Friendly Foot Centers

J. ANDREW PETERY, DPM

Patient Demographics, Contact Information & Consent Form

Name: _____ ☐ Male ☐ Female SS #: _____ - _____ - _____ Status: ☐ Single ☐ Married

Address: _____ _____
CITY STATE ZIP CODE

Birthday: _____ /_____/_____ Age: _____ Home Phone #: _____ -_____ - _____ Cell Phone #: _____ - _____ - _____

*Email address: _____ Race/Ethnicity: _____ Primary Language: _____
(see pg. 3 providing your email address)

Employer: _____ Work #: _____ - _____ - _____Occupation: _____

Policy Holder: _____ Relationship: _____ SSN# _____ - _____ - _____

Policy Holder's Employer: _____ Date of Birth: _____/_____/_____

Responsible Party other than patient: □ Patient is under 18 □ Patient has a Power of Attorney (Please provide documentation)
Name: _____ Relationship: _____ Date of Birth: _____/_____/_____

Address: _____ City: _____ State: _____ Zip Code: _____
Please list your doctors and pharmacy information in order for us to coordinate your care:

Physician's Name	Phone Number	City	Date Last Seen
Primary	____ - ____ - _____	_____	_____/_____/_____
Specialist	____ - ____ - _____	_____	_____/_____/_____
Pharmacy	____ - ____ - _____	_____	_____/_____/_____

Did you sustain an injury at work? Y N Are you covered under an employer or union policy? Y N
Are your injuries accident related? Y N Is your spouse or other family member employed? Y N
Are you currently employed? Y N Do you have a secondary insurance policy? Y N

How did you hear about us? ☐ Phone Book – which city directory? _____

☐ Family/Friend _____ ☐ Co-worker _____ ☐ Special Event/Health Fair_____

☐ Family Doctor_____ ☐ Internet/Web Site ☐ Insurance Directory ☐ Other: _____

Your signature below allows us to bill your insurance carrier for your services and accept payment for these services. Any amount not covered by your carrier will be billed directly to you after preferred provider discounts are applied. Fees for services that are denied by your insurance carrier as "non-covered" or "not medically necessary" are your responsibility. Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.

You further give FFC permission to access any database available to collect and update my medication list.

In addition, (as required by NC Dept. of Public Health and OSHA regulations), in the event that a healthcare worker is exposed to my blood or other bodily fluid, I agree to have my blood tested, at no charge to me, for Hepatitis B, Hepatitis C and HIV following an exposure incident. I understand that an exposure incident does not put my own health at risk. I further understand that the results of my blood test will be discussed with me, used to determine the need for treatment of the health care worker, if any, and otherwise will remain in my confidential medical records with the health care provider who conducts the test.

Patient Signature: _____ **[SEAL]** Date: _____

Witness Signature: _____Date: _____

Comprehensive Patient Medical History

(Review of systems)

Do you have any of the following:

(integument) *(musculoskeletal)* *(constitutional)*

☐ Itching of the skin ☐ arthritis ☐ fever
☐ Psoriasis ☐ stiffness ☐ chills
☐ Skin Cancer ☐ low back pain ☐ nausea
☐ Eczema ☐ Bursitis ☐ recent weight
☐ Hives ☐ gout ☐ recent weight

☐ Rash ☐ Knee Pain ☐ fatigue
☐ Wounds ☐ Hip pain ☐ **NONE of these**

(past medical history)

Do you have or have you ever been treated for:

☐ Stroke ☐ Heart Attack ☐ High Blood
re
☐ Phlebitis ☐ Vascular Disease ☐ Heart Condition
☐ Diabetes ☐ Poor Circulation ☐ Headaches
☐ Hepatitis ☐ Liver Disease ☐ Osteoporosis
☐ Arthritis ☐ Anemia ☐ Hearing/Ear
Disorder
☐ Sciatica ☐ Rheumatic Fever ☐ Lyme's Disease
☐ Alzheimer's ☐ Keloid/Thick Scar ☐ Epilepsy
☐ Nerve Disorder ☐ Tuberculosis ☐ Gout
☐ Glaucoma ☐ Kidney Disease ☐ Thyroid
ms
☐ Asthma ☐ Lung Disease ☐ Psychiatric
disorder
☐ Cancer ☐ Stomach Ulcer ☐ **NONE of these**
☐ HIV ☐ Other(s):
_____

Do you have vascular grafts? **Yes** **No**
Do you have joint implants? **Yes** **No**
Do you have replacement heart valves? **Yes** **No**
Are you now under active chemotherapy? **Yes** **No**
Are you currently in pain management? **Yes** **No**
Please list any serious injuries along with date of accident:
_____

Please list surgeries: Date: any complications?

