MERRITT ISLAND FOOT AND ANKLE, INC.

2404 N. Courtenay Pkwy., Merritt Island, FL 32953
6549 N. Wickham Rd., Suite E103, Melbourne, FL 32940

Dear Patient,

We ask that you please read and sign this form as it concerns you, the patient.

Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy, therefore we ask you, the patient to please check with your insurance company regarding your coverage and benefits. It is **YOUR** responsibility to know **YOUR** individual coverage, limitations and coordination of benefits. Failure to comply with this suggestion could result in you, the patient, being responsible for all costs incurred. **Please remember that your insurance policy is between you and your health insurance company.**

If you need a referral/authorization from your insurance company or from your primary care physician (PCP) or from another doctor to be seen in this office, the referral/authorization must be present at the time of your visit. If it is not available, it will be your responsibility to obtain one. Consequently, you will need to reschedule your visit should the referral/authorization not be available. We welcome you to call your insurance company and/or physician and have your referral/authorization faxed to us at (321) 454-9208.

If you have a co-payment or co-insurance, out of pocket expenses, deductibles, services/products not covered by insurance, etc., it must be paid at the time of service.

Please call your insurance company and learn about your coverage. It may save you a lot of confusion and out of pocket expenses.

_____	_____	_____
Print Name: Patient / Parent	Date	Patient / Parent Signature

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HIPAA PRIVACY POLICY
PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to care out:

- Treatment (including direct or indirect treatment by other healthcare providers and laboratories involved in my treatment)
- The day to day healthcare operation of our practice
- Obtaining payment from third party payers (i.e. insurance companies)

I have also been informed and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of the notice from time to time and that I may contact you at any time to obtain the updated copy of the notice.

I understand that I have the right to request restricts on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to theses requested restrictions. However, if you do agree, you are then bound to comply with these restrictions.

I do understand that I may revoke this consent, in writing at anytime. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Name_____

Signature_____

Date:_____

PATIENT HISTORY

Today's Date: _____

Name: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Reason for today's appointment:

_____

_____

Please List All Prescription and Over the Counter (OTC) Medications (Drug Name and Dosage)

_____

_____

_____

Please List Any Allergies You May Have: □ No Known Drug Allergy

□ Aspirin □ Betadine/Iodine □ Codeine □ IVP Dye □ Morphine □ Penicillin □ Sulfa

□ Anesthetics/Lidocaine/Novocain □ Anti-Inflammatories □ Cortisone □ Latex

□ Other _____ □ Other _____ □ Other _____

Have you or a family member ever had any problems with anesthesia? □ Yes □ No

Social History:

Do you smoke? □ Yes □ No How many packs per day? _____ How many years? _____

Have you ever smoked? □ Yes □ No When did you quit? _____

Do you drink alcohol? _____How often? _____

Have you ever used recreational drugs? _____ Have you abused prescription medications? _____

Do you have hobbies? _____

Do you exercise or participate in sports? _____

Family History:

Do any diseases run in your family?

□ Arthritis □ Bleeding Problems □ Cancer Type: _____

□ High Cholesterol/Triglycerides □ Diabetes Type I II □ High Blood Pressure □ Heart Problems

□ Sickle Cell □ Mental Illness Other: _____

Mother: ____ Alive ____ Deceased Cause of Death: _____

Father: ____ Alive ____ Deceased Cause of Death: _____

Sisters: ____ Alive ____ Deceased Cause of Death: _____

Brothers: ____ Alive ____ Deceased Cause of Death: _____

Past Medical History/Review of Systems:

Do you have any problems with your Heart and/or Circulation?

□ Chest Pain/Angina □ Leg Cramps □ Angioplasty or Bypass □ Heart Attack □ Varicose Veins

□ High Blood Pressure □ Vein Stripping □ Stress Test □ Congestive Heart Failure □ Ulcers

□ Irregular Heart Beat Other: _____

Do you have any problems with your Eyes, Ears, Nose or Throat?

□ Wear Glasses □ Snoring □ Sleep Apnea □ Tonsils Removed □Speech Problems □ Nose Bleeds □ Glaucoma □Hearing Aides □ Retinopathy □ Difficulty Swallowing □ Sore Throat □ Blurred Vision □ Hearing Loss □ Ringing of Ears □Macular Degeneration Other: _____

Do you have any problems with your Lungs?

□ COPD □ Bronchitis □ Tuberculosis □ Asthma □ Fluid in Lungs? □ Emphysema □ Pneumonia □ Shortness of Breath Other: _____

Do you have problems with your Liver?

□ Cirrhosis □ Hepatitis □ Jaundice □ Gall Bladder □ Sickle Cell Other: _____

Do you have problems with your Stomach or Bowels?

□ Ulcers □ Colitis □ Polyps □ Reflux □ Hemorrhoids □Crohn's Disease □Difficulty Swallowing
□ Indigestion □ Blood in Stool □Hernia □ Diarrhea □ Irritable Bowel □ Constipation
Other: _____

Do you have Musculoskeletal problems?

