Central Carolina Foot & Ankle Associates

A division of InStride Foot & Ankle Specialists

Chart No: _______________
(staff use only)

Patient Registration Form

Date: __________________

Patient Demographics

First Name: _________________________ M.I.: _____ Last Name: _________________________ Preferred Name: ___________________

Address: ____ Apt/Unit #:_______ City: ___________________ State: _____ Zip: __________

Email address: ____ SSN: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Date of birth (MM/DD/YYYY): __ __/__ __/__ __ __ __ Pref. Language: ☐English ☐Spanish ☐ Other: _____________

Phone: (______) _____________ ☐Home ☐Cell Secondary Phone: (______) _____________ ☐Home ☐Cell ☐Other: ___________

Reminder preference: ☐ Email ☐ Text ☐ Phone Call

Gender: ☐Male ☐Female Race: ☐White/Caucasian ☐ Black/African American ☐ Hispanic ☐Asian ☐Other:__________

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Primary Care Provider: ____ Phone: (______) _____________

Approximate date of last visit:____________ Information to be released: ☐ Any ☐ As follows:___________________ ☐**NONE**

Who is responsible for patient's bills, if not the patient? ☐ Patient is responsible ☐ Other person(list below):

Name: _________________________________ Phone: (______) _____________ Relationship to patient: ____________________

Authorization for Release of Information to Family and/or Friends (*Optional* Section)

I hereby authorize CCFA to discuss my medical care and release my confidential protected health information (PHI) to:

☐ Emergency Contact: ____ Phone: (______) _____________
Relationship to patient: ___________________ Information to be released: ☐ Any ☐ As follows:____________________

☐ Other: ____ Phone: (______) _____________
Relationship to patient: ___________________ Information to be released: ☐ Any ☐ As follows:____________________

Rights of the patient:

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect a copy of the protected health information to be disclosed as described in this document by sending written notification to **Central Carolina Foot & Ankle Associates, Medical Records, Attn: Security Officer; 4119 Capitol Street; Durham, NC 27704**. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward from the date on the revocation.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization.

This authorization shall be in force and effect until revoked by the patient or representative signing the authorization on behalf of the patient.

____ ________________

Patient Signature, or Parent or Authorized Representative Signature Date
(Representative must provide proof of authority over patient)

I acknowledge that I was offered, or provided, a copy of the Notice of Privacy Practice and that I have read (or had the opportunity to read if I so chose) and understand this Notice. (located in brochure holder at check-in area)

____ ________________

Patient Signature, or Parent or Authorized Representative Signature Date

CENTRAL CAROLINA FOOT & ANKLE ASSOCIATES

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Chart No: ______________ (staff use only)

Patient Name: __________________________ Height: ________ Weight: ________ Shoe Size: _______

Reason for Visit

Chief foot complaint: ____How long have you had this problem? _____________

Is the problem injury related? ☐ Yes ☐ No If yes, date of injury: _________ Was the injury at work? ☐ Yes ☐ No

Pharmacy: _____________________________________ **City/Street:** _________________________

Allergies Please check any drug/medication allergies you may have: or ☐ No known drug allergies

☐ Aspirin ☐ Codeine ☐ Latex ☐ Lidocaine ☐ Penicillin ☐ Sulfa ☐ Other: _____________

Medications

List all current medications (if you have a list, we can copy it): or ☐ No current medications ☐ See attached list

Drug Name	Strength (mg)	Frequency (how often?)	Prescribed by:

Medical History Please check box on any of your current/past conditions: or ☐ None of the following apply

☐ Alzheimer's
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Cancer (type:____________)
☐ Blood Clots
☐ Diabetes ☐ I ☐ II
- Last A1C:__________
- Result:____________
☐ GI problems:______
☐ Gout
☐ Heart disease
☐ Hypertension
☐ HIV
☐ Liver disease
☐ Hepatitis ___
☐ Osteoporosis
☐ Osteopenia
☐ Periph. Vasc. Disease(PVD)
☐ Renal (kidney) disease
☐ Stroke
☐ Thyroid disease
☐ Tuberculosis
☐ Other:___

Surgical History Please check all that apply or ☐ None of the following apply

☐ Angio ☐ Stent placement ☐ Back surgery ☐ Bunion ☐ ORIF ☐ Hammertoe ☐ Hip replacement
☐ Knee replacement ☐ Pacemaker ☐ Other: _________________________________

Social History

Tobacco: ☐ Current smoker - Type: ☐ Cigarettes (packs per day:_____) ☐ Cigar ☐ E-Cigarette ☐ Chewing tobacco
☐ Former Smoker - Age stopped: ______ ☐ Never smoker

Alcohol: ☐ Never ☐ Drinks alcohol ☐ Former

Family Medical History Which of your family members (Father, Mother, Brother, Sister) have/had the following:

Alcoholism	Father	Mother	Brother	Sister	Heart Disease	F M B S	Peripheral Vascular Disease	F M B S
Diabetes	F	M	B	S	Hypertension	F M B S	Renal (kidney) disease	F M B S
Gout	F	M	B	S	Osteoarthritis	F M B S	Stroke	F M B S
Cancer	F	M	B	S	Osteoporosis	F M B S	☐ Other: ______________	F M B S
Type?	______	______	______	______			☐ No relevant family history	

