Triangle Foot & Ankle SPECIALIST

NEW PATIENT FORM

** PLEASE COMPLETE ALL INFORMATION*

Date: _____ **Major Complaint:** _____

DEMOGRAPHIC INFORMATION

NAME: Last: _____ **First:** _____ **MI:** _____

Date of Birth: _____ Social Security #: _____

Gender: ☐ Male ☐ Female ☐ Other _____ Preferred Language: _____

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino Race: _____

How do you prefer to be contacted? ☐ E-mail ☐ Phone

Emergency Contact: _____ Relationship: _____

Emergency Phone #: _____

Home #: _____ Work #: _____ Cell #: _____

Preferred Phone #: ☐ Home ☐ Cell ☐ Work

EMAIL Address: _____

Home Address: _____

City: _____ State: _____ Zip: _____-_____

☐ Retired ☐ Student ☐ Employed Employer: _____Employer #: _____

PHARMACY

Primary Pharmacy: Name: _____ Zip: _____ Phone: _____

PRIMARY CARE INFORMATION

Primary Care Doctor (Who provides your health care): _____

Office #: _____ Date of the last visit: _____

MISCELLANEOUS

How did you hear about us? ☐ Friend ☐ Family ☐ Internet ☐ Referring MD ☐ Other: _____

MEDICAL/SOCIAL HEALTH INFORMATION

- **Tobacco/Smoker: Current _____, Former_____, Never_____ # per day _____**
- **Caffeinated beverages (yes/no) _____ # per day _____**
- **Alcohol: Y_____ N_____ # per day_____**
- **Height: _____, Weight: _____, Shoe size: _____**
- **How Often do you Exercise: ☐ Once a Day ☐ A Few Times a Week ☐ Never ☐ Other _____**

Please circle any illness that may pertain to you:

MAJOR DISEASE
Diabetes
Hypertension
Coronary Artery Disease (CAD)
Heart Attack
Heart Murmur
Stroke

GASTROENTESTINAL
Acid Reflux (GERD)
High Cholesterol

RESPIRATORY
Asthma
COPD

VASCULAR
Anemia
Poor Circulation
Night Cramps
Varicose Veins
Atrial Fibrillation

HEENT
Hearing Loss

PSYCHOLOGICAL
Anxiety
Depression

MISC
Epilepsy
End Stage Kidney Disease
HIV
Arthritis

CANCER
Leukemia
Malignant Lymphoma
Colon Cancer
Breast Cancer
Lung Cancer
Prostate Cancer

Please list details and dates of all operations:_____

_____

FOOT/ANKLE HX
Ulcer: Ankle or Foot
DVT
Fracture: _____
Bunion (Hallux Valgus)
Soft Tissue Tumor
Neuroma
Osteoarthritis
Rheumatoid Arthritis
Peripheral Neuropathy
Peripheral Vascular Disease
Plantar Fasciitis
Gout
Recurrent Falls

FOOT/ANKLE SURGERY
Amputation: _____
Ankle Fusion
Excision of Accessory Bone
Plantar Fasciotomy
Hammertoe
Incision & Drainage
Lengthening of a Tendon
Open Reduction of a Fracture
Removal of Foreign Body
Bunionectomy (Repair of Hallux Valgus)
Tendon Repair

Please list all medications that you are currently taking:_____

_____

_____

Please list all Allergies (include any drug allergies):_____

_____

Please list illnesses of diseases of mother, father, and siblings:
Mother: Deceased/Alive:_____
Father: Deceased/Alive:_____
Brother/Sister: Deceased/Alive:_____

I hereby give permission to Dr. Jeremy M. Thomas and associates to administer treatment and perform such procedures as may be deemed necessary in the diagnosis and / or treatment of the extremity condition. I also, herby assign to the above-named physician all benefits provided by my insurance company policy or policies for medical or surgical care.

_____ _____

Signature of Patient / Guardian Date

Triangle Foot and Ankle Specialist strive to render excellent medical care to you and to the rest of our patients.

