InStride Gaston Foot & Ankle Associates

251 Wilmot Dr.
Gastonia, NC 28054
Phone: 704.861.0425 Fax: 704.861.0274
Website:Gastonfoot.com

Patient Name:_____DOB:_____SSN:_____Gender: ___

Address: _____

City:_____ State: _____ Zip: _____

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

Marital Status : □ single □ married □ divorced □ widowed

Email Address:_____(Permission granted to use email for contacting)

Patient's Height:_____ Weight:_____ Shoe Size:_____ Shoe Width:_____

Primary Language: _____ Ethnicity: _____

Family Doctor:_____Last Visit:_____

Pharmacy:_____Location:_____Phone:_____

Employment Information

Employer Name:_____Occupation:_____

Is insurance through this employer? YES NO

SSN of Insurance Subscriber (Tricare Insurance only): _____

How did you hear about our office?

Doctor / Word of Mouth / Website / Sign / Newspaper / Yellow Pages / Other: _____

If Doctor or Word of Mouth: Whom may we thank for referring you to our office? _____

What is your main foot or ankle complaint?_____

How long has it been going on? **Days / Weeks / Months / Years**

Is this condition affecting your ability to perform daily tasks? **Yes / No**

Are you currently experiencing or suffering from:

□ Flat Feet
□ Pain/Fatigue of feet/legs with activity
□ Leg pain (shin splints)
□ Ankle swelling/stiffness
□ Pain in feet getting out of bed
□ Heel or arch pain
□ Knee, hip or back pain
□ Achilles tendon pain
□ "Toe-in"/"toe-out"/"tip-toe walking
□ Ankle instability (easy twisting foot or ankle)
□ Poor Coordination/ Balance/Falling
□ Coldness in legs/feet
□ Discoloration of toes/feet
□ Slow healing sore on leg/foot
□ Burning in toes/feet/legs
□ Numbness, tingling in feet/toes
□ Other: _____
_____
_____
_____

Patient Name:_____ Date of Birth: _____

Medications

□ **No Current Medications**

□ Please See List Attached

Drug Name	Strength (mg)	How Often?	Prescribed by:

Are you pregnant or a possibility you might be pregnant? _____

Past Medical History (Please check **all** that apply)

□ **None of the following apply**

□ Anemia
□ Arthritis
□ Asthma
□ Blood Clotting Abnormalities
□ Cardiac Disease
□ Circulation problems
□ Congestive heart failure
□ Deep Vein Thrombosis (DVT)
□ Depression
□ Diabetes: □ I □ 2 □ Diet
□ Fibromyalgia
□ Fracture, where? _____
□ Gout
□ Heart Valve disease/replacement
□ Hepatitis
□ High cholesterol
□ HIV/AIDS
□ Hypertension (High Blood Pressure)
□ Kidney problems/dialysis
□ Lung disease
□ Migraines
□ History of MRSA
□ Neuropathy
□ Osteoporosis
□ Phlebitis
□ Polio
□ Psoriasis
□ Respiratory Problems
□ Restless Leg Syndrome
□ Rheumatic Fever
□ Seizure disorder
□ Sickle Cell
□ Skin problems
□ Stomach Reflux
□ Stroke
□ Thyroid disease
□ Tuberculosis
□ Ulcer (stomach/duodenal)
□ Varicose veins
□ Vascular disease
□ Cancer : _____
□ Other problems not listed? _____

Past Surgical History (Please check **all** that apply)

□ Amputation of Extremity
□ Back Surgery
□ Carotid Artery Surgery
□ Foot Surgery
□ Heart Surgery
□ Hip Surgery / Replacement
□ Knee Surgery / Replacement
□ Organ Transplant
□ Vascular Surgery

Family History

Arthritis:	□ Mother	□ Father	Hypertension:	□ Mother	□ Father
Cardiac Disease:	□ Mother	□ Father	Osteoporosis:	□ Mother	□ Father
Circulation Problems:	□ Mother	□ Father	Psoriasis:	□ Mother	□ Father
Diabetes:	□ Mother	□ Father	Restless Leg Syndrome	□ Mother	□ Father

Allergies or Sensitivities Please check any drug/medication allergies you may have:

□ **No known drug allergies** □ Aspirin □ Codeine □ Latex □ Lidocaine □ Penicillin □ Sulfa □Other:_____

Smoker Status:

□ Current every day smoker □ Current some day smoker □ Former Smoker □ Never smoker
□ Heavy tobacco smoker □ Light tobacco smoker

Alcohol Use: □ Never □ Rarely □ Socially □ Daily □ Weekly □ Former

Patient Name:_____ Date of Birth: _____

Financial Policy

For patients with insurance:

- I have provided correct insurance information and understand I will be **responsible for payment at time of service** if I fail to disclose correct information to InStride Gaston Foot & Ankle Associates (GFA).
- I authorize GFA to file a computerized claim form (paper or electronic) on my behalf.
- I authorize benefits to be paid to me or on my behalf to the provider for the covered services. I authorize GFA to pursue a formal appeal or grievance on my behalf for any denied claim that they feel should not be denied. If my insurance fails to respond to the claim within **60 days,** GFA reserves the right to collect full payment from me.
- I also agree to be responsible for any **co-payments**, **co-insurance, unmet deductibles, and non-covered services or supplies and understand that payment is due at the time of service.** Re-billing and collecting fees may apply for past due accounts.

  Note: We recognize it is difficult to understand many of the points in today's insurance policies, with new plans and companies emerging constantly. Our office staff will make every attempt to follow the guidelines required by your insurance company. However, please understand that the contract is made between the insurance company and the patient**.** Therefore, it is **your responsibility** to know and understand the details of your specific coverage.

For patients with Medicare

- As a participating provider of Medicare Plan B (Physician Services), GFA will only bill me for my Medicare coinsurance, deductible and any services rendered but not covered by Medicare. All other services will be billed directly to Medicare. I will be required to pay the co-pay/co-insurance and deductibles for authorized services at the time of service.
- Note: I will be informed of services not covered by Medicare prior to these services being rendered. My signature upon the appropriate Medicare Waiver form represents my authorization for the physician to perform these services and my acceptance of the financial responsibility for these services.
- If I have Medicare Part A only, then the services I will receive from the practice will not be covered by Medicare.

For patients with Medicare and have changed to an HMO Insurance Policy (Medicare replacement plan):

- I understand that if GFA does not participate with my HMO plan, I may be responsible for **payment in full** if there are no out-of-network benefits.

For patients without insurance, or on a plan that GFA does not participate with:

- I understand that GFA financial policy requires payment **in full at time of service.**

Late Cancellation or No Show Fees:

- There will be a $25 fee for any appointment cancelled with less than 24 hours' notice or any appointment missed without prior communication to GFA.

Payments:

- GFA accepts Discover, MasterCard, Visa, American Express, debit cards, personal check, and cash.
- If I am unable to pay my balance in full when due, I understand I need to contact GFA's **billing department immediately at 704-861-0425**. I understand that failure to make payment on my account as required every 30 days will require further action to collect the balance in full and my credit rating will be affected. I understand that if regular monthly payments are not received, and no payment arrangements are made, GFA will no longer be able to extend credit to me for future visits and that an additional collection agency fee will also be added to the outstanding balance at the time of transfer to collections

I have read the above financial policy in full and agree to comply with all the listed policies.

_____ _____

Signature of Patient or Authorized Representative Date

Thank you for complying with these policies so that we can keep your costs as low as possible.

Patient Name:_____ Date of Birth: _____

Notice of Privacy Practices

I acknowledge that I was offered, or provided, a copy of the Notice of Privacy Practice and that I have read (or had the opportunity to read if I so chose) and understand this Notice.

_____ _____

Patient Signature, Parent or Authorized Representative Signature Date

Authorization for Release of Information to Family and/or Friends (*Optional Section)*

InStride Gaston Foot & Ankle Associates is authorized to discuss my medical care and may release my confidential protected health information (PHI) to the following:

Entity to Receive Information Check each person/entity that you approve to receive information	**Information to be released** Check what information each person/entity can have access to
☐ Spouse (provide name & phone number)	☐ Any information ☐ Information as follows: _____
☐ Parent (provide name & phone number)	☐ Any information ☐ Information as follows: _____
☐ Other (provide name & phone number)	☐ Any information ☐ Information as follows: _____
☐ **Family Doctor** (provide name & phone number) Approximate date of last visit: _____	☐ Any information ☐ Information as follows: _____ ☐ A copy of our physician's note from this visit

Rights of the Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect a copy of the protected health information to be disclosed as described in this document by sending written notification to **InStride Gaston Foot & Ankle Associates, Medical Records, Attn: Security Officer; 251 Wilmot Dr. Gastonia, NC 28054.** I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward from the date on the revocation.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization.

