pay doctors and hospitals for your health care and help run their businesses

•With your family, relatives, friends and others you identify who are involved with your health care bills, unless you object

•To make sure doctors give good care and offices are clean and safe

•To protect the public's health, such as by reposting when the flu is in your area

•Your health information **CANNOT** be used or shared without your written permission unless this law allows it. For example, with your authorization, your provider generally cannot

- Give your information to your employer
- Use of share your information for marketing or advertising purposes
- Share private notes about your mental health counseling sessions

The Law Protects the Privacy of Your Health Information

•Providers and health insurers who are required to follow this law must keep your information private by teaching the people who work for them how your information may and may not be used and shared

•Taking appropriate and reasonable steps to keep your health information secure

You can learn more about your health information privacy and rights by selecting "Your Health Information Privacy Rights" online at www.hhs.gov/ocr/hippa/.

FINANCIAL POLICY

THANK YOU for selecting us for your Foot, Ankle, and Lower Extremity medical care.

No Insurance: Payment in full is due at the time of service. It will vary depending of the severity of your problem.

Private Insurance: You must have a current insurance card and be prepared to pay any deductibles and/or co-payments that may apply. We will file a claim to your insurance company as a courtesy.

Medicaid /Salud: You must have a current MEDICAID Card and a referral from your Primary Care Provider.

Medicare: You must have a current MEDICARE Card and be prepared to pay your deductible and 20% of the allowed charges. Medicare regulations suggest that the Doctor should inform you in advance if some certain services may not be covered. Your signature below indicates that you fully understand the above information and agree to be personally and fully responsible for payment of services not covered.

For your convenience, we accept payment by Cash, Personal Check, Visa, MasterCard, Discover and American Express. There will be a $30.00 charge on all returned checks.
Please remember you are responsible for your co-pays, deductibles, co-insurance and non-covered services after reimbursement rates set by your insurance carrier have been paid. If your insurance company has not paid your claim in full within 90 days, you will be contacted by our office and asked to pay your balance in full. This matter will then be between you and your insurance carrier.

All outstanding balances must be paid in full within 90 days of your date of service. If a payment is not received, the account could be turned over to a **Collection Service**.

Outstanding accounts will be assessed a service charge of $5.00 per month until account is resolved. I fully understand the above financial policy.

______________________________ ______________

Patient Signature **Date**

Records Release/ Signature on File

I request that payment of authorized benefits be made on my behalf for any service furnished to me by the listed provider. I authorize any holder of medical information about me to release any information needed to determine these benefits or the benefits payable to the related services to the insurance agent. The Foot and Ankle Clinic of Albuquerque, P.C. has my express permission to examine, perform tests, administer treatment including in-office, outpatient, and inpatient procedures deemed necessary in the diagnosis and treatment of my foot, ankle, and lower extremity condition, including use of photographs or video recording, when necessary.

______________________________ ______________

Patient Signature **Date**