David B. Moats, DPM
Luis J. Sanchez, DPM
John G. Durham, DPM
Paul C. Durney, DPM
E. Corry Maguire, DPM
Douglas M. Childs, DPM
Todd C. Talbert, DPM
Christopher L. Reeves, DPM
Anthony D. Saranita, DPM
Amber M. Shane, DPM
Andres M. Perez, DPM
Robert J. Estrada, DPM
Paul B. Thurston, DPM
Joseph A. Conte, DPM
Jasmine N. Raymond, DPM
Fraaz M. Sayeed, DPM

Soothing, effective treatments for:

- Foot & ankle injuries
- Foot disorder correction
- Diabetic ulcer & wound care
- Bunion & hammertoe outpatient correction
- Children's foot disorders
- Reconstructive & traumatologic surgery of the foot & ankle
- Heel & arch pain
- Corns & calluses
- Warts
- Fungus nails
- Ingrown nails

Convenient & affordable:

- Appointments worked around your schedule
- Extremity MRI, X-rays, Doppler studies, Diagnostic Ultrasound, Nerve Conduction Velocity Studies, On-site lab
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Administrative Office:
3165 McCrory Place, Suite 174
Orlando, FL 32803
407.423.1234
Fax: 407.517.1040
www.OrlandoFoot.com

Dear New Patient: WELCOME!

Thank you for the opportunity of adding you to the growing family of satisfied patients of Orlando Foot & Ankle Clinic. Our goal is to provide you with the best medical care available in a relaxed warm atmosphere.

The information you gave us at the onset of your appointment was the first step to assist us in better serving you as our valued patient. We feel that mailing you the attached paperwork prior to your appointment will save valuable time that can be better spent with the physician. Please complete the enclosed paperwork prior to your appointment and bring it with you along with your insurance ID card, a picture ID card and any other information as may be required in your insurance handbook.

Please arrive 20 minutes before your scheduled appointment time. If you cannot keep your appointment as scheduled, we expect our patients to grant us the courtesy of notifying us within 24-hours in order to give that time to another patient.

If you are being seen for a second opinion, or have seen another doctor for foot problems or past surgery, please bring your past medical records, x-rays, MRIs or any other diagnostic reports with you. This will assist the doctor in providing you with the best care and address your foot problems during your first visit so you can get on the road to recovery.

If your insurance requires an authorization, it will be your responsibility to furnish that at the time of your visit. As a courtesy to our patients, we will verify your insurance benefits prior to your appointment. Payment for insurance copays, deductibles or coinsurance amounts as well as non-covered services by your insurance company are due at the time the services are rendered. For your convenience we accept personal checks, money orders, Visa/MasterCard, Discover and American Express.

Please do not hesitate to call our office if you have any questions. We look forward to treating you.

Sincerely,

Doctors' & Staff
Orlando Foot & Ankle Clinic

ORLANDO FOOT & ANKLE CLINIC

Personalized foot pain solutions for active adults

Welcome to our office! This information is important for our records and your health.

Name: ______________________, ______________________ **Age:** ______ **Male Female** **Date:** ______________
(last) (first) (circle) **DOB:** ______________