Review of Systems: Please mark any current symptoms you are experiencing: or ☐ None of the following apply

☐ Fatigue
☐ Fever/Chills
☐ Night Sweats
☐ Recent weight loss
☐ Recent weight gain
☐ Vision impairment
☐ Vision loss
☐ Blurry vision
☐ Hearing loss
☐ Ringing in ears
☐ Chest pain
☐ Palpitations
☐ Leg pain with exercise
☐ Varicose Veins
☐ Cough
☐ Shortness of breath
☐ Difficulty swallowing
☐ Heartburn
☐ Nausea
☐ Vomiting
☐ Abdominal pain
☐ Diarrhea
☐ Constipation
☐ Frequent urination
☐ Urinary incontinence
☐ Heat/cold intolerant
☐ Excessive sweating
☐ Loss of body hair
☐ Easy bleeding
☐ Easy bruising
☐ Dry skin
☐ Itchy skin
☐ Rash
☐ Loss of muscle strength
☐ Muscle weakness
☐ Joint pain
☐ Back pain
☐ Joint stiffness
☐ Muscle aches
☐ Headaches
☐ Memory loss
☐ Numbness/tingling
☐ Anxiety
☐ Depression

Have you had your flu shot this year?
☐ Y ☐ N

Have you had your dilated eye exam ?
☐ Y ☐ N

______________________________________ ___________
Signature of Patient or Person Completing Medical History Date

______________________________________ ___________
Signature of Physician Reviewing Medical History Date

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Chart No: ______________
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Financial Policy

- For patients with Insurance:
  - I have provided correct insurance information and understand I will be **responsible for payment at time of service** if I fail to disclose correct information to Central Carolina Foot & Ankle Associates (CCFA).
  - I authorize CCFA to file a computerized claim form (paper or electronic) on my behalf.
  - I authorize benefits to be paid to me or on my behalf to the provider for the covered services. I authorize the release of any medical information to my carrier or its agents needed to determine benefits. I authorize CCFA to pursue a formal appeal or grievance on my behalf for any denied claim that they feel should not have been denied. If my insurance fails to respond to the claim within **60 days**, CCFA reserves the right to collect full payment from me.
  - I also agree to be responsible for any **co-payments, co-insurance, unmet deductibles, and non-covered services or supplies and understand that payment is due at the time of service**. Re-billing and collecting fees may apply for past due accounts.

    Note: We recognize it is difficult to understand many of the points in today's insurance policies, with new plans and companies emerging constantly. Our office staff will make every attempt to follow the guidelines required by your insurance company. However, please understand that the contract is made between the insurance company and the patient. Therefore it is **your responsibility** to know and understand the details of your specific coverage.

- For patients with Medicare
  - Medicare will only pay for services that they determine to be "reasonable and necessary" under Section 1862(a)(1) of the Medicare law. The following services are ones we know are not covered by Medicare:
    - Routine Foot Care (debridement, cutting, or trimming of corns, toenails, or calloused tissues)
    - Post-operative Surgical Shoes
    - Wound care supplies
    - Vitamin B-12 injections
    - Prescription Foot Orthotics
    - Laser treatments
    - Routine Pre-operative blood work/lab handling fees
    - Treatment of warts or benign lesions
    - Night Splints/podous boots)

- For patients with Medicare and that have changed to an HMO Insurance Policy (Medicare replacement plan):
  - I understand that if CCFA does not participate with my HMO plan, I may be responsible for **payment in full** if there are no out-of-network benefits.

- For patients without insurance, or on a plan that CCFA does not participate with:
  - I understand that CCFA's financial policy requires payment **in full at time of service**.

- Late Cancellation or No Show Fees:
  - There will be a fee (according to the length of the appointment) for any appointment cancelled with less than 24 hours' notice or any appointment missed without prior communication to CCFA.
    - Less than 30 min: $35
    - 30 minutes: $50
    - 1 hour/orthotic casting: $75
  - There is a **cancellation fee** of $100 for surgeries cancelled with less than 1 full week's notice of the surgery date.

- Payments
  - CCFA accepts American Express, Discover, MasterCard, Visa, Honor Debits, personal check, money order and cash. CCFA also participates with the CareCredit 6-month, no interest plan.
  - I understand that a $25 fee will be applied to my account for returned checks.
  - If I am unable to pay my balance in full when due, I understand I need to contact CCFA's **billing supervisor immediately at 919-421-3701.** A re-billing fee of $5.00 will be charged monthly to any balance over 30 days past due. I understand that failure to make payment on my account as required every 30 days will require further action to collect the balance in full and my credit rating will be affected. I understand that if regular monthly payments are not received, and no payment arrangements are made, CCFA will no longer be able to extend credit to you for future visits and that an additional collection agency fee will also be added to the outstanding balance at the time of transfer to collections.

I have read the above financial policy in full and agree to comply with all of the listed policies.

____ ______________

Signature of Patient or Authorized Representative — Date