□Ankle Pain □ Arch Pain □ Arthritis □Bunions □Fractures □Hammertoes □ Herniated Disc
□ Bursitis □ Low Back Pain □ Shoulder Pain □Knee Pain □ Hip Pain □ Paresis/Paralysis
□ Muscle Weakness Other: _____

Do you have problems with your Skin?

□ Rashes □ Dryness □ Scaliness □ Herpes □ Psoriasis □ Fungal Infection □ Bacterial Infection
□ Squamous Cell Carcinoma □ Basal Cell Carcinoma □ Shingles □ Acne □ Itching
Other: _____

Do you have any Neurological problems?

□ Numbness □ Tingling □ Alzheimer's □ Parkinson's Disease □ TIA □ Stroke □ Epilepsy
□ Blurred Vision □Weakness □ Burning □ Dementia □ Under the care of Psychologist/Psychiatrist
Other: _____

Do you have any General Medical Problems?

□ Diabetes If yes, when where you diagnosed? _____ Last Hemoglobin AIC result _____ □ High Blood Pressure □ High Cholesterol/Triglycerides □ Cushing's Disease □ Thyroid Disease
□ Adrenal Gland □ Gout □ Dementia □ Rheumatoid Arthritis □ Pituitary Gland
Other: _____

Do you have any problems with your Blood or History of Blood Infections?

□ HIV (AIDS) □ Hepatitis □ Nose Bleeds □ Anemia □ Hemophilia □ Thrombocytopenia
□ Leukopenia □ Sickle Cell or Trait Other: _____

Do you have any problems with your Immune System or Allergies?

□ Allergy Shots □ Autoimmune Disease Other: _____

Please list your Surgical History

□ Orthopedic □ Heart □ Vascular □ Appendix □ Joint Replacement □ Intestinal □ Gallbladder
□ Implants □Pregnancy □Hysterectomy/D&C □ Tonsils
□ Other _____

_____ _____

Print Name Signature

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HEALTH INFORMATION RELEASE AUTHORIZATION

Date: _____

I, _____ authorize the specified person(s) to disclose
(Print Name)
protected health information as follows:

Person(s) authorized to make disclosure:

_____
(Name of Health Care Provider, Hospital, Diagnostic Center, etc.)

_____
(Address)

_____ _____
(Telephone) (Fax)

Person(s) authorized to receive disclosed information:

_____
(Name of Health Care Provider, Hospital, Diagnostic Center, etc.)

_____
(Address)

_____ _____
(Telephone) (Fax)

_____ _____
(Signature) (Date of Birth)

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PATIENT INFORMATION

(Please Print)

Our physicians, along with the staff, would like to welcome you to this office. It is our priority to improve quality of life through treatment of foot and ankle conditions. We are committed to a relationship built on care, compassion, and trust. Please assist us in answering the following questions.

Today's Date: _____

First Name: _____ MI _____ Last Name: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip Code: _____

E-mail: _____

Home Phone: _____ Cell:_____ Work: _____

Date of Birth_____ SSN: _____

Sex: □ Male □ Female Marital Status: □S □M □D □W

Employer: _____ Occupation: _____

In case of an emergency, who should be notified?

Name: _____ Relationship: _____

Address/Telephone: _____

How did you hear about us? _____

Who can we thank for the referral? _____

PRIMARY INSURANCE INFORMATION:

Insurance Company: _____

Member ID: _____ Group No: _____

SECONDARY INSURANCE INFORMATION:

Insurance Company: _____

Member ID: _____ Group No: _____

Please provide the front desk with a copy of your insurance card(s) and a Photo ID

Is your condition related to employment (current or previous)? □ No □ Yes (Please Complete Next Section)

Is your condition related an auto accident? □ No □ Yes (Please Complete Next Section)

Other type of accident? □ No □ Yes (Please Complete Next Section) Please Describe: _____

_____

WORKERS COMPENSATION & AUTO ACCIDENT/ACCIDENT INFORMATION:

Carrier Information: _____

Date of Injury: _____ Case/Claim #: _____

Address: _____ City/State/Zip _____

Telephone: _____ Contact Name: _____

PRIMARY CARE DOCTOR

Name: _____ City/State _____

Telephone: _____ Reason for visit: _____

AUTHORIZATION FOR TREATMENT/FINANCIAL AGREEMENT/RELEASE OF INFORMATION

I, the undersigned, knowing the patient, minor, and or self, certify that the information above is true and correct to the best of my knowledge. I give permission to the physician and staff to administer and perform diagnostic and therapeutic procedures, including, but not limited to injections, as may be deemed necessary in the diagnosis and/or treatment of lower extremity. I understand that no guarantee has been made as to the result of the procedure/treatment. I authorize release of medical information to my doctor, health agency, insurance company, government agency, or worker's compensation. I request and authorize payment of insurance benefits and/or government benefits made on my behalf to be paid directly to Merritt Island Foot and Ankle, Inc. I assume full financial responsibility for all services rendered, even if I have insurance, and agree to pay if not paid or covered by my insurance within 90 days. It is my responsibility to obtain authorization from my Primary Care Physician or insurance company (if required) prior to services rendered.

_____ _____

Print Name Signature