CURRENT COMPLAINT

1. What is your primary complaint? ______________________
2. Are you diabetic? ☐ Yes ☐ No
3. Where is your pain or problem located?
   ☐ Right Side ☐ Left Side ☐ Big Toe ☐ Lesser Toes
   ☐ Ball of the foot ☐ Top of the foot ☐ Arch ☐ Heel
   ☐ Ankle ☐ Leg ☐ Toenail ☐ Corns
   ☐ Skin between the toes ☐ Calluses ☐ Bunion ☐ Skin
4. How would you describe the type of pain or problem?
   ☐ Sharp ☐ Radiating ☐ Dull ☐ Stabbing
   ☐ Aching ☐ Itching ☐ Burning ☐ Bruised
   ☐ Cramping ☐ Tender ☐ Throbbing ☐ Tingling
   ☐ Shooting ☐ Other
5. What is the level of the severity of the pain?
   ☐ No Pain ☐ Minimal Pain ☐ Moderate Pain ☐ Severe
6. When did the problem start?
   ☐ Today ☐ _____ Days ago ☐ _____ Weeks ago
   ☐ _____ Months ago ☐ _____ Years ago
7. Did this problem start suddenly or gradually?
   ☐ Suddenly ☐ Gradually
8. Do you have swelling with this problem? ☐ Yes ☐ No
9. Do you have redness or inflammation with this problem?
   ☐ Yes ☐ No
10. What makes it better?
    ☐ Ice ☐ Tylenol ☐ Ibuprofen ☐ Rest
    ☐ Elevation ☐ Staying off the foot ☐ Sandals
    ☐ Barefoot ☐ Other ______________
11. What makes it worse?
    ☐ Standing ☐ Walking ☐ Running ☐ Exercise
    ☐ Daily Activities ☐ Work ☐ Shoe ☐ Other ______________
12. What time of the day is it worse?
    ☐ All the time ☐ In the evening ☐ In the morning
    ☐ While trying to sleep
    Have you had previous treatment for this problem? ☐ Yes ☐ No
    If yes, what treatments have you had? Please also list the doctor's name: ______________________
13. Is this problem related to an injury? ☐ Yes ☐ No
    Work related injury? ☐ Yes ☐ No
    If yes, what was the exact date of injury? ______________
    Please describe what caused the injury: ______________

DR. USE ONLY Initials ______

PAST MEDICAL HISTORY

ILLNESS
☐ Alcoholism ☐ Hepatitis C ☐ Lyme Disease
☐ Cancer ☐ HIV / AIDS ☐ Lymphoma
☐ Diabetes ☐ Hyperthyroidism ☐ Malignant Hyperthermia
☐ Elevated Cholesterol ☐ Hypo (low) thyroid
☐ Hepatitis B ☐ Liver Disease/Cirrhosis ☐ Rheumatic Fever

CARDIAC
☐ Angina ☐ Coronary Artery Disease ☐ High Blood Pressure
☐ Arrhythmia ☐ Fainting/Syncope ☐ Low Blood Pressure
☐ Atrial Fibrillation ☐ Heart Disease ☐ Mitral Valve Prolapse
☐ Cardiac Arrest (heart attack) ☐ Heart Murmur ☐ Myocardial Infarction
☐ Heart Valve Replacement ☐ Pacemaker/ Defibrillator
☐ Congenital Heart Disease
☐ Congestive Heart Failure

VASCULAR
☐ Blood Clots ☐ Leg Ulcers ☐ Raynaud's
☐ Cellulitis ☐ Lymphedema ☐ Spider Veins
☐ DVT (deep vein thrombosis) ☐ Peripheral Artery Disease ☐ Varicose Veins
☐ Phlebitis ☐ Vasculitis
☐ Greenfield Filter ☐ Poor Circulation ☐ Vein Problems
☐ Leg Swelling ☐ Pulmonary Embolism

BLOOD / HEMATOLOGIC
☐ Anemia ☐ Hemophilia ☐ Previous Transfusion
☐ Bleeding Disorder ☐ Leukemia ☐ Sickle Cell Disease

RESPIRATORY
☐ Asthma ☐ Cystic Fibrosis ☐ Sleep Apnea
☐ Bronchitis ☐ Emphysema ☐ Tuberculosis
☐ COPD ☐ Pneumonia
☐ CPAP ☐ Sarcoidosis

EENT
☐ Blindness ☐ Hearing Loss ☐ Sinus Headaches
☐ Cataract ☐ Macular Degeneration ☐ Sinus Infection
☐ Eye Disease ☐ Migraine Headaches ☐ Tinnitus
☐ Glaucoma ☐ Nasal Polyps

GI (Gastrointestinal)
☐ Acid Reflex/GERD ☐ Duodenal Ulcer ☐ Hemorrhoids
☐ Colitis ☐ Gallbladder Disease ☐ Hiatal Hernia
☐ Crohn's Disease ☐ Gastric By-Pass Surgery ☐ Ulcerative Colitis
☐ Diverticulitis ☐ Irritable Bowel Syndrome ☐ Gastric Ulcer

DR. USE ONLY Initials ______

Name: ______________________, ____________________ DOB: ____________
(last) (first)

PAST MEDICAL HISTORY (Cont.)

