



**Foot and Ankle Associates  
of Florida**  
Medicine and Surgery of the Foot and Ankle

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**PERSONAL INFORMATION (Please Print)**

Patient's Name (Last)		First	Middle Initial	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Today's Date
Residence Address		City	State	Zip	Patient Age
Date of Birth	Patient's SS# (Guardian's SS# if child)		Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		
Mailing Address (If Different from Above)					
Home Phone No.	Work Phone No.	Emergency Contact & Phone No.			
Name of Employer (Guardian's Employer if a Minor)			Occupation	Business Phone	
Person Responsible for Account <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Guardian <input type="checkbox"/> Parent	Name			Employer Phone No.	
How did you hear about us? (Please give name, address and phone of friend, doctor, etc.)					

**INSURANCE INFORMATION (Insurance Card will be Copied)**

MEDICAL INSURANCE		SECONDARY MEDICAL INSURANCE	
Insurance Company Name		Insurance Company Name	
Name of Policy Holder		Name of Policy Holder	
Policy Holder Date of Birth	Policy Holder Employer	Policy Holder Date of Birth	Policy Holder Employer
Policy No.	Group No.	Policy No.	Group No.

**MEDICAL INFORMATION**

List any medical conditions you have (allergies, impairments, etc.) What medicines do you take regularly (including birth control, if applicable):?

Name of Family Physician	Phone	Are you currently under your physician's care? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, for what?			
Have you had previous treatment by a podiatrist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last visit:	Reason for last visit:	
Name and address of previous podiatrist:			
My chief foot complaint is:			
If your injury is due to an accident, was it: <input type="checkbox"/> Work Related <input type="checkbox"/> Auto <input type="checkbox"/> Other (Describe)			Date of Injury
HOW LONG HAS THIS CONDITION EXISTED:	Days	Weeks	Months
			Years

I hereby give **Foot and Ankle Associates of Florida** permission to examine and treat me. I also authorize the release of any medical information necessary to process my claim. I hereby request payment of any insurance or 3rd party benefits that I am entitled to be made directly to **Foot and Ankle Associates of Florida** for any services furnished to me during the course of my treatment.

Patient, Parent or Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

# LIFETIME AUTHORIZATION FOR MEDICARE

\_\_\_\_\_  
(Patient's Name)

\_\_\_\_\_  
(Patient's Medicare Number)

I hereby request payment of authorized Medicare benefits and/or any other insurance benefits to be made either to me or my behalf to \_\_\_\_\_ (physician) for any services furnished me by \_\_\_\_\_ (physician). I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine this benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the medicare carrier.

\_\_\_\_\_  
(Patient's Signature)

\_\_\_\_\_  
Date

# MEDIGAP AUTHORIZATION FORM

\_\_\_\_\_  
(Name of Beneficiary)

\_\_\_\_\_  
(Health Insurance Claim)

\_\_\_\_\_  
(Medigap Policy Number)

I request that payment of authorized medigap benefits be made on my behalf to \_\_\_\_\_ (physician's name) for the services furnished me by \_\_\_\_\_ (physician's name). I authorize any holder of medical information about me to release to \_\_\_\_\_ (name of medigap insurer) any information needed to determine these benefits or the benefits payable for related services.

\_\_\_\_\_  
(Patient's Signature)

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer Phone # ( \_\_\_\_\_ ) \_\_\_\_\_ Contact Person \_\_\_\_\_

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## GENERAL MEDICAL HISTORY

Please indicate whether you have a personal or family medical history of any of the following:

Problem	Yes, Personal History	Yes, Family History
AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>
Allergy to anesthetics	<input type="checkbox"/>	<input type="checkbox"/>
Allergy to drugs	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis, osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis, rheumatoid	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valve	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Back problems	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding disorders	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Chemical dependency	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
Circulation problems	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea, chronic	<input type="checkbox"/>	<input type="checkbox"/>
Ear, hearing problems	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Eye problems	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Foot cramps	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>
Headaches, chronic	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Problem	Yes, Personal History	Yes, Family History
Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>
Leg cramps	<input type="checkbox"/>	<input type="checkbox"/>
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Nervous problems	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric disorders	<input type="checkbox"/>	<input type="checkbox"/>
Radiation treatment	<input type="checkbox"/>	<input type="checkbox"/>
Rash, chronic	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory disease	<input type="checkbox"/>	<input type="checkbox"/>

- |                             |                          |                          |
|-----------------------------|--------------------------|--------------------------|
| Rheumatic fever             | <input type="checkbox"/> | <input type="checkbox"/> |
| Shortness of breath         | <input type="checkbox"/> | <input type="checkbox"/> |
| Sinus problems              | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Swelling, ankle(s), chronic | <input type="checkbox"/> | <input type="checkbox"/> |
| Swelling, foot, chronic     | <input type="checkbox"/> | <input type="checkbox"/> |
| Swelling, leg(s), chronic   | <input type="checkbox"/> | <input type="checkbox"/> |
| TB                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Ulcers, skin                | <input type="checkbox"/> | <input type="checkbox"/> |
| Ulcers, stomach             | <input type="checkbox"/> | <input type="checkbox"/> |
| Varicose veins              | <input type="checkbox"/> | <input type="checkbox"/> |
| Venereal disease            | <input type="checkbox"/> | <input type="checkbox"/> |
| Weight loss, unexplained    | <input type="checkbox"/> | <input type="checkbox"/> |
| Other: _____                | <input type="checkbox"/> | <input type="checkbox"/> |
| Other: _____                | <input type="checkbox"/> | <input type="checkbox"/> |

List the surgeries you have had (both minor and major): \_\_\_\_\_

\_\_\_\_\_

List any hospitalizations (other than for the surgeries above) you have had: \_\_\_\_\_

\_\_\_\_\_

Are you now, or have you been, under any other doctor's care for any reason over the past two years? Yes \_\_\_ No \_\_\_

If yes, please list the names of your doctors (including your primary care physician – PCP):

PCP: \_\_\_\_\_ City \_\_\_\_\_

Other Physicians: \_\_\_\_\_

\_\_\_\_\_

## MEDICATIONS

Please list all prescription and over-the-counter medications you are currently taking:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## ALLERGIES

Please check any known allergies you may have.

