NEW MEXICO Foot & Ankle INSTITUTE

Patient Information

Patient Name: _____ Date: _____

Social Security Number: _____-_____-_____ DOB: _____ Gender: M / F

Address _____

City_____ State _____ Zip _____

Home Phone: _____ Work: _____ Cell: _____

Email: _____ Permission to email? Yes / No

Preferred Method of Communication *(please circle)* Home Phone Work Phone Cell Phone Email

Employment Status: [ ] Employed [ ] Unemployed [ ] Retired [ ] Disabled [ ] Student

Employer: _____ Occupation: _____

Race/Ethnicity: ☐ Asian ☐African American ☐Caucasian ☐Hispanic ☐Pacific Islander ☐Native American ☐Other ☐ Decline

Who do you authorize us to release to/discuss your medical information with?

Name: _____ Phone Number _____

Name: _____ Phone Number _____

Emergency Contact Name **(for emergencies only)**: _____

Contact Phone: _____ Relationship:_____

Billing & Insurance Information

Primary Insurance name: _____

Policy# _____ Group #: _____

Policy Holder Name: _____ DOB: _____Relationship: _____

Secondary Insurance name: _____

Policy# _____ Group #: _____

Policy Holder Name: _____ DOB: _____Relationship: _____

Referral Information *Who may we thank for referring you to our office?*

☐ FRIEND/FAMILY ☐ PCP/OTHER SPECIALIST ☐ WEBSITE/GOOGLE, ETC ☐OTHER_____

Name _____ Address _____

Primary Care Physician _____ Phone # _____

Pharmacy Name _____

Location_____ Phone # _____

NEW MEXICO Foot & Ankle INSTITUTE

FINANCIAL POLICY

- **Insurance and Financial Liability**: I allow NMFAI to bill my medical insurance for all services rendered. However, I assume responsibility for any balance if I have provided incorrect, outdated or invalid insurance information. When multiple policies exist, it is my responsibility to inform NMFAI which policy is the primary plan. I will also have an up-to-date copy of my insurance card at each visit. If coverage cannot be verified at the time of service, I agree to pay in full on the date of service.
- **Self Pay**: Full payment is due at the time of service.
- **Payment**: I assume financial responsibility for all services not covered by my insurance plan. NMFAI will submit a claim on my behalf to insurance, but there is no guarantee of payment. Please be aware of your insurance coverage benefits. Payments are expected at the time of service which include co-payments, deductible/co-insurances, and any personal balances due. NMFAI accepts cash, all major credit cards, and personal checks.
- **Co-payments**: I understand that NMFAI is contractually obligated to collect my co-payment at the time of service per my agreement with my insurance plan.
- **Deductibles & Co-Insurance**: If you have a deductible plan, we may collect payment toward your deductible and co-insurance at the time of service.
- **Referrals**: It is my responsibility to obtain necessary referrals; if there is no referral, I will be financially responsible. If you have an HMO plan, it will not cover services without a valid referral from your primary care physician as listed by your plan.
- **Non-Covered Items**: I understand payment for products is expected at the time of dispensing. There will be no refund on these products.
- **Balances/Collection Fee**: You will receive a billing statement for all personal balances due. If we have not received a response from you by phone or received a payment regarding your unpaid balance within 90 days, your account will be sent to a collection agency and a $50 administrative fee will be added.
- **Returned Check Fee**: I understand there will be a $25 returned check fee on all returned checks.
- **Medical Records and X-Ray Fees**: I understand that a reasonable fee will be charged to obtain copies of my medical records and/or X-Rays.
- **Late Arrival Policy**: We ask you to arrive 15 minutes prior to your appointment time. I understand if I arrive more than 10 minutes past my appointment time, I may be asked to reschedule.
- **Cancellation Notice**: If you miss an appointment or cancel an appointment less than 24 hours prior to your appointment time you may be assessed a $25 fee. Missed appointment fees are the responsibility of the patient.
- **Surgery Cancellation Notice**: I understand there may be a $100 cancellation fee if I cancel a booked surgery.
- **Authorization to Release Information and Pay Benefits**: I authorize the release of any medical information necessary to process claims and to assign NMFAI all payments from my insurance companies for services rendered to me or my dependents.

