CELEBRATION Foot & Ankle INSTITUTE

Who is responsible for this patient? □ Self □ Parent □ Employer □ Other _____

How did you hear about us? _____

Patient's Last Name _____ First Name _____Middle Initial _____

Patient's Social Security Number _____ Date of Birth _____

Address _____ Apt # _____

City _____ State _____ Zip Code _____

Telephone#: Home ( ) _____ Business: ( ) _____

Race: _____ Ethnicity: _____ Sex: □ Male □ Female

Would you like to sign up for patient portal? □ Yes □ No

Email Address: _____

Do you have an alternate address? □ Yes □ No If yes, please print here: _____

_____

Marital Status (check one): □ Single □ Married □ Divorced □ Widowed □ Separated

Employment Status (check one): □ Full- Time □ Part- Time □ Retired □ Other _____

Employer: _____ Occupation: _____

Employer Address: _____

Student: □ Yes □ No □ Full- Time □ Part- Time

Spouse/Parent Name: Last _____ First _____ Middle Initial _____

SSN: _____ Date of Birth: _____

Employer: _____

Employer Address: _____ Phone # _____

Name of closest relative not living with you: _____

Relationship: _____ Phone #: _____

Referring Physician: _____

Address: _____ Phone #: _____

INSURANCE INFORMATION

Primary Insurance: _____ Secondary Insurance: _____

Insured's Name: _____ Insured's Name: _____

I.D. # _____ I.D. # _____

Relationship to Patient: _____ Relationship to Patient: _____

ACCIDENT INFORMATION

EMPLOYER: _____ Date of injury: _____

Place of accident or injury: _____ Was the Accident: □ Work- Related □ Auto-Related

Date & Time of Accident: _____ □ Other _____

Do you have notice of injury on file? □ Yes □ No W. C. Claim# _____

Insurance Co: _____Policy Holder: _____

I.D.# _____

Address: _____ Zip: _____

Telephone# _____ Were X-rays taken of this injury or problem? □ Yes □ No

If yes, where were X-rays taken? _____ Date X-rays taken _____

A $40 no show fee will be applied if your appointment is not cancelled 24 hours prior to your appointment. Please call our office 3 business days prior to your surgery/procedure to cancel or reschedule your surgery. If a 3-business day notice is not given there will be a $250 charge. Payment is required prior to rescheduling a new date and time.

_____ _____

Patient/Guardian Signature **Date**

OFFICE POLICY FOR PRESCRIPTION REFILL REQUESTS

We require a 48-hour notice for all prescription refill requests.

Please leave the following information on the Medical Assistant's voice mail:

- Your Name & Telephone Number
- Your Physician's Name
- Pharmacy Telephone Number
- Medication Name & Strength

Dear Patients,

We are now doing electronic prescriptions. Please list your preferred pharmacy below.

Pharmacy Name: _____Pharmacy Phone #: _____

Address: _____

_____

Please initial: _____ **Date:** _____

INSURANCE ASSIGNMENT & RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Celebration Foot & Ankle Institute all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance admissions.

The above-named physician may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Patient/Guardian Signature **Date**

_____ _____

Please print name of Patient/Guardian **Relationship to Patient**

MEDICARE/MEDIGAP AUTHORIZATION

Print Name: _____ Date of Birth: _____

Medicare#:_____ Patient I.D. # :_____

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to Celebration Foot & Ankle Institute, for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to the centers for Medicare and Medicaid Services, any Medigap insurer and their agents any information needed to determine these benefits and related services.

_____ _____

Patient/Guardian Signature **Date**

_____ _____

Please print name of Patient/Guardian **Relationship to Patient**

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services or items provided to me, to my minor/child, or to the patient for whom I have legal responsibility. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

_____ _____

Patient/Guardian Signature **Date**

_____ _____

Please print name of Patient/Guardian **Relationship to Patient**

CONSENT FOR EVALUATION OR TREATMENT

Patient Name: _____ Date of Birth:_____

By signing below, I voluntarily agree to the following provisions of this form: Consent to Treatment

I allow Celebration Foot & Ankle Institute (the "Practice") to provide health care services to me that may be deemed to be routine or otherwise necessary. I consent to evaluation or treatment that the assigned healthcare provider may deem necessary. This may include diagnostic, radiology and laboratory procedures, and medication administration. I understand that I have the right to refuse consent to any proposed procedure or treatment at any time prior to its performance.

_____ _____

Patient/Guardian Signature **Date**

Patient Name: _____ Date of Birth: _____

AUTHORIZATION TO VERBALLY COMMUNICATE WITH FAMILY MEMBERS AND FRIENDS INVOLVED IN YOUR CARE

AUTORIZACION PARA COMMUNICACION CON FAMILIARES Y AMIGOS INVOLUCRADO EN SU CUIDADO

I, _____ (print name) hereby authorize Celebration Foot & Ankle Institute to verbally disclose the minimum amount of protected health information necessary to individuals listed below who are directly involved in my care or payment of my care.
Yo, _____ (escriba su nombre en letra de molde) por la presente autorizo a Celebration Foot & Ankle Institute, a divulgar verbalmente la cantitad minima de informacion de salud protegida necesaria para los individuos nombrados a continuacion que estan directamente involucrados en mi cuidado o en el pago de mi cuidado.