OUR POLICIES ARE AS FOLLOWS

1. **PAYMENTS:**

- ***When verifying benefits, it is never a guarantee of payment per your insurance company's disclaimer. You are responsible for all co-pays, deductibles, co-insurance amounts and non-covered services. The Patient/Guardian is aware that their insurance company may not make payment on a claim and that it will be the Patient's/Guardian's responsibility to do so.***
- All Co-Pays, Deductibles, Co-insurance and any additional charges will be collected at the time of your visit. You are ultimately responsible for all payment of charges for services from our office.
- ***Account balances must be paid in full at the time of today's appointment prior to seeing the doctor. If there is any balances due on the account and you are attempting to schedule a new appointment the balance must be paid in full prior to scheduling.***
- It is your responsibility to provide accurate insurance information and to present your insurance ID card at the time of your visit.
- If your plan requires a referral, it is your responsibility to obtain this prior to being seen.
- If procedures are done in the office that are deemed non-covered by your insurance company, you will be responsible for the payment.
- Returned check fee is ***$35.00,*** the balance and all future visits to our office must be paid via credit card or cash. We will no longer accept checks if there has ever been a returned check to our office for insufficient funds.
- We do not go back and submit claims to patient's insurance companies if at time of visit they had requested to be self-pay or if at the time of visit their insurance company states the service/product is non-covered.
- Your visits will be coded based on documentation from your provider during the visit, which may not be covered by your insurance carrier at 100%. Diagnosis codes will not be changed in an attempt to reduce out of pocket expenses.
- The Patient will be responsible for all Attorney Fees, Legal Fees, and Court Costs if the account is turned over to collections.
- A 35% Administration fee will be automatically added to all patients that are submitted to collections.
- If the Patient is a minor the Patient's Legal Guardian will be responsible for all Attorney Fees, Legal Fees, and Court Cost if the account is turned over to collections.
- A demographic information update is required at the beginning of every year. Please have your insurance information and photo identification readily available at the time of check in, to allow us to process your demographic information update in a timely manner.

- **CANCELLATIONS:**

- When an appointment is scheduled, that time has been set-aside for you and when it is missed, that time cannot be used to treat another patient.
- Cancellations for appointments and procedures must be received 24 hours prior to the scheduled appointment. You may leave a ***24-hour*** cancellation message on the answering machine
- ***Patients who fail to keep or cancel a scheduled appointment more than 24 hours in advance will be charged a $50.00 No-Show / No-Call Fee.*** (We make reminder calls as a courtesy, but it is your responsibility to keep track of your appointment).
- Repeat failure to keep your scheduled appointments may force us to have your medical care transferred elsewhere.
- If a patient has two consecutive No-Show/No-Call fees, the balance of $100 must be collected via credit card prior to scheduling another appointment in our office.
- If a patient is late on the day of an appointment, the office will do everything possible to see the patient in a timely manner. If the patient decides to not keep that day's appointment or reschedule the appointment a $50.00 fee will be applied to the patient chart for the missed appointment.

- ***A $250.00 deposit is required at time of scheduling a surgery.*** Once all of your insurance claims have processed and your account has been paid in full and if you are due a refund, one will be issued to you upon request within 30 days.
- Patients who fail to keep or cancel a scheduled surgery less than ***30 days*** before the scheduled surgery will not be refunded the $250.00 surgery deposit, regardless of when the surgery was scheduled.

- **DURABLE MEDICAL EQUIPMENT:**
- If you have received a DME (Durable Medical Equipment) product (Ex: L1902, L1906, L4396, L2116) code in the last 5 years anywhere else and one is dispensed to you from our office it is the patient's responsibility to alert us to this prior to dispensing. Some insurance only cover these codes once every 5 years and if we are not made aware it will not be covered by your insurance and the patient will be made responsible for the self-pay price of the device.