- |                   |                          |
|-------------------|--------------------------|
| Adhesive tape     | <input type="checkbox"/> |
| Aspirin           | <input type="checkbox"/> |
| Codeine           | <input type="checkbox"/> |
| Eggs              | <input type="checkbox"/> |
| Iodine            | <input type="checkbox"/> |
| Local anesthetics | <input type="checkbox"/> |
| Novocain          | <input type="checkbox"/> |

- Penicillin
  - Rubber
  - Shellfish
  - Sulfa
  - Other: \_\_\_\_\_
  - Other: \_\_\_\_\_
  - Other: \_\_\_\_\_
- 

## CONSENT

I certify that the above information is true and correct to the best of my knowledge.

I give my permission for Foot and Ankle Associates of Florida to examine, photograph, administer and perform such minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of my foot and/or ankle problems.

\_\_\_\_\_  
Patient or Guardian's Signature

\_\_\_\_\_  
Date



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Robert J. Duggan, D.P.M., F.A.C.F.A.S.  
Duane McRone, D.P.M.

**Financial Policy**

Welcome to our office. We are committed to provide you with the best possible care and to establish a mutual understanding regarding the financial policies of this office. In order to achieve these goals, we need your assistance and understanding of these policies. Your signature below indicates that you have read, understand and agree that:

Co-payments and/or deductibles are due at the time the service is rendered unless arrangements have been made in advance. For your convenience we accept cash, checks, and certain credit cards.

Your insurance is a contract between you, your employer and the insurance company. We are generally not a part of that contract. Foot and Ankle Associates of Florida participates with a limited number of insurance contracts. It is the patient's responsibility to assure that we are a participating provider on your plan. Due to the constant changes in provider lists, you are encouraged to verify this information prior to each visit to our office. You will be responsible for benefits that have been reduced or denied due to our participation status with your plan. If we are not a participating provider under your agreement, full payment is required at the time services are rendered. We will be happy to provide you with an itemized statement so that you may file your claim.

Not all services and supplies provided by your Physician may be considered covered benefits under your insurance contract. You are encouraged to review and understand your policy coverage. You understand that you will be held financially responsible for the payment of such services or supplies if they are determined to be cosmetic in nature or otherwise not a covered benefit.

In certain instances, we may not be able to secure a guarantee from your insurance company that they will reimburse us for certain Durable Medical Equipment items to be provided to you. We will require that you pre-pay for these items, and upon receipt of payment from your insurance company, we will be happy to issue you a refund, or we will provide you with an itemized receipt so that you may file your claim.

If you are covered by Medicare, we will file and accept assignment on your claim. You will be responsible for your deductible and 20% co-insurance as dictated by Medicare. Our practice does accept a limited number of Medicare Secondary Insurance policies. We will be happy to file the claim to your secondary carrier for those policies that we accept. If we do not accept your secondary coverage, we will be pleased to provide you with an itemized bill to assist you in filing your own claims.

This practice imposes a returned check fee calculated to the maximum as allowed by law. If you have made payment on your account with an NSF check, we will be unable to schedule your non-emergent appointment until all past due amounts and fees have been paid in full. Future payments will be honored when made with cash, money order or credit card only.

Balances that are the responsibility of the patient and which are not paid in 120 days will be referred to our collection agency. Please help us protect your credit record by promptly paying any balance that you may owe.

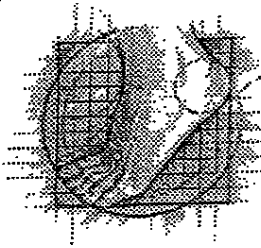
We want you, our patient to know that we will assist you in any way we can. If you have any questions, PLEASE don't hesitate to ask us. We will gladly discuss your proposed treatment costs and any questions you may have regarding your insurance. We ask however that you DO NOT discuss finances with the doctor, but direct those questions to our business coordinator.

Thank You!

\_\_\_\_\_  
Patient Signature (Parent if a minor)

\_\_\_\_\_  
Patient Printed Name

\_\_\_\_\_  
Date



# Foot and Ankle Associates of Florida

Medicine and Surgery of the Foot and Ankle

## Request for Confidential Communication of Protected Health Information

I, \_\_\_\_\_,

Patient Name (Please Type or Print)

hereby request and authorize that confidential communication of protected health information be disclosed to the following individual.

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Patient Name (Signature)

\_\_\_\_\_  
(Date)

# Foot and Ankle Associates of Florida

## Consent to Use and Disclosure of Protected Health Information

### Use and Disclosure of Your Protected Health Information

Your protected health information will be used by **Foot and Ankle Associates of Florida** or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

### Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

### Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information.

**Foot and Ankle Associates of Florida** may or may not agree to restrict the use or disclosure of your protected health information.

If **Foot and Ankle Associates of Florida** agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

### Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

### Reservation of Right to Change Privacy Practices

**Foot and Ankle Associates of Florida** reserves the right to modify the privacy practices outlined in the notice.

### Signature

I have reviewed this consent form and give my permission to **Foot and Ankle Associates of Florida** to use and disclosure my health information in accordance with it.

\_\_\_\_\_  
Name of Patient (Print or Type)

\_\_\_\_\_  
Signature of Patient