MODERN
Foot & Ankle Centers

MEDICAL RECORDS RELEASE FORM

By signing this form, I authorize Advanced Foot & Ankle Specialists of Arizona, to release confidential health information about me, to Modern Foot & Ankle Centers, PLLC.

Patient Name:_____

Address:_____

City, State, and Zip Code:_____ Phone:_____

Date of Birth:_____

Release my protected health information to the following facility below:

Modern Foot & Ankle Centers, PLLC

2680 S. Val Vista, BLDG 14, Suite 177, Gilbert, AZ 85295 (P)480-909-3700 (F)877-839-9972.

Please include all the following:

Progress notes Radiology Reports Operative Reports Physical therapy reports

Lab Reports (blood work, nail culture reports, and any culture & sensitivity)

Hospital Reports

The purpose/reason for this release of information is for the continuing of my care.

_____ _____

Signature (Patient or legal guardian) Date

_____

Printed Name (Patient or legal guardian)

PATIENT NAME: _____

DATE OF BIRTH: ____/____/_____

PERMISSION TO TREAT / RELEASE OF INFORMATION/PRIVACY PRACTICES

1. I HEREBY GIVE MY PERMISSION TO MODERN FOOT & ANKLE CENTERS, PLLC TO ADMINISTER TREATMENT AND TO PERFORM SUCH PROCEDURES AS MAY BE DEEMED NECESSARY IN THE DIAGNOSIS AND TREATMENT OF MY EXTREMITY CONDITION.
2. I HEREBY ASSIGN TO MODERN FOOT & ANKLE CENTERS, PLLC BENEFITS PROVIDED BY MY INSURANCE COMPANY POLICY/POLICIES FOR MEDICAL & SURGICAL CARE.
3. I HEREBY ACKNOWLEDGE RECEIPT OF NOTICE OF PRIVACY PRACTICES. I HAVE BEEN PROVIDED A COPY OF THE NOTICE OF PRIVACY PRACTICES (AVAILABLE ON WEBSITE & POSTED IN OFFICE) AND I HAVE READ (OR HAD THE OPPORTUNITY TO READ IF I SO CHOOSE) AND UNDERSTOOD THE NOTICE.
4. I AUTHORIZE MODERN FOOT & ANKLE CENTERS, PLLC TO CALL ME FOR APPOINTMENT REMINDERS/CHANGES, FOLLOW-UP OF TREATMENT OR ANY OUTSTANDING ISSUES WITH MY ACCOUNT.

_____ _____

PATIENT SIGNATURE (PARENT/GUARDIAN IF PATIENT IS A MINOR) DATE

_____

PRINT

DATE:___/___/____

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PATIENT INFORMATION FORM

PATIENT NAME:_____ DATE OF BIRTH:___/___/___ AGE:____ SEX: M F
LAST FIRST MI

HOME ADDRESS:_____ CITY/STATE:_____ ZIP: _____

MAY WE LEAVE A MESSAGE?

HOME PHONE #: (____) ___-_____ YES NO

WORK PHONE #: (____) ___-_____ YES NO

CELL PHONE #: (____) ___-_____ YES NO

E-MAIL: _____

PRIMARY LANGUAGE: _____

RACE: _____ ETHNICITY: _____

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO
IF YES, NAME:_____ RELATIONSHIP:_____ PHONE # ----------_____

EMERGENCY CONTACT:_____ RELATIONSHIP:_____ PHONE # ----------_____
PRIMARY CARE DOCTOR:_____ LAST VISIT:___/___/___ PHONE# ----------_____
PHARMACY:_____ LOCATION: _____ PHONE # ---------- _____

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?
_____YES NAME(S) _____
_____NO

WHO IS RESPONSIBLE FOR PAYMENT?_____ RELATIONSHIP TO PATIENT? _____

ADDRESS:_____ CITY/STATE:_____ ZIP:_____ PHONE #: (____) ___- WHO

REFERRED YOU TO US? _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____

ADDRESS:_____ CITY/STATE:_____ ZIP:_____ PHONE #: (____)___- INSURED

NAME:_____ DATE OF BIRTH_____ EMPLOYER_____

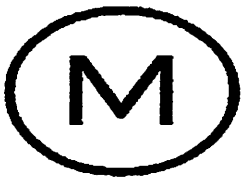
CONTRACT #_____ GROUP # _____

SECONDARY INSURANCE COMPANY NAME: _____

ADDRESS:_____ CITY/STATE:_____ ZIP:_____ PHONE #: (____)___- INSURED

NAME:_____ DATE OF BIRTH_____ EMPLOYER_____

CONTRACT #_____ GROUP # _____



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Your insurance policy is a contract that exists between you and your insurance company. Our relationship is with you, the patient, and not the insurance company. If you have questions about your policy, please call the phone number provided on the back of your insurance card. The patient or responsibly party is responsible for their bill being paid in full. Please inform us at every visit of any changes to your insurance coverage.

Please initial each line indicating your understanding of our policies:

___**COPAYMENTS:** It is a requirement of your insurance company that we collect your co-pay. Payment is required before meeting with the doctor. Acceptable payments that we take for copays are cash and all major credit cards. We do not except checks for copayments.