- **MEDICAL RECORDS:**
- Medical Records request must be received at least ***48 hours*** prior to the date needed.
- There is a non-refundable fee of ***$25.00*** for requested copies of medical records.
- There is an additional non-refundable fee of ***$25.00*** for requested copies of X-rays.
- Copies of medical records fees and copies of x-rays fees are set in accordance with the State of North Carolina.
- WE DO NOT FAX MEDICAL RECORDS TO PATIENTS OR FAMILY.
- All fees and account balances must be paid prior to pick up of medical records.

4. **REFUNDS: (Pertaining to Insurances Only)**
- An insurance company has Ninety Days to process your claim. Even after Ninety Days the insurance company may still be processing your claim.
- Once we have received confirmation and payment from your insurance company and the remaining balance on your account is paid in full, upon request a refund check will be issued to you within ***30 days*** of the request.

5. **RETURNS:**
- We do not accept returns for any reason on custom orthotics, over the counter orthotic inserts or medical products that have been made specifically for you or a product dispensed to you by the doctor in the office.
- We do not accept returns of diabetic shoes or diabetic inserts for any reason. (See Authorization for Payment and Warranty form if dispensed diabetic shoes)
- HIPAA and NC Health Regulations prohibit the re-sale of previously dispensed products.

6. **SUMMARY / STATEMENTS:**
- Your summary may not be ready for pickup at the end of your office visit, due to the fact that our doctor must first chart your visit, which will be after he sees all of his patients for the day.
- Statements are mailed out the first week of the month.
- If there is no balance on your account, you will not receive a statement.

By signing you fully understand your rights and responsibilities.

_____ _____

Signature of Patient / Guardian Date

PATIENT BILL OF RIGHTS

1. The patient has the right to considerate and respectful care.
2. The patient has the right to obtain complete current information concerning diagnosis, treatment, and prognosis in terms the patient can reasonably understand. When it is not medically advisable to give such information should be made available to an appropriate person on their behalf. A patient has the right to know by name the physicians responsible for coordinating the patient's care.
3. The patient has the right to receive from their physician any information necessary to give informed consent prior to the start of any procedure and or treatment. Except in emergencies, such information for informed consent should include, but not necessarily be limited to, the specific procedure and or treatment, the medically significant risks involved, and the probable duration of incapacitation. Where medically significant alternatives for care or treatment exist, or when the patient request information concerning medical alternatives, the patient has the right to such information. The patient also has the right to know the name of the person responsible for the procedure and or treatment.
4. The patient has the right to refuse treatment to the extent permitted by law, and to be informed of the medical consequences of this action.
5. The patient has the right to expect all communications and records pertaining to their care to be treated as confidential.
6. The patient has the right to every consideration of privacy concerning his or her own medical care program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discretely. Those not directly involved in treatment must have the permission of the patient to be present.
7. The patient has the right to expect that within its capacity, an office must make a reasonable response to the request of services. Medical facilities must provide evaluation, service, and / or referral as indicated by the urgency of the case. When medically permissible, the patient may be transferred to another facility only after receiving complete information and explanation concerning the needs for an alternate transfer.
8. The patient has the right to obtain information as to the existence of any professional relationships among individuals, by name, which is treating them.
9. The patient has the right to expect reasonable continuity of care, as well as, the right to know in advance what appointment times and physicians are available.

_____ _____

Signature of Patient / Guardian Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name and Address: _____
_____

_____

I have received a copy of the Notice of Privacy Practices.

_____ _____
Signature of Patient / Guardian Date

PATIENT PRIVACY INFORMATION

When notifying you for any reason, may we (Please check all that apply)

_____ Leave message on home answering machine

_____ Leave message with spouse

_____ Call you on your cell

_____ Call you at your place of employment

_____ Other_____

FOR OFFICE USE ONLY

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

_____ An emergency existed and a signature was not possible at the time.

_____ The individual refuses to sign.

_____ A copy was mailed with a request for a signature by return mail.

_____Unable to communicate with the patient for the following reason: _____
_____

_____Other_____

Prepared by _____ Signature _____ Date _____