GU (Genitourinary)

- ☐ Bladder Infections
- ☐ Cystic Kidney Disease
- ☐ Kidney Infections
- ☐ Kidney Stones
- ☐ Prostate Disease
- ☐ Renal Insufficiency
- ☐ Renal/Kidney Failure
- ☐ STD
- ☐ Syphillis

MUSCULOSKELETAL

- ☐ Achilles Tendonitis
- ☐ Amputation - Foot / Toes
- ☐ Amputation - Leg
- ☐ Ankle Sprain
- ☐ Back Pain
- ☐ Bunion
- ☐ Bursitis
- ☐ Charcot Foot Deformity
- ☐ Club Foot
- ☐ Difficulty Walking
- ☐ Dislocation - Foot / Ankle
- ☐ Dropfoot
- ☐ Fibromyalgia
- ☐ Foot Sprain Fracture
- ☐ Ankle Fracture - Toes / Foot
- ☐ Fracture - Leg
- ☐ Ganglion
- ☐ Gout
- ☐ Hammertoe
- ☐ Heel Spur
- ☐ Joint Instability
- ☐ Joint Stiffness
- ☐ Lupus (SLE)
- ☐ Muscle Spasms
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Plantar Fascitis
- ☐ Psoriatic Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Rupture - Achilles Tendon
- ☐ Shin Splints
- ☐ Tailor's Bunion
- ☐ Tendonitis, Other
- ☐ Unequal Leg Length

NEURO / PSYCH

- ☐ Alzheimer's Disease
- ☐ Anorexia
- ☐ Anxiety Disorder
- ☐ Bi-Polar Disorder
- ☐ Brain Injury
- ☐ Cerebral Palsy
- ☐ Charcot-Marie-Disease
- ☐ Dementia
- ☐ Depression
- ☐ Diabetic Neuropathy
- ☐ Drug Abuse
- ☐ Drug Dependency
- ☐ Epilepsy
- ☐ Hemiplegia
- ☐ Idiopathic Neurology
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Pain Management
- ☐ Panic Disorder
- ☐ Paraplegia
- ☐ Parkinson's Disease
- ☐ Polio
- ☐ Poor Balance
- ☐ Psychotherapy / Medications
- ☐ Ruptured Disc
- ☐ Schizophrenia
- ☐ Sciatica
- ☐ Seizure Disorder
- ☐ Spina Bifida
- ☐ Spinal Cord Injury
- ☐ Stroke
- ☐ TIA
- ☐ Tremors
- ☐ Vertigo

SKIN

- ☐ Acne
- ☐ Athlete's Foot
- ☐ Contact Dermatitis
- ☐ Dermatitis
- ☐ Eczema
- ☐ Fungal Nail Infection
- ☐ Fungal Skin Infection
- ☐ Hyperkeratosis Plantaris
- ☐ Ingrown Toenail
- ☐ Keloid / Scarring
- ☐ Malignant Melanoma
- ☐ Psoriasis
- ☐ Rash
- ☐ Scleroderma
- ☐ Skin Cancer
- ☐ Skin Disorders
- ☐ Warts
- ☐ Vitiligo

PREVIOUS SURGERIES OR HOSPITALIZATIONS:

☐ No previous surgery

____
____
____
____
____
____
____

FAMILY MEDICAL HISTORY:

	Mother	Father	Brother	Sister	Son	Daughter
Kidney Disease	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐

SOCIAL HISTORY:

☐ Single ☐ Married ☐ Widowed
☐ Divorced

Tobacco Use: (please choose one)

☐ Never ☐ Former (Quit date) ____________
☐ Current (How many years?) __________ Packs/day: __________

Alcohol Use: (please choose one)

☐ Never ☐ Rare ☐ Occasional
☐ Moderate ☐ Daily
Drinks/week: ____________________________

Occupation:______________**Employer:**______________

Do you exercise?

☐ Sedentary ☐ Minimal ☐ Active but no formal exercise ☐ Heavy

Type of exercise? ______________ How many times a week? ______

Are you Pregnant? ☐ Yes (*Due Date:*) ☐ No

Are you Breastfeeding? ☐ Yes ☐ No

CURRENT MEDICATIONS:

Medication	Dosage

*If more medications, please attach with paperwork.