This authorization shall be in force and effect until revoked by the patient or representative signing the authorization on behalf of the patient

_____ _____

Signature of patient or personal representative Date

(Personal representative must provide proof of authority over patient)

Patient Name:_____ Date of Birth: _____

Welcome New Patient

Our practice is a division of InStride Foot & Ankle Specialists, PLLC. We have divisions across the state and we operate under one tax ID number. As such, if you have seen any of the following physicians in the past three years, we need to know so that it we will not file a new patient code for your visit today. Since the insurance carriers look at the InStride Foot & Ankle Specialists, PLLC as one large practice, if you have been seen at any of the following divisions, you will not be considered a new patient in our practice. **Visits prior to 2013 do not need to be disclosed.**

Please review the names of the divisions and podiatrists below and indicate if you have been seen at any of these divisions by putting a √ on the line to the left of the practice name. Thank you for disclosing this information to us- it will allow us to be in compliance with nationally mandated correct coding initiatives.

	Division	Podiatrist
	Alta Ridge Foot Specialists	Robert van Brederode, William Broyles
	Ankle & Foot Center of Charlotte	Scott Basinger
	Brunswick Foot & Ankle Surgery, PA	Joseph Kibler
	Carmel Foot Specialists	Barbara Kaiser, Richard Lind, Richard Miller, Kevin Molan
	Carolina Foot Care Associates, PLLC	Ashma Davidson, Terry Donovan, William O'Neill
	Central Carolina Foot & Ankle Associates	Melissa Hill, John Iredale, Gary Liao, Phill Ward
	Chapel Hill Foot & Ankle Associates, P.A.	Nicholas Adams, Jane Andersen, Alan Bocko
	Charlotte Foot & Ankle Specialists, PLLC	Kristine Strauss
	Comprehensive Foot & Ankle Center, P.A.	Zack Nellas
	Crystal Coast Podiatry	Thomas Bobrowski
	Eastern Carolina Medical Center	Scott Matthews
	Eastover Foot & Ankle, P.A.	Chris Fuesy, Ron Futerman, Kent Picklesimer
	Edgewater Medical Center	Scott Matthews
	Family Foot & Ankle Center, P.A.	Patrick Dougherty, Doug Smith
	Family Foot Care	Kevin McDonald, Tori Simmons-Lewis
	Foot & Ankle Ctr of Durham	Eric Simmons
	Foot & Ankle of the Carolinas, PLLC	Eric Ward, Blaise Woeste
	Gaston Foot & Ankle Associates, P.A.	David Kirlin, Ryan Meredith, Wagner Santiago
	Greensboro Podiatry Associates, P.A.	Martha Ajlouny, N'Tuma Jah
	Hendersonville Podiatry	Russ Barone, Pam Stover
	James Mazur, D.P.M., P.A.	James Mazur
	Matthews Foot Care	Brian Killian, Kevin Killian
	Mt. Airy Foot & Ankle Center, PLLC	Jim Shipley
	Piedmont Foot & Ankle Clinic	Rick Hauser, Rob Lenfestey, Jason Nolan, Joel Kelly, Scott Matthews
	Queen City Foot & Ankle Specialists, P.C.	Roxanne Burgess
	Raleigh Foot & Ankle	Alan Boehm, Robert Hatcher, Jordan Meyers, Kirk Woelffer
	Ryan Foot & Ankle Clinic	David Garchar, Jeff Glaser, Michael Ryan, Scott Whitman
	Salem Foot Care	Walter Falardeau
	Wake Foot & Ankle Center	Mike Hodos, Jim Judge
	Wilson Podiatry Associates, PA	Kendall Blackwell

____I attest that I have been seen in the above indicated division of InStride since 01/01/2013

____I attest that to my best recollection, I have not been seen by any of the above divisions/physicians since 01/01/13

Signature of Patient:_____ Date: _____