_____ _____ _____

_____ _____ _____

_____ _____ _____

(Past family/social history)

List relationship to you of *family members* who have had:

Diabetes: _____ Foot Problems: _____
Arthritis: _____ Heart Attack: _____
Cancer: _____ Birth Defects: _____
Stroke: _____High Blood Pressure: _____

Are you currently pregnant? **Yes** **No**
Do you smoke? **Yes** **No** Packs/day ____ years ____
Alcoholic beverages? (circle one)
None Rarely Moderately Daily Quit
Are you taking Insulin? **Yes** **No**
Are you taking blood thinners? **Yes** **No**

List all medications: ☐ **see separate list attached**
_____
_____
_____
_____

Allergies: ***(review of systems-Immunogenic)***

☐ **No allergies**

Penicillin……...… ☐ _____
Morphine……...…… ☐ _____
Codeine……...……☐ _____
Demerol……...☐ _____
Novocain…… ☐ _____
Aspirin…….☐ _____
Tylenol……☐ _____
Advil, Aleve or Motrin……☐ _____
Sulfa drugs……...☐ _____
Adhesive tape……☐ _____
Latex…….☐ _____
Shrimp, Iodine or Merthiolate…..☐ _____
Others: _____
_____

Additional comments:

Name:_____**DOB:**_____

Primary Care Physician: _____**Date of last visit:**_____

Today's Date: _____

Friendly Foot Centers

FINANCIAL RESPONSIBILITY: I agree to pay and guarantee payment in full of any and all charges for services and/or durable medical equipment ("DME") provided or to be provided to the patient ("Patient") by Friendly Foot Centers ("Facility") and by healthcare providers who may provide services during this patient visit (a "Provider").

ASSIGNMENT OF INSURANCE BENEFITS: I authorize payment of medical benefits payable to me directly to the Facility and/or the Provider. The rates will not exceed regular charges for similar services. I understand that **BILLING OF INSURANCE IS A SERVICE ONLY AND NOT A GUARANTEE OF PAYMENT.** I understand that it is entirely my responsibility to ensure that the Facility has my correct insurance information and that I am financially responsible for payment of all charges not covered by my insurance. Also, if my insurance carrier requires pre-certification for any services or DME I receive or may receive from the Facility, I understand that, while the Facility may offer to contact my insurer for pre-certification, I am ultimately responsible for securing the necessary approvals.

MEDICARE-MEDICAID CERTIFICATION: The information given by me in applying for payment under Titles V, XVIII, and XIX of the Social Security Act is correct. I request that payment of benefits under Title XVIII (Medicare) and XIX (Medicaid) of the Social Security Act for any services and/or DME provided by Facility and/or Provider(s), including physician services, be made on my behalf.

CONSENT FOR HEALTHCARE AND RELEASE OF MEDICAL INFORMATION: I consent to health care services from healthcare providers practicing at this Facility. I am aware that the provision of healthcare is not an exact science and I agree that no guarantees have been made or implied. I consent to any necessary lab work, including HIV testing, and understand that I may receive an invoice for lab work provided by a third-party vendor that is separate from and in addition to charges for services provided at this Facility. I consent to the use and disclosure of protected health information about me for treatment, payment, and healthcare operations. I understand and agree that my healthcare information may be disclosed to my family member(s), other relatives, close personal friends, or others if it is directly related to their involvement in my healthcare or payment for my healthcare.

Please list who we may discuss your medical history with:

PROVIDIN portal program. This program allows online access to certain parts of your electronic medical records. Once you provide your email address a secure message with your login information will be generated to you. Follow the link for instructions on how to access your portal. Furthermore, by providing your email address, you are authorizing statements to be emailed to you. Foot Centers conforms to state and federal laws to safeguard your privacy. You may request to have your email removed at any time by contacting our office.

HIPAA- Acknowledgement of Receipt of Privacy Practices: I have received a copy of the Facility's Notice of Privacy Practices. I am aware that the Notice may be changed at any time, and that I may obtain a copy of the Notice by requesting one at the Facility's office.

MY SIGNATURE BELOW INDICATES APPROVAL OF THE ABOVE UNLESS OTHERWISE MARKED AND INITIALED.

Patient Signature:	**Witness:**	**Date:**

Complete below ONLY if patient is under age 18 or has power of attorney:

Authorized Signature:	**Name:**

Relationship:	Witness:	Date: