A Step Ahead Foot & Ankle Center

Dr. Schulte - Dr. Johnson - Dr. Overman – Dr. Lehrman – Dr. Whiting

Welcome To Our Office

Patient Information:

Patient's Legal Name: _____ **Preferred Name**: _____

Address: _____ **City**: _____**State**: _____ **Zip Code**: _____

Date of Birth: _____ **M** ____ **F** ____

Home Phone: _____ **Cell Phone**: _____ **Work Phone**: _____ **Ext**: _____

Marital Status: Single ____, Married ____, Divorced ____, Widowed____, Other ____

Employer: _____ **Email:** _____

Appointment Reminders:

Check **ONLY one** of the following for your appointment reminder preference:

Home (Call) ___, Cell (Call) ___, Work (Call) ___, Text ___, or *Patient Portal* ____

***Patient Portal*reminders requires set up on the patient portal. If not done you will not receive the reminders.**

Can we leave you a detailed voicemail at the phone number you provided? Yes ____ No ____

How did you hear about us?

How did you hear about us? _____

Primary Care Physician: _____ **Date Last Seen**: _____

Did your primary care physician refer you to us? Yes _____ No _____

Insurance Information:

Are you the Primary on your insurance? Yes ____ No ____

If No, Name: _____ Date of Birth: _____ Relationship: _____

Emergency Contact:

Name: _____ **Relationship**: _____ **Phone**: _____

Meaningful Use for Electronic Medical Records:

Race: Alaska Native ____, American Indian ____, Asian ____, Black or African American ____, White ____,
Other ____: _____, Decline to Specify ____

Ethnicity: Hispanic or Latino ____, Not Hispanic or Latino ____, Decline to Specify ____

Preferred Language: English ____, Spanish ____, Other ____: _____

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To ensure complete medical history, please complete ALL Sections of this form.

Patient Name: _____

If female, could you be pregnant? □ Yes □ No

Medications:

List all medications you are currently taking or provide a list to be photocopied.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Injuries:

1. _____
2. _____
3. _____
4. _____
5. _____

Allergies and reactions:

□ Sulfa _____ □ Latex _____

□ Penicillin _____ □ Aspirin _____

□ Silver _____ □ Codeine _____

□ Tylenol _____ □ Adhesive _____

□ Contrast Iodine _____ □ Local Anesthesia _____

□ Erythromycin _____ □ Clindamycin _____

□ Augmentin _____ □ Ibuprofen _____

□ Other: _____

Surgeries:

1. _____
2. _____
3. _____
4. _____
5. _____

Hospitalizations:

1. _____
2. _____
3. _____
4. _____

Medical History:

□ Peripheral Vascular/Artery Disease, □ High Blood Pressure

□ High Cholesterol, □ Osteoarthritis, □ Rheumatoid Arthritis

□ Peripheral Neuropathy, □ Congestive Heart Failure

□ Polio, □ Epilepsy, □ Gout, □ Raynaud's phenomenon

□ Tuberculosis, □ Rheumatic Fever, □ Alcoholism,

□ Drug Addiction, □ Hepatitis, Type: _____,

□ Heart Attack, Year: _____

□ Blood Clot, Location: _____

□ Cancer, Type: _____

□ Diabetes, Type: _____, Age of diagnosis: _____

Last A1C Result: _____

□ Other: _____

Family History:

Mother	Father
□ Living □ Deceased	□ Living □ Deceased

Diabetes	□ Mother □ Father
High Blood Pressure	□ Mother □ Father
Heart Disease	□ Mother □ Father
Stroke	□ Mother □ Father
Cancer	□ Mother □ Father
Gout	□ Mother □ Father
Other	□ Mother □ Father

Social History:

How often do you drink alcohol?

□ Never, □ Monthly or less, □ Two to four times a month

□ Two to three times per week, □ Four or more times a week

Do you use tobacco products?

□ No, □ Former Smoker, □ Current Smoker, □ Loose Tobacco, □ Pipe Tobacco

If a current smoker, how many cigarettes do you smoke a day?

□ 1-9 a day, □ 10-19 a day, □ 20-39 a day

Are you interested in quitting? □ Yes, □ No, □ Maybe

Signature of Patient/Responsible Party: _____ Date: _____

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Patient Name: _____

Height: _____ Weight: _____ Shoe Size: _____

SHOE TYPE (most common): ☐ Tennis ☐ Dress ☐ Heels ☐ Flats ☐ Boots ☐ Sandals ☐ Other _____

What is your present foot or ankle problem? _____

HOW LONG have you noticed it? ☐ Days ☐ Weeks ☐ Months ☐ Years How many? _____

HOW did it start? ☐ Gradual ☐ Sudden ☐ Intermittent ☐ Injury—Date:_____ ☐ Other_____

WHEN does it bother you the most? ☐ Morning ☐ Night ☐ Midday ☐ Running ☐ Walking

☐ Other _____

TYPE of pain: ☐ Constant ☐ Intermittent ☐ Sharp ☐ Dull ☐ Achy ☐ Throbbing ☐ Tingling ☐ Burning

☐ Other _____

IS IT: ☐ Worsening ☐ Improving ☐ Staying the same

RATE the pain (0 = no pain, 10 = worst pain of your life): 0 1 2 3 4 5 6 7 8 9 10

TREATMENT: ☐ OTC inserts ☐ Custom orthotics ☐ Lessening activities ☐ Ice ☐ Heat ☐ Bracing/Splinting

☐ Cast boot/Surgical shoe ☐ Soaking ☐ Physical Therapy ☐ Chiropractic ☐ Acupuncture

☐ Prescription medication _____

☐ Over the counter/At home treatment: _____

☐ Other _____

WHAT MAKES IT WORSE? _____

WHAT MAKES IT BETTER? _____

WHAT MADE NO CHANGE? _____

HAVE OTHER PHYSICIANS EVALUATED YOUR CONDITION? ☐ Yes, ☐ No, WHO? _____

FOR THIS ISSUE, HAVE YOU HAD ANY: ☐ X-RAYS ☐ MRIs ☐ CT scans ☐ Ultrasound

LOCATION/DATE (mm/yyyy) of testing: _____

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HIPAA & General Consent

ONLY COMPLETE this box section if Legal Parent/ Guardian or POA Information:

ONLY complete the information in this boxed section **if you are financially/ legally responsible for the patient**.
If you are the patient's Power of Attorney, POA, we do need to scan a copy of that paperwork into the patient's chart for our records.