DR. USE ONLY Initials ________

Name: ______________________, ______________________ DOB: __________
(last) (first)

PAST MEDICAL HISTORY (Cont.)

DRUG ALLERGIES:

☐ No allergies

☐ Penicillin ☐ Sulfa ☐ Bactrim
☐ Amoxicillin ☐ Keflex ☐ Erythromycin
☐ Neosporin ☐ Cipro
☐ Other Antibiotic(s): please list:
☐ Iodine ☐ Betadine ☐ Shellfish
☐ Contrast Dye ☐ Codeine ☐ Demerol
☐ Aspirin ☐ Hydrocodone ☐ Tape
☐ Skin Adhesives ☐ Metal ☐ Anti-inflammatories

OTHER KNOWN ALLERGIES:

☐ Food: ______________________

☐ Environmental: ______________________

☐ Other: ______________________

____

DR. USE ONLY Initials ______

REVIEW OF SYSTEMS

CONSTITUTIONAL

☐ Fatigue ☐ Fever ☐ Night Sweats
☐ Malaise ☐ Body Aches ☐ Loss of Appetite
☐ Weight Loss ☐ Chills

EYES

☐ Discharge From Eye ☐ Eye Discomfort/Pain ☐ Blurred Vision
☐ Double Vision ☐ Impaired Vision ☐ Changes in Vision
☐ Floaters ☐ Foreign Body Sensation

HENT

☐ Headaches ☐ Lightheadedness ☐ Dizziness
☐ Nasal Discharge ☐ Neck Stiffness ☐ Neck Pain
☐ Recent Head Injury ☐ Nasal Congestion ☐ Sinus Pain
☐ Sore Throat ☐ Thyroid Mass ☐ Hoarseness
☐ Nose Bleeding ☐ Dentures
☐ Dental or Gum Disease

CARDIOVASCULAR

☐ Chest Pain ☐ Irregular Heartbeat ☐ Lower Extremity Edema
☐ Syncope / Fainting ☐ Shortness of breath - Exertion ☐ Cardiac Arrest
☐ Varicose Veins ☐ Slow or Rapid Heartbeat ☐ High Blood Pressure
☐ Pacemaker/ Defibrillator

RESPIRATORY

☐ Shortness of Breath ☐ Productive Cough ☐ Wheezing
☐ Pain with Breathing ☐ Difficulty Breathing ☐ Asthma
☐ Painful Cough ☐ Coughing up Blood

GASTROINTESTINAL

☐ Nausea ☐ Vomiting ☐ Diarrhea
☐ Constipation ☐ Gallstones ☐ Loss of Appetite
☐ Blood in Stools ☐ Heartburn ☐ Jaundice
☐ Abdominal Pain ☐ Black Stools ☐ Eating Disorder

GENITOURINARY

☐ Urinary Frequency ☐ Possible Pregnancy ☐ Kidney Stones
☐ Painful/Difficulty Urinating ☐ Blood in Urine ☐ Pelvic Pain

INTEGUMENT

☐ Rash ☐ Change/Loss Hair Growth ☐ Discolored, Thickened or Damaged Nails
☐ Dry Skin ☐ Skin/Mole Change in Pigmentation ☐ Blisters
☐ Acne ☐ Ingrown Nail
☐ Itching

NEUROLOGIC

☐ Muscle Weakness ☐ Tingling ☐ Loss of Consciousness
☐ Loss of Muscle Control ☐ Tremors ☐ Loss of Sensation
☐ Seizures ☐ Memory Loss/ Confusion
☐ Loss of Coordination ☐ Dizziness
☐ Loss of Balance ☐ Paralysis
☐ Numbness ☐ Difficulty with Speech

MUSCULOSKELETAL

☐ Muscle Weakness ☐ Leg Swelling ☐ Ankle Pain
☐ Joint Stiffness ☐ Instability ☐ Knee Pain
☐ Joint Swelling ☐ Ankle Weakness and/or Leg Pain ☐ Leg Pain
☐ Muscle Cramps ☐ Hip Pain
☐ Limitation of Motion ☐ Foot Pain ☐ Joint Pain/Other

