

Chesapeake Foot and Ankle Center

Patient Name _____ **Birth Date** _____
Last First MI
Age _____ **Height** _____ **Weight** _____ **Shoe Size** _____

Reason for your visit: _____
 How long has this been a problem? _____ It occurs when? Morning Afternoon Evening Off and On All Day
 Please list previous treatments (either prescribed or home remedies): _____

Percent spent daily on your feet: 20% 40% 60% 80% 100%
 List sports/activities that you are currently active in: _____

******Family Physician (PCP):** _____

	Name	Address	Phone Number
Medical History: please circle P (personal history) and/or F (family history).			
P F Alzheimer's / Dementia	P F Hearing Problems	P F Seizures/ Epilepsy	
P F Anemia – type _____	P F Heart Disease	P F STD's (sexually transmitted ds.)	
P F Arrhythmias – type _____	P F Hepatitis A B C /Liver Disease _____	P F Sickle Cell Trait/Disease	
P F Arthritis - type _____	P F High Blood Pressure	P F Stroke/ TIA's	
P F Asthma circle(adult or childhood)	P F High Cholesterol	P F Thyroid problems	
P F Blood Clotting Problems	P F HIV/ Aids/ ARC	(Hyper__ Hypo__)	
P F Cancer - type _____	P F Kidney/ Renal Disease	P F Tuberculosis	
P F Depression / Anxiety disorder / Bipolar depression / other _____	P F Lung Disease/Pulmonary Embolus	P F Other, Please Specify	
P F Diabetes (how long? _____)	P F Lyme's Disease	_____	
P F Emphysema	P F Nervous Condition (type?) _____	P F Other, Please Specify	
P F Glaucoma	P F Osteoporosis	_____	
P F Gout	P F Phlebitis (blood clots in legs)		
P F GERD (Reflux) / GI ulcers (circle)	P F Poor Circulation / PVD	P F NONE of the above	
	P F Rheumatic Fever / Scarlet Fever		

Have you been hospitalized? Y N Please list

Have you ever had surgery? Y N Please list

Do you have a history of allergies/skin reaction/sickness following the administration of any of the following:

	Y	N	** If yes, list REACTION
Adhesive tape	—	—	_____
Anesthesia	—	—	_____
Aspirin	—	—	_____
Caffeine	—	—	_____
Codeine	—	—	_____
Cortisone	—	—	_____
Demerol	—	—	_____
Foods	—	—	_____
Iodine	—	—	_____
Latex	—	—	_____
Local Anesthetics	—	—	_____
Penicillin	—	—	_____
Sulfa Drugs	—	—	_____
Other, please list:			_____

Woman: Are you currently pregnant? YES NO
 Due date? _____

Social History: PLEASE FILL OUT COMPLETELY
SMOKING:

Do you currently smoke? YES NO If yes, how many years? _____
 How long does a pack of cigarettes last you? _____
 Have you ever smoked? _____ If yes, for how long? _____
 How long ago did you quit? _____

ALCOHOL USE:

Do you currently drink alcoholic beverages? YES NO
 Do you drink some form of alcohol every day? YES NO
 How many drinks will you consume in a day? _____ week? _____
 Do you have a history of drinking? YES NO
 How long ago did you quit? _____

RECREATIONAL DRUG USE:

Do you currently use illicit/recreational drugs? _____
 If yes, which ones _____
 Have you ever used illicit/recreational drugs? If yes, please list below.

 How long ago did you quit? _____

Consent for Treatment:

I certify that the information above is true and correct to the best of my knowledge. I have been informed that if I am uncertain about any question on the form I should ask the doctor or a member of the office staff for assistance. I give permission to Drs. Gottlieb, Leone and Nguyen to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet and ankles.

 Patient or Guardian Signature

 Date

Medication/Surgery List

Please list all medications you are currently taking including: aspirin, over the counter medications, herbal products and vitamins.

Medication	Dose	Frequency	Start Date	Stop Date
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

Have you ever had surgery before? YES ___ NO ___

Have you ever been hospitalized? YES ___ NO ___

Please list all previous hospitalizations and surgeries:

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

Patient's Name: _____ DOB: _____

Allergies: _____

FINANCIAL POLICY

☐ **CHESAPEAKE FOOT AND ANKLE CENTER, P.A.**

☐ **CHESAPEAKE AMBULATORY SURGERY CENTER, LLC**

Thank you for choosing our offices to provide you with medical and surgical care. We are committed to serving you with skillful and high quality care. The medical/surgical services provided by our centers are services you have elected to receive which may imply a financial responsibility on your part.

COPAYS. Co-pays are due at the time of service.

SELF PAY. Full payment is due at the time of service for those without health insurance benefits.

MEDICARE. We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. You are responsible for co-payment or deductible amounts as stated by Medicare and your secondary insurance company.

SECONDARY INSURANCE. Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company.

REFERRALS/AUTHORIZATIONS. We are required to follow the guidelines of your managed care plan, which mandates that when you visit a specialist such as ours, you must have a referral from your PCP prior to seeking specialty care. Therefore, you are financially responsible for the services received, unless your referral is presented at the time of this visit. If you do not have a referral from your PCP at the time of the visit, payment for all services received will be due in full upon completion of the visit. Full credit will be given if a valid referral is presented to our office within 48 hours of this visit. You will be given the option to reschedule your appointment.

MEDICAL/DISABILITY FORMS. All Medical/Disability forms require 5-7 business days and an administrative fee of \$10.00 will be charged.

PATIENT BILLING. You will be sent up to three notices for your financial responsibility (co-insurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. All unpaid balances over 45 days will accrue 1½% monthly interest. After the third and last notice, your balance and a \$20.00 processing fee will be forwarded to a collection agency. Please let the billing office (**410-768-5800**) know if you have any difficulties resolving your bill. Payment arrangements can be made on a case by case basis. We accept the following payment methods: Cash, check or VISA/MasterCard. An additional \$25.00 will be added to your statement if your check is returned for insufficient funds. In the event that your insurance company should happen to send payment to you, the patient, please forward it to our office within **5** business days to or you will be responsible for 100% of the charges.

A \$25.00 fee will be assessed for any missed appointments without a 24 -hour cancellation notice.

SURGICAL BENEFITS. Should I require a surgical procedure with Chesapeake Ambulatory Surgery Center, LLC, I authorize the center to and its' representative to review my surgical chart for the purposes of quality and peer review. I am aware that my physician may have ownership in the center and that separate facility fees may apply.

PRIVACY STATEMENT. Any information disclosed in your records will remain confidential and will not be used for any reason except in providing quality care and treatment as well as to submit your claim to your insurance company and contact you as needed.

I have read the above policy regarding my *financial responsibility* to Chesapeake Foot and Ankle Center, P.A./Chesapeake Ambulatory Surgery Center, LLC for providing medical services to me or the below named patient. I agree to pay Chesapeake Foot and Ankle Center, P.A. /Chesapeake Ambulatory Surgery Center, LLC any amount due after insurance payment has been made by my carrier and any contractual adjustments have been credited or the full amount of all bills incurred by me or the below named if no health insurance coverage exists.

ASSIGNMENT OF BENEFITS. I, the undersigned, certify that I (or my dependant) have coverage with my insurance as presented and assign directly to Chesapeake Foot and Ankle Center, P.A./Chesapeake Ambulatory Surgery Center, LLC all insurance benefits payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize **RELEASE OF MEDICAL INFORMATION** to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information.

FINANCIALLY RESPONSIBLE PARTY:

Patient Name: _____

Please Print

Signature

Date: _____