

COMPREHENSIVE FOOT & ANKLE SURGERY

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COMPREHENSIVE FOOT & ANKLE SURGERY, PLLC

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JUPITER, FL 33458

(561) 799-9581

F (561) 799-0062

Patient Name _____ Date of Birth _____

Florida Address _____ City _____ State ____ Zip _____

Out of State Address _____ City _____ State ____ Zip _____

Primary Phone # _____ Secondary Phone# _____

Marital Status _____ Social Security Number _____ Male _____ Female _____

Employer name/ phone number _____

Spouse's name _____ **Your E-mail Address**

Family Doctor name and phone number _____

Pharmacy name and phone number _____

How did you hear about our office? _____

I give permission to Comprehensive Foot & Ankle Surgery to release any information requested by my insurance company. I also give permission for Dr Pan Perkins/Dr Zaidi to perform general procedures in the diagnosis and/or treatment of my foot condition. I authorize payment of medical benefits to Comprehensive Foot & Ankle Surgery for service provided.

PATIENT SIGNATURE

DATE

What is the chief complaint for which you came to be treated? (Include foot, ankle and leg) _____

When did it start? _____

What treatment have you tried before?

Other _____

ALLERGIES

___ Adhesive Tape
___ Aspirin
___ Codeine
___ Demerol
___ Iodine
___ Local Anesthetics
___ Novocaine
___ Penicillin Other _____

MEDICAL HISTORY

___ Diabetic
___ Circulatory Problems
___ Epilepsy/Seizures
___ Stroke
___ High Blood Pressure
___ Low Blood Pressure
___ Stomach Ulcers
___ Heart Disease
___ Phlebitis
___ Respiratory Disease
___ Artificial Heart Valve/Joints
___ Blood Clot/DVT
___ Bleeding Disorders
___ Cancer/Type
___ Liver Disease
___ Aids/ HIV
___ High Cholesterol
___ Anemia
___ Arthritis
___ Gout
___ Hepatitis
___ Depression
___ Varicose Veins
___ Hypothyroidism
___ Glaucoma
___ Anxiety

Have you seen a Podiatrist before? Please indicate any family history of foot or ankle problems:
If yes, Name _____

Last Visit _____

Previous foot problems :

Ankle Pain _____
Athletes Foot _____
Bunions _____
Corns and Calluses _____
Numbness Foot/leg _____
Flat Foot _____
Foot/Leg Cramps _____
Heel Pain _____
Ingrown Toenails _____
Plantar Warts _____

Swelling Ankles/Feet _____
Tired Feet _____

MEDICATIONS

Please list all medications with dosage and strength

SURGICAL HISTORY

Please list any surgeries you have had

SOCIAL HISTORY

Do you smoke _____ Amount _____ per day/ week

Do you drink alcohol _____ Amount _____ per week

SHOE SIZE _____ WIDTH _____

____Kidney Problems ____Other_____

HEIGHT _____WEIGHT_____

Release of Medical Records and Information

This office is HIPAA compliant. We make every effort to protect your privacy. We feel it is important that you understand your patient rights to confidentiality. If you have any concern, please feel free to discuss them with our office manager. I consent to receive automatic appointment text and voice messages from Comprehensive Foot & Ankle Surgery, PLLC.

Medical Records Information Release

I understand by signing this document I am authorizing the release of my medical information to my insurance carrier(s) needed for this or any related medical insurance claim. I authorize any holder of medical information or other information about me to release to the social security administration and the health care financial administration, its intermediaries, carriers and information needed for this or any related claim.

_____ INITIALS

Medical Record Release to Hospitals/Physicians

I, the undersigned, authorize the release of my medical information to other physicians needed to provide my care. I further authorize release to hospitals and/or healthcare facilities as pertaining to my care. I understand that my records may be faxed to hospitals and/or physicians and that all reasonable efforts will be made to maintain confidentiality. I authorize Comprehensive Foot & Ankle to receive all medical records from other physicians and or hospitals.

_____ INITIALS

Medical Records Release to Family

I authorize Dr. Pan Perkins to release information pertaining to my illness and or treatment to_____. I authorize Dr. Pan Perkins/Dr. Sara Zaidi to leave medical information on my answering machine. I also authorize information to be given to my spouse.

_____ INITIALS

Patient Rights to Confidentiality

I understand that Comprehensive Foot & Ankle Surgery office complies with HIPAA regulations. All medical records are confidential and cannot be disclosed without the written consent of the person to whom they pertain. I further understand that under Florida law I have the right to my medical records. I further understand that I may request that my records be released to a physician and/or medical facility; however, this request must be in writing. I understand that by law this office may only release medical records that were generated by Comprehensive Foot & Ankle Surgery. We cannot release medical records from other physicians, hospital or facility. I agree to accept responsibility for a copying fee as provided by Florida statutes. I understand that employees have no responsibility or liability regarding any aspect of this authorization. Furthermore, I have the right to complain to the practice or the State of HHS if I feel that my privacy rights have been violated. It is the policy of this office that no retaliation of any type will be taken against any patient that files a complaint.

PATIENT NAME _____ SIGNATURE _____

Financial Policy

Payment of Benefits to the Physician/Provider

I, the undersigned, understand that Dr. Pan Perkins/Dr. Sara Zaidi has agreed to accept Medicare and/or Health Insurance for payment of my medical bills. By my signature below, I acknowledge and understand that I am fully responsible for any yearly deductible and/or coinsurance balance after Medicare or my health insurance payment which is paid to Dr Perkins/Zaidi. I understand that I am financially responsible for any charges that are not covered by my insurance plan. If I fail to give updated or current information and the claim is denied, I will be totally responsible for the entire balance.

SIGNATURE _____ DATE _____

Method of Payment

Payment is required at the time of service is rendered. Please present your insurance card(s) to our office staff for photocopying and benefit eligibility verification. You will be responsible for any copay or coinsurance amount at the time of your visit.

In the event your check is returned for any reason, your account will be charged \$25. In the event it is necessary for your account to be placed with an outside collection agency or attorney, you will be assessed an additional \$20.00 or 30% of the balance to recover the collection charges. We file your medical insurance as a courtesy. If your claim is not paid within 90 days, the claim will be transferred to patient responsibility. If timely payment is not received, the account may be referred to a collection agency or attorney.

For your convenience, we accept MasterCard, Visa, American Express and Discover, as well as cash and checks.

Thank you for taking the time to review our financial policy. Your cooperation is greatly appreciated. If you should have any questions, or require any assistance, we will be pleased to be of service.

I have read this financial policy and understand my rights and responsibilities.

Medical Records

One copy of your medical records will be provided upon request at no charge. A pre-paid charge is required for **any additional** copies. There will be a charge of \$1.00 per page. Please allow 10 days for copying all medical records. There is an Xray copy charge of \$5.00.

SIGNATURE _____ DATE _____