ENDOCRINE

☐ Cold Intolerance ☐ Heat Intolerance ☐ Loss of Hair
☐ Weight Gain/Loss ☐ Diabetes ☐ Thyroid Problems

PSYCHIATRIC

☐ Anxiety ☐ Bi-polar ☐ Hallucinations
☐ Depression ☐ Difficulty Sleeping

HEME-LYMPH

☐ Easy Bleeding ☐ Easy Bruising ☐ Enlarged Lymph Nodes

Who is your primary physician? ______________________ Did your physician refer you to our office? ☐ Yes ☐ No

If diabetic, who is currently treating you for your diabetes? ______________________

When did you last see this doctor? ______________________

Patient (Parent or Guardian) Signature ______________________ Date __________

Print Name ______________________ Relationship (if patient is not signing) ______________________

DR. USE ONLY Initials ______

PATIENT INFORMATION

NAME ______________________________ HOME PH. __________/CELL __________
FIRST M.I. LAST

MAILING ADDRESS______________________________WORK PH. __________ EXT. _______
STREET CITY ZIP

EMPLOYER______________________________OCCUPATION ______________________________

EMPLOYER ADDRESS ______________________________
STREET CITY ZIP

AGE___ RACE________ ETHNICITY: HISPANIC or NON-HISPANIC DOB___/___/___ SOC. SECURITY #__________

SEX ☐ M ☐ F MARITAL STATUS ☐ M ☐ S ☐ W ☐ D DRIVER'S LICENSE # ______________________________

EMAIL ADDRESS ______________________________

EMERGENCY CONTACT NAME ______________________________ PHONE __________

EMERGENCY CONTACT ADDRESS ______________________________
STREET CITY ZIP

PHARMACY ______________________________ PHONE __________

ADDRESS ______________________________

PERSON RESPONSIBLE FOR BILL: (circle) SELF SPOUSE PARENT CHILD OTHER__________

NAME______________________________ HOME PH. __________
FIRST M.I. LAST

ADDRESS______________________________WORK PH.__________EXT. _______
STREET CITY ZIP

SEX ☐ M ☐ F AGE_________BIRTHDATE____/____/____ SOCIAL SECURITY # __________

EMPLOYER______________________________
NAME ADDRESS

IF PATIENT IS DEPENDENT COMPLETE THIS SECTION AND CIRCLE RELATIONSHIP TO RESPONSIBLE PARTY: SPOUSE CHILD PARENT OTHER

DEPENDENT NAME______________________________BIRTHDATE____/____/____AGE______ SEX ☐ M ☐ F

FIRST INSURANCE NAME______________________________

INSURED PERSON'S NAME __________ INSURANCE I.D.#__________ GROUP #__________

SECOND INSURANCE NAME______________________________

INSURED PERSON'S NAME __________ INSURANCE I.D.#__________ GROUP #__________

THIRD INSURANCE NAME ______________________________

PATIENT'S FAMILY DR.______________________________ DO YOU HAVE A "LIVING WILL"? ☐ YES ☐ NO

HOW DID YOU HEAR ABOUT US? ______________________________

I WILL PAY FOR SERVICES RENDERED AT THE TIME THEY ARE RENDERED UNLESS OTHER PRIOR ARRANGEMENTS HAVE BEEN MADE.

To my insurance companies and/or the social security administration, or their representative; I authorize and request the release of any information about me needed to process claims for services rendered to me by the Orlando Foot & Ankle Clinic and I authorize and request payment to be made to the Orlando Foot & Ankle Clinic on my behalf for services provided to me for which I do not pay for in full at the time services are rendered. I authorize the Orlando Foot & Ankle Clinic to submit claims for me on my behalf. I permit a copy of this authorization to be used in place of the original. My signature below will act as my authorization for the above as long as I am provided services by the Orlando Foot & Ankle Clinic. I authorize Orlando Foot & Ankle Clinic physicians to consult with other physicians concerning my case as deemed necessary by them. I authorized the photographic and audio recording of my feet and or legs for the purpose of documentation as deemed necessary by Orlando Foot & Ankle Clinic. I understand that my account will incur a 1.5% per month service charge on balances not paid by my insurance company. I agree to pay all balances due, plus a 1.5% service charge on any unpaid balances, and collection costs of 35% for outstanding balances referred to our external collection agency.