___**DEDUCTIBLES & CO-INSURANCE:** If you have a deductible plan, we will collect on the services rendered and to apply it towards your deductible and co-insurance. Any remaining balance after submission to your insurance company is your responsibility. Acceptable payments that we take for deductible and/or coinsurance are cash and all major credit cards. We do not except checks for deductibles and/or coinsurance

___**SELF-PAY:** Full payment is due at time of service. A down-payment will be required before seeing the doctor. **At a minimum, an evaluation and management fee will be charged.** Additional procedures/services may be recommended by the doctor but you will be informed of these charges before proceeding with treatment.

___**REFERRAL:** If your insurance plan requires a referral from your primary care doctor, this will be required at the time of your visit. Without a referral available, we may need to reschedule your appointment.

___**NO SHOW:** 24 hours notice is required for cancellation of your appointment and failure to do so will incur a **$30** fee. Failure to show up to an appointment with no notice, will result in a $50 fee. These will not be covered by your insurance company.

___**SURGERY CANCELLATION:** Failure to provide **3 business days** notice of cancellation prior to scheduled surgery date will incur a **$200** fee. Surgery will not be rescheduled until this is paid.

___**BALANCES/COLLECTION FEES:** Accounts due more than 60 days will be turned over to our collection agency. There will be an additional mark up of 35% to the balances. There will also be an additional $50 reinstatement fee to be seen in the office once the collections is paid off. We accept cash, checks, and all major credit cards.

___**FMLA/DISABILITY/MEDICAL RECORDS:** There is a **$25** charge for completion of these forms. Each additional set of documents will also require additional charges.

I have read and understand these financial policies.

Patient Name (print):_____

Patient/Responsible Party Signature:_____

Date:_____

PATIENT NAME: _____
DATE OF BIRTH: ___/___/____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME	DOSE	HOW OFTEN DO YOU TAKE?

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE
☐ CURRENT USE - TYPE_____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO?_____ ☐ SMOKE____PACKS/DAY FOR____YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO?_____TYPE _____
☐ CURRENT USE - TYPE_____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

EMPLOYER:_____ OCCUPATION: _____

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐10% ☐25% ☐50% ☐75% ☐100%

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? ☐ CHILDREN–AGE(S)_____ ☐ PET(S)–WHAT KIND? _____
☐ ELDERLY OR DISABLED FAMILY MEMBER ☐ OTHER _____

EXERCISE: ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY
TYPES OF EXERCISE:_____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES: TYPE 1 OR TYPE 2 ☐ CANCER ☐ HEART DISEASE
☐ HIGH BLOOD PRESSURE ☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE
☐ RHEUMATOID ARTHRITIS ☐ OTHER _____

PATIENT NAME: _____

DATE OF BIRTH: ___/___/____

YOUR MEDICAL HISTORY

ALLERGIES: ☐ MEDICATIONS _____

☐ ANESTHESIA _____ ☐ FOODS _____

☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER _____

☐ NONE KNOWN

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

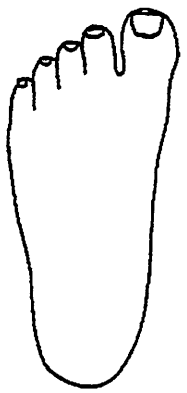
ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES: TYPE 1 OR TYPE 2 (CIRCLE)	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N
OTHER CONDITIONS:								

CURRENT PROBLEM

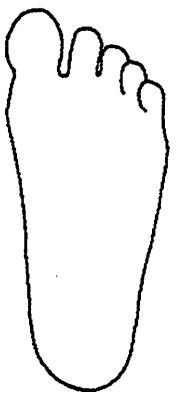
WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

LEFT FOOT



TOP OF FOOT

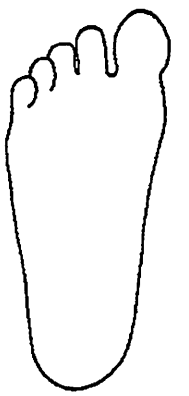


BOTTOM OF FOOT

INSIDE OF FOOT

OUTSIDE OF FOOT

RIGHT FOOT



BOTTOM OF FOOT

TOP OF FOOT

OUTSIDE OF FOOT

INSIDE OF FOOT

Revised July 2016

PATIENT NAME: _____
DATE OF BIRTH: ___/___/____

HOW LONG AGO DID THIS PROBLEM FIRST START?_____DAYS / WEEKS / MONTHS / YEARS DID YOUR PAIN OR PROBLEM: ☐ BEGIN ALL OF A SUDDEN ☐ GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? ☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING ☐ RADIATING ☐ ITCHING ☐ STABBING ☐ OTHER_____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)
(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 *(WORST PAIN POSSIBLE)*

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: ☐ STAYED THE SAME ☐ BECOME WORSE ☐ IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? ☐ WALKING ☐ STANDING ☐ DAILY ACTIVITIES ☐ RESTING ☐ DRESS SHOES ☐ HIGH HEELS ☐ FLAT SHOES ☐ ANY CLOSED TOE SHOE ☐ RUNNING ☐ OTHER _____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? _____

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? _____

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ YES (DESCRIBE) _____ ☐ NO

IF YES, WAS IT A WORK-RELATED INJURY? ☐ YES ☐ NO

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

_____ PRINT NAME OF PATIENT, PARENT OR GUARDIAN

_____ SIGNATURE OF DOCTOR

_____ IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

_____ DATE

_____ SIGNATURE

_____ DATE