FLORENCE FOOT CENTER

PATIENT INFORMATION

First Name_____ MI_____ Last Name_____ Sex ☐ M ☐ F

Date of Birth_____ Age_____ Social Security #_____

Email_____ Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Address_____ City/State_____ Zip_____

Name of Employer_____ City/State_____

Are you a resident of a nursing home or assisted living facility? ☐ Yes ☐ No

If Yes, which one? _____

CONTACT INFORMATION

Home Phone_____ Cell Phone_____

May we leave messages for you regarding your protected health information? ☐ Yes ☐ No

Please indicate who we may speak with regarding your protected health information:

_____

In case of emergency, please contact:

Name_____ Relationship_____ Phone_____

PLEASE GIVE ALL INSURANCE CARDS TO RECEPTIONIST

RELEASE OF INFORMATION, BENEFIT ASSIGNMENT, PAYMENT AUTHORIZATION, FULL DISCLOSURE AND AGREEMENT TO PAY FOR PROFESSIONAL SERVICES

I hereby authorize Florence Foot Center to release any information necessary to process any insurance claim acquired in the course of my examination or treatment to allow a photocopy of my signature to be used to process my insurance claim. I claim, direct, and authorize my carrier to issue payment check(s) directly to Florence Foot Center, for any insurance benefits to which I am entitled. I understand that failure to disclose precertification/second opinion requirements for any and all plans to which I subscribe may cause me to incur full liability for professional charges as a result of non-payment by my carrier. Regardless of insurance benefits, if any, I understand that I am fully responsible for any and all fees incurred, and I agree the above is a legal and lawful debt. If it becomes necessary to forward this account to collections, I agree to be responsible for any/all collection costs, attorney fees, and/or court costs. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other state. I realize that in extraordinary circumstances, some insurance companies will not pay for certain procedures (i.e., MRI's or Ultrasounds). I understand that my insurance is filed as a courtesy and I am responsible for the bill.

Patient/Responsible Party Signature_____ Date_____

Patient Name_____ DOB_____

Reason for today's visit _____

Family Doctor/PCP_____ Pharmacy_____

Have you ever been under the care of a pain clinic/pain contract? ☐ Yes ☐ No

If yes, when and where? _____

Do you smoke? ☐ Yes ☐ Never ☐ Former Tobacco User # of years_____ Packs Per Day_____

Do you drink alcoholic beverages? ☐ Yes ☐ No Drinks per week_____

MEDICATIONS/ALLERGIES

Please list all medications that you are currently taking (prescription and non-prescription)

OR ☐ MEDICATION LIST GIVEN TO RECEPTIONIST

Are you allergic to any medications? ☐ Yes ☐ No Latex? ☐ Yes ☐No

Please list any medications you are allergic to and the reaction _____

_____

HEALTH HISTORY/PRIOR SURGERIES

☐Alzheimer's	☐Anemia	☐Anxiety	☐Arthritis
☐Asthma	☐Back Problem	☐Blood Clots/DVT	☐Chemical Dependency
☐Cholesterol Problem	☐Dementia	☐Depression	☐Diabetes
☐Emphysema/COPD	☐GERD	☐Gout	☐Heart Disease
☐High Blood Pressure	☐HIV/AIDS	☐Hepatitis	☐Kidney Disease
☐Kidney Failure/Dialysis	☐Liver Disease	☐Lupus	☐Neuropathy
☐Psychiatric Care	☐Sickle Cell	☐Stomach Ulcers	☐Stroke
☐Swelling/Edema	☐Tuberculosis	☐Shortness of Breath	☐Thyroid Disease

☐Cancer/Type_____

Other conditions/illnesses not listed_____

_____

<u>Please list all prior SURGERIES:</u>

Patient Name_____ Today's Date_____

I hereby certify by my signature that the medical information given on this form is correct to the best of my knowledge.

Patient Signature_____ Date_____

CONSENT TO TREAT

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary. I also acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

X_____ Date_____

Signature of Patient, Parent, Guardian, or Personal Representative

_____

Please print name of Patient, Parent, Guardian, or Personal Representative/Relationship to patient

RELEASE OF INFORMATION, BENEFIT ASSIGNMENT, PAYMENT AUTHORIZATION, FULL DISCLOSURE. AND AGREEMENT TO PAY FOR PROFESSIONAL SERVICES

Please Give ALL Insurance Cards to Receptionist

I hereby authorize Florence Foot Center, to release any information necessary to process any insurance claim acquired in the course of my examination or treatment to allow a photocopy of my signature to be used to process my insurance claim. I claim, direct, and authorize my carrier to issue payment check(s) directly to Florence Foot Center, for any insurance benefits to which I am entitled. I understand that failure to disclose precertification/second opinion requirements for any and all plans to which I subscribe may cause me to incur full liability for professional charges as a result of non-payment by my carrier. Regardless of insurance benefits, if any, I understand that I am fully responsible for any and all fees incurred, and I agree the above is a legal and lawful debt. If it becomes necessary to forward this account to collections, I agree to be responsible for any/all collection costs, attorney fees, and/or court costs. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other state. I realize that in extraordinary circumstances, some insurance companies will not pay for certain procedures (i.e., MRI's or Ultrasounds). I understand that my insurance is filed as a courtesy and I am responsible for the bill.

X_____ Date_____

Signature of Patient, Parent, Guardian, or Responsible Party