Carolina Foot Centers

Consent Form

Lifetime Signature of File (for Medicare Patients):

I request that payment of authorized Medicare benefits be made on my behalf directly to this practice for any services furnished to me by the physician. I authorize the release of any medical or other information necessary for processing claims to the center for Medicare and Medicaid Services.

Initials: _____

Private Insurance Authorization for Assignment of Benefits/Information Release:

I authorize the payment of medical benefits to be made on my behalf directly to the practice for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I authorize the release of my insurance company information concerning health care, advice, or treatment provided to me necessary for processing insurance claims. I understand if my insurance requires a prior authorization for office visits or procedures, it is my responsibility to make sure the authorization is obtained prior to the visit or service. I understand that if I am seen without an authorization, I will be considered a self-pay patient and will be required to pay in full for all services.

Initials: _____

HIPAA Notice of Privacy Practices Acknowledgment:

I have received, read, and understand your notice of privacy practices. I understand that this information will be used to carry out treatment, payment, and normal healthcare operations of the practice. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my request restrictions, but if you do agree you are bound to abide by such restrictions.

Initials: _____

Diagnostic Services:

Our physician may use the latest diagnostic technologies (such as x-ray & ultrasound) to effectively diagnose and treat problems of the foot. I understand I may undergo diagnostic testing for a complete podiatric evaluation.

Initials: _____

Authorization to Release and/or Obtain Medical Records:

I hereby authorize all physicians participating in my health care, and Carolina Foot Centers, the release, use, and disclosure of my entire medical record by mail, phone, and fax to carry out my treatment, payment, and healthcare operations.

Initials: _____

Minor Patient:_

I understand that patients under the age of 18 must be accompanied by a parent or guardian. The parent who consents for treatment will be the responsible party on the account and is responsible for all charges regardless of divorce or separation degree. We request patients aged 18 or older covered under their parent's insurance to sign an authorization allowing Carolina Foot Centers to contact parents regarding insurance and bills.

Initials: _____

I understand that the authorization for release of information can only be revoked upon written notice. By signing below, I acknowledge that this form has been read in full and explained, as necessary.

Patient/PartySignature:_____Date_____

Carolina Foot Centers

Demographics

Date: _____ First Name: _____Last Name: _____
Preferred Name: _____ Date of Birth: _____ Age: _____
SSN (For insurance purposes): _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Email Address: _____
Place of Employment: _____
Employment Address: _____ Work Phone: _____
Responsible Party (If a Minor): _____
Marriage Status: _____ Spouse Name/Phone Number: _____
Primary Physician: _____
Referred By: _____ How did you hear of us? _____
In Case of Emergency - Name: _____Relationship: _____
Phone Number: _____

Thank you for completing the above form. Please read the statements below, sign your name, and date.
We appreciate you choosing us to provide your medical care!

Certification: I do hereby state the information provided above is correct to the best of my knowledge.

Payment Guarantee: I hereby agree to pay the established rates of this office for all services rendered to me or my dependent while I am/they are under the care of Carolina Foot Centers. In the event my account is turned over to a collection agency, I will be billed the additional collection fees.

Assignment of Benefits and Authorization to Release Information: I do hereby authorize Carolina Foot Centers to permit any insurer providing me or my dependent under their care to inspect the medical record in connection with any charges arising from my treatment in this office. Further, I authorize any such insurer to pay directly to Carolina Foot Centers any payment for charges arising from services to me.

Witness Signature:_____ Date:_____

Patient/PartySignature:_____Date_____

Carolina Foot Centers

Medical History

Patient Name: _____ Birthdate: _____
Pharmacy Name: _____ Pharmacy Phone Number: _____
Pharmacy Address: _____

Past Medical & Family History: Please check, if yourself or any blood family had any of the following conditions

Condition	Self	Family (who)	Condition	Self	Family (who)
Headaches			Epilepsy/Neurological		
Heart/Vascular			Arthritis		
Stroke			Diabetes		
Rheumatic			Anemia/Blood Disorders		
High Blood Pressure			Blood Transfusion		
High Cholesterol			DVT/Embolism		
Asthma/Lung Condition			Skin Disease		
Jaundice/Liver Condition			Thyroid Disease		
Reflux/Ulcer			Cancer (type)		
Gout			Uterine/Ovarian		
Bowel Disease			Osteoporosis		
Kidney Disease			AIDS/Hepatitis STDs		
Pregnant/ Breastfeeding			Problems with Anesthesia		
Other			Other		

Vaccines: Chicken Pox : Y or N | Childhood Vaccines: Y or N | HPV: Y or N | Hep B: Y or N
Last Tetanus: _____

Past Surgical History - Please give the year of the procedure:

_____

_____

Social History:

Smoking:_____cigs/day for:_____years | Alcohol:_____ oz/week | Caffeine:_____cups/day
Smoking:_____ E-Cigs/Day | Smoking Cannabis:_____ | Street Drugs:_____

Allergies & Reactions:

_____

_____

Medications (you may also write on the back or attach your list):

_____

_____

Nature of Foot Complaint/Foot Problem - Location, Duration, & Onset:

_____

_____

Review of Systems

Patient/PartySignature:_____Date_____

Carolina Foot Centers

Name:_____ Date:_____ Office Use Chart: _____

Please circle Yes (Y) or No (N) for any current symptoms/issue

General:

Fever Y or N
Night Sweats Y or N
Weight Gain Y or N
Weight Loss Y or N
Change in Appetite Y or N
Other:_____

Cardiovascular:

Chest Pain at Rest Y or N
Chest Pain with Activity Y or N
Chest Palpitations Y or N
Hypertension Y or N
Other: _____

Respiratory:

Shortness of Breath at Rest Y or N
Shortness of Breath with Activity Y or N
Cough Y or N
Wheezing Y or N
Blood in Sputum Y or N
Other: _____

Musculoskeletal:

Pain in Arms, Legs, or back Y or N
Decrease Range of Motion Y or N
Arthritis Y or N
Joint Swelling Y or N
Muscle Weakness Y or N

Skin:

History of MRSA (Infection) Y or N
Rash Y or N
Itching Y or N
Wounds Y or N
Excessive dryness Y or N
Hair Loss Y or N
Nail Changes Y or N
Other: _____

Neurological/Psychiatric:

Dizziness Y or N
Seizures Y or N
History of Fainting Y or N
Difficulty with Memory or Speech Y or N
Anxiety Y or N
Depression Y or N
Other: _____

Allergic/Lymphatic/Endocrine:

Bruise/Bleed Easy Y or N
Previous Blood Transfusion Y or N
Lymph Node Enlargement Y or N
Heat Intolerance Y or N
Cold Intolerance Y or N
Frequent Urination Y or N
History of Allergic Response Y or N
(Insect bites, food, animals, etc.)
_____
Other: _____

Patient/PartySignature:_____Date_____

Carolina Foot Centers

Cancellation Policy / No Show Policy for Doctor Appointments and Surgery

Cancellation/No Show policy for Doctor Appointments:

We understand that there are times when you must miss an appointment due to emergencies or obligation for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. **If an appointment is not cancelled at least 24 hours in advance you will be charged a no-show fee of $25.**

Schedule Appointments:

We understand that delays can happen however, we must try to keep the other patients and doctors on time. If a patient is 15 minutes past their scheduled time, we will have to reschedule the appointment.

Account Balances:

We will require that patients with self-pay balances to pay their account balances down to zero (0) prior to receiving further services by our practice. Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns. Patients with balances over $100 must make payment arrangements prior to future appointments being made.

FMLA/Release of Medical Records for Personal Use:

If you want a copy of your medical records for any reason, there will be a flat rate charge of $25.00 with an additional 0.65 cents per page for the first 30 pages of the medical record. For any pages after the initial 30 there will be a 0.50 cent charge. These are the state/HIPAA guidelines for printing out medical release forms for personal use.

Witness Signature:_____ Date:_____

Patient/PartySignature:_____Date_____

Carolina Foot Centers

Notice of Privacy Practices

- This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This Notice of Privacy Practices describes how we may use and disclose your protected health information to conduct treatments, payments, and health care operations and for other purposes that are permitted or required by law. It also describes our rights to access and control your protected health information.

- We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notices at any time. Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice. We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you.

- Others involved in your healthcare: Unless you previously authorize, we will not disclose any of your confidential information to any member of your family, any close friend, or any other person requesting your information. The following are situations that are permitted and required uses and discloses that may be made without your authorization or opportunity to object: required by law, public health, communicable diseases, health oversight, abuse or neglect, food and drug administration, legal proceedings, law enforcement, coroners, funeral directors, and organ donation, research, criminal activity, military activity, and national security, worker's compensation, inmates, required uses and disclosures.

- You have the right to inspect and request a copy of your protected health information. Depending on the circumstances, a decision to deny this access may be reviewed.

- You have the right to request restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment, or health care operations. You may also request that any part of your protected health information not be disclosed to any family member or friend who may be involved in your care or for the notification purposes described in this Notice of Privacy Practices. Your request must state the specific restriction request and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. Please discuss any restriction you wish to request with your physician.

- **Complaints:** You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact, the office manager, of your complaint. We will not retaliate against you for filing a complaint.

Patient/PartySignature:_____Date_____