NEW PATIENT FORM

** PLEASE COMPLETE ALL INFORMATION*

Date: ____________________ **Major Complaint:** ____

Have you seen a Podiatrist? __________ **Name of Podiatric Group:** ______________________________

DEMOGRAPHIC INFORMATION

NAME: First: ____________________________ **MI:** ________ **Last:** ______________________________

Date of Birth: _______________________________ **Gender**: ☐ Male ☐ Female ☐ Undifferentiated

Ethnicity: _________________________________ Preferred Language: ______________________________

Social Security #: _________________________________

Address: ____

City: __________________________________ State: _____________ Zip: _______________________

☐ Retired ☐ Student ☐ Employed Employer: ____

Home #: ______________________ Work #: ________________________ Cell #: _______________________

EMAIL Address: ____

How do you prefer to be contacted? ☐ E-mail ☐ Mail

Emergency Contact: ___________________ Emergency Phone #:_______________ Relationship: __________

INSURANCE INFORMATION

Primary Insurance: _________________________ Secondary Insurance: _______________________

Primary Card Holder: ______________________ Secondary Card Holder: ______________________

Card Holder DOB: _________________________ Card Holder DOB: ____________________________

Member #: _______________________________ Member #: _________________________________

Group #: __________________________________ Group #: _____________________________________

PRIMARY CARE INFORMATION

Primary Care Doctor (Who provides your health care): ____

Office #: __________________________________ Date of the last visit: ____________________________

MISCELLANEOUS

How did you hear about us? ☐ Friend ☐ Family ☐ Internet ☐ Referring MD ☐ Other: ______________

Primary Pharmacy: Name: _______________________________ Zip: __________ Phone: _______________

MEDICAL/SOCIAL HEALTH INFORMATION

- **Tobacco/Smoker: Current ________, Current Everyday ________,**
  Current Some Days ________, Former________, Never________
- **Alcohol: Y______ N______ # per day__________**

Please list illnesses of diseases of mother, father, and siblings:

Mother: Deceased/Alive:______________________________

Father: Deceased/Alive:______________________________

Brother/Sister: Deceased/Alive:______________________________

Please list details and dates of all operations and injures:______________________________

____

____

Please list all Allergies (include any drug allergies):______________________________

____

____

Please list all medications that you are currently taking:______________________________

____

____

Please circle any illness that may pertain to you:

MAJOR DISEASE
Diabetes
Hypertension
Angina
Heart Disease
Heart Attack
Murmur
Mitral Valve Prolapsed
Stroke
Chest Pain

HEENT
Headaches
Hearing Problems

GASTROENTESTINAL
Ulcers
Stomach Problems
Hiatal Hernia
Bowel Disorders
GI or Rectal Bleeding
Acid Reflux

VASCULAR
Anemia
Sickle Cell
Bleeding Disorders
Poor Circulation
Night Cramps
Leg Pain w/walking
Vein Problems
Spider Veins
Varicose Veins
Swelling Phlebitis
Leg Ulcerations
Blood Clots
Transfusions

PSYCHOLOGICAL
Anxiety
Depression
Psychiatric Conditions
Drug Dependency
Alcohol Dependency

RESPIRATORY
Asthma
Bronchitis
Frequent Colds
Lung Disease
Shortness of Breath
Tuberculosis
Emphysema

MISC
Epilepsy
Thyroid
Muscle Disease
Kidney Disease
Bladder Disease
Prostate Problems
Venereal Disease

SKIN CONDITIONS
____

CANCER HISTORY
____

ARTHRITIS

Osteoarthritis, Gout, Sero-negative, Reiter's Anklyosing, Spondylitis, Irritable Bowel Syndrome, Rheumatoid Arthritis

I hereby give permission to Dr. Jeremy M. Thomas and associates to administer treatment and perform such procedures as may be deemed necessary in the diagnosis and / or treatment of the extremity condition. I also, herby assign to the above named physician all benefits provided by my insurance company policy or policies for medical or surgical care.

______________________________ ____________________

Signature of Patient / Guardian Date

Triangle Foot and Ankle Specialist strive to render excellent medical care to you and to the rest of our patients.

OUR POLICIES ARE AS FOLLOWS

1. PAYMENTS: ***When verifying benefits, it is never a guarantee of payment per your insurance company's disclaimer. You are responsible for all co-pays, deductibles, co-insurance amounts and non-covered services. The Patient/Guardian is aware that their insurance company may not make payment on a claim and that it will be the Patient's/Guardian's responsibility to do so.***

- All Co-Pays are due at the time of today's appointment prior to seeing the doctor.
- Account balances must be paid in full at the time of today's appointment prior to seeing the doctor.
- Deductibles, Co-insurance and any additional charges will be collected at the time of check out. You are ultimately responsible for all payment of charges for services from our office.
- It is your responsibility to provide accurate insurance information and to present your insurance ID card at the time of your visit.
- If your plan requires a referral, it is your responsibility to obtain this prior to being seen.
- It is our desire to help you as much as possible with claims that are submitted to your insurance company, you will be responsible for the payment.
- Returned check fee is ***$25.00***
- We do not go back and submit claims to patient's insurance companies if at time of visit they had requested to be self-pay or if at the time of visit their insurance company states the service/product is non-covered.
- Your visits will be coded based on documentation from your provider during the visit, which may not be covered by your insurance carrier at 100%. Diagnosis codes will not be changed in an attempt to reduce out of pocket expenses.
- The Patient will be responsible for all Attorney Fees, Legal Fees, and Court Costs if the account is turned over to collections.
- If the Patient is a minor the Patient's Legal Guardian will be responsible for all Attorney Fees, Legal Fees, and Court Cost if the account is turned over to collections.