1. _____ _____
Name/*Nombre* (Please print/*En letra molde)* Relationship/*Relacion*

_____ _____
Address/*Direccion* City/*Ciudad* State/*Estado* Phone Number/*Numero de telefono*

2. _____ _____
Name/*Nombre* (Please print/*En letra molde)* Relationship/*Relacion*

_____ _____
Address/*Direccion* City/*Ciudad* State/*Estado* Phone Number/*Numero de telefono*

This authorization will expire on the following date, event or condition: _____
I understand that this authorization extends to all or any part of the records designated above, which may include psychiatric information, and/or genetic counseling/testing, and/or alcohol/drug abuse and/or AIDS (Acquired Immunodeficiency Syndrome), and/or may include the result of an HIV test or the fact that an HIV test was performed. I expressly consent to the release of information designated above unless initialed below or otherwise required by law.
Esta autorizacion vencera en la sigiente fecha, evento o condicion: _____
Comprendo que esta autorizacion cubre todos o cualquier parte de los expedimientos indicados arriba, los cuales podrian incluir informacion psiquiatrica, y/o pruebas/asesoramiento genetico, y/o de abuso de alcohol/drogas, y/o SIDA (Sindrome de Inmunodeficiencia Adquirida) (AIDS segun sus siglas en ingles), y/o podria incluir el resultado de una prueba de VIH (Virus de Inmunodeficiencia Humano) (HIV segun sus siglas en ingles) o el hecho de que se llevo a cabo una prueba de VIH. Especificamente autorizo que se divulgue la informacion segun se ha indicado arriba al menos que este marcado abajo con mis iniciales o en alguna otra forma sea exigido por la ley.

Please indicate information you **DO NOT** want disclosed: (Initial each selection)
*Indique la informacion que **NO QUIERE** que se divulgue: (ponga sus iniciales en cada seccion)*
_____ HIV/AIDS *VIH/SIDA* _____ Drug and/or Alcohol Abuse/*Abuso de sustancias y/o alcohol)*
_____ Mental Health *Salud mental*
_____ Genetic Counseling/Testing Information/Information/Informacion sobre asesoria o pruebas geneticas
_____ Other (be specific)/ Otros (sea especifico) _____
If I fail to specify an expiration event or condition, the authorization will expire in one year. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. I understand that my protected health information that is used or disclosed under this authorization may be subject to re-disclosure by the recipient and the privacy of my protected health information may no longer be protected by law. I further understand that Celebration Foot & Ankle Institute may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization. I understand that I will receive a signed copy of this form.
Si yo no especifico un evento o condición de vencimiento, la autorización vencera en un año. Comprendo que esta autorización es revocable al dar aviso por escrito a la oficina donde se retiene la autorización original, excepto al grado de accion ya tomada de acuerdo con esta autorización. Comprendo que mi información médica protegida que se usada o divulgada de acuerdo con esta autorización podria estar sujeta a una nueva divulgación por el recibidor y que la privacidad de mi información médica protegida ya no podría estar protegida bajo la ley. Tambien comprendo

que Celebration Foot & Ankle Institute no puede poner condiciones a la disposición de tratamiento, pago, inscripción en el plan de salud o elegibilidad de beneficios en la disposición de esta autorización. Comprendo que yo recibiré una copia firmada de este formulario.

_____ _____

Patient Signature/Firma del paciente Date/Fecha Witness Signature/Firma del testigo Date/Fecha

☐ I wish to revoke this authorization. Signature:_____ Date: _____

☐ Deseo revocar esta autorizacion. Firma: _____ Fecha: _____

Patient Name: _____ Date of Birth: _____

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Private Practices describes how we may use and disclose your protection health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. 'Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your healthcare bill, to support the operation of the physician's practice, and any other use required by law.
Treatment: We will use and disclose your protected health information to provide coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, if necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situation without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law

Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will be made only with your consent, authorization, or opportunity to object unless required by law.
You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in this authorization.

CELEBRATION Foot & Ankle INSTITUTE

Your Rights:
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records, psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.
Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**
We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices.

Print Name: _____
Signature: _____ **Date:** _____

CELEBRATION FOOT AND ANKLE INSTITUTE

Patient Name: _____ **Date:** _____

Clinical History- Please Complete

List all medications you are taking at present time Medication Dosage Taken For	List physicians seen in the last 5 years (list most recent first) Name Seen For
1. _____ 2. _____ 3. _____ 4. _____ 5. _____	1. _____ 2. _____ 3. _____ 4. _____ 5. _____

List Any Allergies

How would you rate your general health?	Do you Smoke?	Do you Drink?
€ Good € Fair € Poor	€ Yes € No If yes, how much?	€ Yes € No If yes, how much?