First and Last Name of Responsible Party: _____

Relationship: _____ Date of Birth: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Signature of Parent/guardian or POA: _____

Authorization to Treat a Minor:

By signing below I authorize A Step Ahead Foot & Ankle Center to treat the named minor for any medical care without an adult being present.

Signature of Parent/guardian or POA: _____

Pharmacy and Medication History:

The providers at A Step Ahead Foot & Ankle Center use an electronic medical record system that allows electronic prescribing of medications. To optimize the use of this electronic capability, and coordinate your care between us, your family practice physician, and other specialists, we ask that patient's allow us to access their external medication history through the Rx Hub.

Preferred Pharmacy: _____

Please check only one of the following:

_____ I consent to allow A Step Ahead Foot & Ankle Center to access all of my medication history.

_____ I DO NOT CONSENT for A Step Ahead Foot & Ankle Center to access any of my medication history.

Authorization to Release Protected Information:

My emergency contact may be added to receive my protected health information if necessary? Yes_____ No _____

I authorize the following additional people who may receive my protected health information. I understand I may revoke this authorization at any time by giving written notification to this office.

Name: _____ Relationship: _____

Name: _____Relationship: _____

Acknowledgement of Receipt of Notice of Privacy Practices (HIPAA)

I acknowledge that I was provided a copy of the Notice of Privacy, which is located on the office website, and that I have read (or had the opportunity to read if I so choose) and understand the notice.

Signature of Patient/Responsible Party: _____ Date: _____

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Financial Policy

Thank you for choosing A Step Ahead Foot & Ankle Center for your care. Due to increase insurance company demands, we ask you to read and agree to the following provisions:

Referrals- If your insurance plan requires a referral from your primary care physician, it is **your** responsibility to obtain it prior to your appointment and have it faxed to our office. If you do not obtain your referral, you will be responsible for the visit charges **in full at the time of service.**

Appointments- as a courtesy, we attempt to contact every patient to remind them of their appointment. **Three (3) missed appointments result in a missed appointment fee of $25 and or dismissal from our practice.** For the hearing impaired, if you **miss more than one (1) appointment or reschedule/cancel within 48 hours of your scheduled appointment, you will be billed for the interpreter fee in full (if applies).**

Insurance- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you. This allows the insurance company to pay the doctor's office directly. **Any amount remaining after filing with the insurance company will be your responsibility.**

Co-Payments- Our policy is to collect your portion of the insurance designated co-payment **at the time of service.**

Out of network benefits- If we do not participate with your plan, but you would like to be treated in our office, we will send a courtesy bill to your carrier on your behalf. **Payment for services provided is required in full at the time of service.**

Services Not Covered by Your Insurance Plan- Services not covered by your insurance plan are **your responsibility and are to be paid in full at the time of service.**

Private Pay Patient- If you have no insurance coverage, or do not wish to bill your insurance company, **full payment for services provided is required at the time of service.** We accept personal checks (no third-party checks), cash, and Visa, Master Card, Discover, and American Express. We no longer accept Care Credit.

Authorization of Additional Treatments- I authorize A Step Ahead Foot & Ankle Center to perform, examine, diagnose, and/or treat my foot/ankle problem. I also authorize the taking of and the use of clinical photographs. It is understood that these photos may be used to further medical education and my identity will not be revealed. I further understand that these photos are property of A Step Ahead Foot & Ankle Center

Delinquent Accounts- Account balances are to be paid off within 30 days. **Past due accounts are subject to collection proceedings without further notice if unpaid after 60 days. In the event your account is turned over to collections, you are responsible for all associated collection costs and late fees.**

Returned Checks- Returned checks are subject to a **$20.00** fee.

Laboratory Fee- Laboratories bill separately for their services. Any lab services that are not covered by your insurance will be your responsibility.

Address and Insurance Changes- Please let us know if you have any changes in your phone number, address, insurance, etc., so your information is always current in our records.

Divorce/ Custody- Our policy is to hold the parent who brings the child in for medical treatment responsible for payment at the time of service. Our office does require documentation from the court for all legal matters that relate to your child's care; i.e. custody, medical decisions, medical record access, etc.

I have read and understand this financial policy and agree to the terms. I understand that I am financially responsible for all charges incurred in the event my insurance denies payment after a claim has been submitted by A Step Ahead Foot & Ankle Center. I understand that my insurance is an agreement between myself and my insurance company, and that it is my responsibility to understand my benefits. I hereby authorize A Step Ahead Foot & Ankle Center to release my medical information and necessary data pertinent to the filling of insurance papers in the interest of the patient and the facility. I authorize my insurance carriers to pay benefits to A Step Ahead Foot & Ankle Center on any unpaid services filed on my behalf by A Step Ahead Foot & Ankle Center. I also understand A Step Ahead Foot & Ankle Center is not ultimately responsible for collecting my insurance or negotiating settlements of claims.

Signature of Patient/Responsible Party: _____ Date: _____