2. **CANCELLATIONS:**

- When an appointment is scheduled, that time has been set-aside for you and when it is missed, that time cannot be used to treat another patient.
- Cancellations for appointments and procedures must be received 24 hours prior to the scheduled appointment. You may leave a ***24 hour*** cancellation message on the answering machine
- ***Patients who fail to keep or cancel a scheduled appointment will be charged a $25.00 No-Show / No-Call Fee.*** (We make reminder calls as a courtesy, but it is your responsibility to keep track of your appointment).
- ***A $250.00 deposit is required at time of scheduling a surgery.*** Once your account has been paid in full and if you are due a refund, one will be issued to you upon request within 30 days.
- Patients who fail to keep or cancel a scheduled surgery less than ***30 days*** before the scheduled surgery will not be refunded the $250.00 surgery deposit, regardless of when the surgery was scheduled.
- Cancellations for scheduled surgery must be received at least ***72 hours*** prior to schedule surgery date and time.

3. **MEDICAL RECORDS:**

- Medical Records request must be received at least ***48 hours*** prior to the date needed.
- There is a non-refundable fee of ***$25.00*** for requested copies of medical records.
- There is an additional non-refundable fee of ***$25.00*** for requested copies of X-rays.

- Copies of medical records fees and copies of x-rays fees are set in accordance with the State of North Carolina.
- WE DO NOT FAX MEDICAL RECORDS TO PATIENTS OR FAMILY.
- Fees must be paid prior to mailing or pick up of medical records.

4. **REFUNDS: (Pertain to Insurances Only)**

- An insurance company has Ninety Days to process your claim. Even after Ninety Days the insurance company may still be processing your claim.
- Once we have received confirmation and payment from your insurance company and the remaining balance on your account is paid in full, upon request a refund check will be issued to you within ***30 days***.

5. **RETURNS:**

- We do not accept returns for any reason on custom orthotics, over the counter orthotic inserts or medical products that have been made specifically for you or dispensed to you by the doctor in the office.
- We do not accept diabetic shoes or diabetic inserts for any reason. (See Authorization for Payment and Warranty form if dispensed diabetic shoes)
- HIPAA and NC Health Regulations prohibit the re-sale of these products.

6. **SUMMARY / Statements:**

- Your summary will be ready for pick at the end of your office visit. due to the fact the doctor must first chart your visit, which will be after he sees his patients for the day.
- If there is no balance on your account, you will not receive a statement.

______________________________________ ______________________

Signature of Patient / Guardian Date

PATIENT BILL OF RIGHTS

1. The patient has the right to considerate and respectful care.
2. The patient has the right to obtain complete current information concerning diagnosis, treatment, and prognosis in terms the patient can reasonably understand. When it is not medically advisable to give such information should be made available to an appropriate person on their behalf. A patient has the right to know by name the physicians responsible for coordinating the patient's care.
3. The patient has the right to receive from their physician any information necessary to give informed consent prior to the start of any procedure and or treatment. Except in emergencies, such information for informed consent should include, but not necessarily be limited to, the specific procedure and or treatment, the medically significant risks involved, and the probable duration of incapacitation. Where medically significant alternatives for care or treatment exist, or when the patient request information concerning medical alternatives, the patient has the right to such information. The patient also has the right to know the name of the person responsible for the procedure and or treatment.
4. The patient has the right to refuse treatment to the extent permitted by law, and to be informed of the medical consequences of this action.
5. The patient has the right to expect all communications and records pertaining to their care to be treated as confidential.
6. The patient has the right to every consideration of privacy concerning his or her own medical care program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discretely. Those not directly involved in treatment must have the permission of the patient to be present.
7. The patient has the right to expect that within its capacity, an office must make a reasonable response to the request of services. Medical facilities must provide evaluation, service, and / or referral as indicated by the urgency of the case. When medically permissible, the patient may be transferred to another facility only after receiving complete information and explanation concerning the needs for an alternate transfer.
8. The patient has the right to obtain information as to the existence of any professional relationships among individuals, by name, which is treating them.
9. The patient has the right to expect reasonable continuity of care, as well as, the right to know in advance what appointment times and physicians are available.

____ ________________________

Signature of Patient / Guardian Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name and Address:
____
____
____

I have received a copy of the Notice of Privacy Practices.

____ _________________________
Signature of Patient / Guardian Date

PATIENT PRIVACY INFORMATION

When notifying you for any reason, may we (Please check all that apply)

_______ Leave message on home answering machine

_______ Leave message with spouse

_______ Call you on your cell

_______ Call you at your place of employment

_______ Other____

FOR OFFICE USE ONLY

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

_______ An emergency existed and a signature was not possible at the time.

_______ The individual refuses to sign.

_______ A copy was mailed with a request for a signature by return mail.

_______Unable to communicate with the patient for the following reason:_______________
____

_______Other____

Prepared by _________________________ Signature ____________________________ Date ________________