Have you ever had an alcohol or drug abuse problem?	Have you ever used intravenous (IV) drugs?	Have you been expose to HIV (AIDS virus)?
€ Yes € No	€ Yes € No	€ Yes € No

Note: This is a confidential record of your medical history and will be kept in this office. Information contained herewith will not be released to anyone unless you authorize us to do so.

Medical History: Have you ever had any of the following? Please circle **YES** or **NO** to all questions.

Childhood Diseases			Cardiac Diseases			Infections		
Measles	Yes	No	Heart Attack	Yes	No	After Surgery	Yes	No
Chicken Pox	Yes	No	Angina	Yes	No	Hepatitis	Yes	No
Whooping Cough	Yes	No	Heart Murmur	Yes	No	Venereal Disease	Yes	No
Scarlet Fever	Yes	No	Arrhythmia	Yes	No	HIV (AIDS)	Yes	No
Rheumatic Fever	Yes	No	Valve Problems	Yes	No	Osteomyelitis	Yes	No
Other _____			Other _____			Other _____		
Metabolic Diseases			GI Diseases	Yes	No	Blood Disorders		
Diabetes	Yes	No	Ulcer	Yes	No	Anemia	Yes	No
High Blood Pressure	Yes	No	Gallbladder	Yes	No	Clotting Problems	Yes	No
Thyroid Disease	Yes	No	Hiatal Hernia	Yes	No	Hemophilia	Yes	No
Osteoporosis	Yes	No	GI Bleeding	Yes	No	Other _____		
Other _____			Obstruction	Yes	No	Arthritis		
Pulmonary Diseases			Other _____			Rheumatoid	Yes	No
Pneumonia	Yes	No	Urological Diseases			Osteoarthritis	Yes	No
Asthma	Yes	No	Urinary Tract Infection	Yes	No	Gout	Yes	No
COPD	Yes	No	Kidney Stones	Yes	No	Other _____		

Tuberculosis	Yes	No	Dialysis	Yes	No	Miscellaneous		
Other _____			Other _____			Blood Clots	Yes	No
CNS Diseases			Cancer			Thrombophlebitis	Yes	No
Stroke	Yes	No	If yes, Location _____			Any Other Disease	Yes	No
Seizure	Yes	No	Year Diagnosed _____			List _____		
Other _____			Reoccurrence	Yes	No	_____		
			Current Treatment	Yes	No	Prior Blood Transfusion	Yes	No
						If Yes, Year _____		

Surgical History

Have you had previous surgery? □ Yes □ No

If yes, what type?	Year		Year
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

Hospitalizations

Have you ever been hospitalized for any illness other than surgery or child birth? □ Yes □ No

If yes, Please list: Diagnosis	Year		Year
1. _____	_____	3. _____	_____
2. _____	_____	4. _____	_____

Review of Systems (Please circle Yes or No for all categories)

Musculoskeletal			Heent			Respiratory			Neurological		
Fracture/Broken Bone	Yes	No	Impaired Sight	Yes	No	Cough	Yes	No	Weakness	Yes	No
Body Part: _____			Headache	Yes	No	Shortness of Breath	Yes	No	Temporary	Yes	No
Sprains	Yes	No	Skin			Gastroenterological			Paralysis	Yes	No
Body Part: _____			Frequent Rashes	Yes	No	Spitting up Blood	Yes	No	Temporary Loss	Yes	No
Dislocation	Yes	No	Psoriasis	Yes	No	Constipation	Yes	No	Of Sight	Yes	No
Body Part: _____			Immunological/			Diarrhea	Yes	No	Psychiatric		
Back Injury	Yes	No	Lymphatics			Heartburn	Yes	No	Depression	Yes	No
Concussion/Head Injury			Frequent Infections	Yes	No	Rectal Bleeding	Yes	No	Schizophrenia	Yes	No
Constitutional			Swelling of Feet	Yes	No	Black Stool	Yes	No	Hospitalization for		
Night sweats	Yes	No	Cardiological			Genitourinary			Psychiatric Illness	Yes	No
Abnormal Thirst	Yes	No	Dizziness	Yes	No	Frequent Urination	Yes	No	Bipolar Disorder	Yes	No
			Fainting	Yes	No	Painful Urination	Yes	No	Drug Abuse	Yes	No
			Chest Pain	Yes	No				Alcohol Abuse	Yes	No

OB/GYN (Woman Only)

Is there any chance you could be pregnant? □ Yes □ No □ Not Sure	Taking Estrogen? □ Yes □ No
Any history of abnormal menstrual cycle? □ Yes □ No	Menopause? □ Yes □ No If yes, What year?

Family History

	If Living		If Deceased	
	Age	Health	Age At Death	Cause
Father				
Mother				
Brother/Sister				
Brother/Sister				
Brother/Sister				
Brother/Sister				

Has any blood relative ever had any of the following?

Heart Problems □ Yes □ No Who? _____

Diabetes □ Yes □ No Who? _____

High Blood Preassure □ Yes □ No Who? _____

Stroke □ Yes □ No Who? _____

Epilepsy □ Yes □ No Who?_____

Tuberculosis □ Yes □ No Who?_____

Cancer □ Yes □ No Who? _____