DATE______________________________ SIGNATURE ______________________________

PLEASE TURN OVER AND COMPLETE THE OTHER SIDE

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR
PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

Date______________________________

Patient ____

Employer ____

Claim Group ____

SS # / ID # ____

I hereby instruct and direct ____ Insurance Company to pay by check made out and mailed to ORLANDO FOOT & ANKLE CLINIC, or if my current policy prohibits direct payment to doctor, I hereby instruct and direct you to make out the check to me and mail it as follows:

ORLANDO FOOT & ANKLE CLINIC
P.O. BOX 140233
ORLANDO, FL 32814-0233

for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

Payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges that are applied to a deductible or copay requirement of my policy, or for any services provided that are not a covered benefit under my policy.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated at___________________________________ this ___________day of __________________ 20 _____

____ ____
Signature of Policyholder Witness

____
Signature of Claimant, if other than policyholder.

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM! THIS WILL BETTER ENABLE US TO SERVE YOU.

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

The Patient hereby consents to the use or disclosure of his/her individually identifiable health information ("protected health information") and patient medical record information by Orlando Foot & Ankle Clinic, Inc. (the "Practice") in order to carry out treatment, payment, or health care operations. The Patient may review the Practice's Notice of Privacy Practices for a more complete description of other potential uses and disclosures of such information, and the Patient has the right to review such Notice prior to signing this Consent Form.

Patient has the right to request that the Practice further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Practice is not required to agree to such requested restrictions; however, if the Practice does agree to Patient's requested restriction(s), such restrictions are then binding on the Practice.

Patient acknowledges and agrees that the Practice may disclose Patient's protected health information and patient medical record information to the Patient's immediate family members (mother, father, spouse or children), legal representatives, guardians, health care surrogates, or have power of attorney on behalf of the Patient **unless** they are identified below:

____

____

The Patient agrees that the Practice **may disclose** the following types of information contained in the Patient's medical records **unless** they are initialed below:

_______ HIV/AIDS Information

_______ Mental Health Information

_______ Substance Abuse Information

_______ Sexually Transmitted Disease Information

_______ Pregnancy Information if Patient is under the age of eighteen (18)

Patient **agrees and consents** to the Practice releasing information to Patient in the following alternative manners **unless** they are initialed below:

_______ Via Regular Mail with any envelopes addressed to Patient.

_______ Via telephone, if Patient contacts the Practice and provides the appropriate information (including the Patient's name and social security number).

At all times, Patient retains the right to revoke this Consent. Such revocation must be submitted to the Practice in writing. The revocation shall be effective except to the extent that the Practice has already taken action in reliance on the Consent.

The Practice may refuse to treat Patient if he/she (or an authorized representative) does not sign this Consent Form. If Patient (or an authorized representative) signs this Consent and then revokes it, the Practice has the right to refuse to provide further treatment to Patient as of the time of revocation (except to the extent that the Practice is required by law to treat individuals).

I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT. I AM AWARE THAT I MAY REQUEST A COPY OF THIS CONSENT, AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS SEALED DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

Date: _______________ Time __________ AM/PM

Signature of Patient (or Authorized Representative*) ______________________________

Please Print Name ______________________________

*Please explain Representative's Relationship to Patient and include a description of Representative's Authority to act on behalf of the Patient:

____

Patient Financial Agreement

Thank you for choosing Orlando Foot & Ankle Clinic as your healthcare provider. We are committed to your treatment being successful and we appreciate your trust in us. The following is a statement of our Financial Policy which you are required to read and sign. Our staff will address any questions that you may have but you will need to agree to and sign prior to your treatment being rendered:

- **Self pay patients -** Payment in full is due at the time of service.
- **Patients with Insurance** - We will file your insurance claim for you. However, in order to work with your insurance company, we must have complete and current information, a copy of your insurance card and your signature on file.
- **Insurance benefits** – It is your responsibility to know your insurance benefits. Please contact your insurance company with any questions that you may have regarding coverage of podiatric services.
- **Co-payments, co-insurances and deductibles –** All patient balances are due at time of service. We accept cash, checks as well as Visa, MasterCard, Discover and American Express credit cards.
- **Non Covered Charges** - Please understand there may be some charges for our services which your insurance company considers non-covered and may be excluded from your policy. Accordingly, you will be responsible for these charges.
- **Denied Claims** - You will be responsible for any charges that are denied by your insurance company which result from your failure to provide our office with complete and current information in a timely manner.
- **Medicare -** We are a participating Medicare provider. We will bill Medicare, as well as any secondary insurance that you may have, for you. However, that does not mean that all services are covered. Additionally, you are responsible for any copayments, usually 20% of the allowed amount, as well as any unmet annual deductible. Please realize that Medicare may allow a service but your secondary may not so you will be responsible for that portion.
- **Missed appointments** - Failure to cancel an appointment with at least 24 hour notice will be subject to a $25 patient charge. ($100 will be charged for MRI's and Laser's). This is an internal charge and cannot be billed to your insurance company.
- **Returned checks** – Any returned check is subject to a $25 bank fee.
- **Special financial arrangements** – We offer monthly payments plans with balances to be paid off in 4 consecutive payments. Also, we offer financial hardship discounts but these required the patient to complete a Financial Evaluation Form with proper supporting documentation that shows the patient's income.
- **Past due accounts –** All past due accounts are subject to collection proceedings. All fees including but not limited to the maximum interest that is allowable by law, a 35% collection agency fee and awarded court fees will become your responsibility in addition to the patient balance should you be placed with an external collection agency.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE FINANCIAL POLICY

____

Signature of Patient or Financially Responsible Person

____ ______________

Signature of Employee Date

Other Fees Acknowledgment

Date:____________________

Office Visits:

As a patient of the Orlando Foot & Ankle Clinic, I acknowledge that I ***will*** be charged a $25 fee should I no show and/or do not cancel my appointment at least 24 hours in advance.

MRI Scan & Laser Procedure for Pain:

As a patient of the Orlando Foot & Ankle Clinic, I acknowledge that I ***will*** be charged a $100 fee should I be scheduled for these types of procedures and should I no show and/or do not cancel my appointment at least 24 hours in advance.

Sign Language / Interpretive Services:

As a patient of the Orlando Foot & Ankle Clinic, I acknowledge that I ***will*** be charged a $120 fee should I request an interpreter and should I no show and/or do not cancel my appointment at least 25 hours in advance.

Completion of Forms:

As a patient of the Orlando Foot & Ankle Clinic, I acknowledge that I ***will*** be charged a $20 fee for completion of a simple form (one page) and a $40 fee for completion of a **complex form** (Multiple Pages), i.e. FMLA, Disability, etc.

Surgical Procedures:

As a patient of the Orlando Foot & Ankle Clinic, I acknowledge that I ***will*** be charged a $100 fee should I be scheduled for these types of procedures and should I no show and/or do not cancel my appointment at least 48 hours in advance.

Same day surgery:

If same day surgery is required, I am responsible for contacting my insurance and obtaining my **Out Patient Surgery Benefits.** This may include obtaining an authorization, and paying a separate co-pay, deductible, and co-insurance (which may be 20% of the total cost) at the Surgical Center. **(You may receive a bill from the Anesthesiologist, Surgical Center and the Dr. performing the surgery, this will be based on your insurance benefit plan).**

______________________________ ______________________________

Patient Signature | Print Patient Name

Parent / Guardian Consent for Medical Treatment

Name(s) of Child(ren)

First Name	Last Name	Date of Birth

______________________________ ______________________________
Parent/ Guardian Name Phone

______________________________ ______________________________
Caregiver Name Relationship

The above named person shall be authorized to bring my child(ren) to *Orlando Foot & Ankle Clinic* for medical treatment in my absence. This consent includes

☐ All Medical Treatment (including injections)

☐ Office Visit Only

I agree to be financially responsible for all services rendered in my absence.

This authorization is valid until specifically cancelled by the primary parent/guardian

The "Caregiver" must bring a proper form of identification to the office

______________________________ ______________________________
Parent/Guardian Signature Date

______________________________ ______________________________
Witness Signature Date