*I understand that NMFAI financial policy is in effect for the entire time I am a patient. I acknowledge by signing below, as the patient or guardian of the patient, that I have read, understand, and will comply.

Patient/Responsible Party Signature: _____ Date: _____

NEW MEXICO Foot & Ankle INSTITUTE

Summary of Notice of Privacy Practices

(This summary is designed to assist you in understanding our Notice of Privacy Practices)

Health Information Use and Disclosure

The office of New Mexico Foot & Ankle Institute understands that medical information about you and your health is personal and we are committed to protecting that information. With that understanding, we will use and disclose your health information for the following purposes: to treat you, to assist other health care providers in treating you, to allow insurance companies to process insurance claims for services rendered to you, to obtain payment for services rendered to you and for certain limited operational activities, such as quality assessment, licensing, accreditation and training of students. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization. We reserve the right to change this notice and will post a copy of the current *(dated)* notices in effect in our facility and on our website.

Additional Disclosure Authority: In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

Name_____Relationship_____Ph#_____

Name_____Relationship_____Ph#_____

Name_____Relationship_____Ph#_____

Use and Release of Medical Information

We may use and release your medical information (clinical and billing) for:

- Payment, Treatment, Healthcare Operations
- Business Associates
- Appointment Reminders
- Treatment Alternative Education
- Health-related Benefits or Services
- As required by law to State/Federal Agencies
- Family involved in your care
- Entities assisting in Disaster Relief

Your Health Information Rights

Although your health record is the physical property of the healthcare provider, you have the ***Right*** to:

- Access Information
- Request Amendments
- An Accounting of Disclosures
- Request Privacy Restrictions
- Request Alternate Communication
- File Complaints
- Obtain a Detailed Copy of this Notice

If you have any questions, concerns, or complaints regarding our privacy practices, please refer to the actual Notice of Privacy Practices for the person(s) whom you may contact.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____

Patient Name or Authorized Representative *(print)* Date

_____

Signature

NEW MEXICO Foot & Ankle INSTITUTE

Patient Name_____ DOB: _____

Name of Primary Care Physician _____

Physicians Address: _____

Physicians Phone _____ Date of last visit with PCP: _____

Pharmacy Name: _____ Phone #: _____

Pharmacy Address: _____

PBM (Pharmacy Benefit Manager) CONSENT: Provides NMFAI information about which drugs are covered by the drug benefit plan and provides information about medications the patient is already taking by any provider to minimize adverse drug events.

I give consent to access my pharmacy records *(please circle)* **Agree / Decline**

Signature: _____ Date: _____

PODIATRIC HISTORY

What is the **main foot or ankle complaint** for which you came to be treated?

_____

_____

_____

When did it begin? _____

Have you received treatment(s) for this condition? YES / NO

Circle all treatments received for this condition:

Pain Medication	Antibiotics	X-Rays
Injection	Surgery	CT Scan
Hospitalization	Physical Therapy	MRI
Bone Scan	Ice/Stretching	

OTHER:

_____

Does this problem interfere with your activities? YES / NO

Explain:

_____

_____

_____

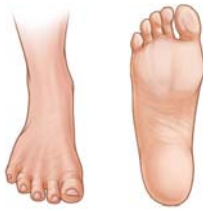
Have you ever experienced any of the following conditions?

Please ☑ check all that apply:

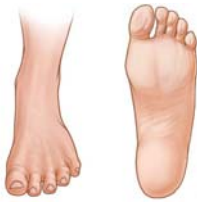
__ Ankle Instability	__ Hip Pain
__ Arthritis	__ Ingrown Toenails
__ Back Pain	__ Intoe-Out toe walking
__ Blisters	__ Knee Pain
__ Bone Spurs	__ Limb Length Discrep.
__ Bunions	__ Neuromas
__ Burning Feet	__ Numbness or Tingling
__ Corns / Calluses	__ Plantar Fasciitis
__ Flat Feet	__ Shin Splints
__ Foot Infections	__ Sprains
__ Fracture	__ Sweating / Odor
__ Fungal infections	__ Tendonitis
__ Gout	__ Tired Feet
__ Hammertoes	__ Ulcers
__ Heel Pain	__ Warts

Circle the degree of pain: Minimal 1 2 3 4 5 6 7 8 9 10 Severe

CIRCLE OR MARK THE PROBLEM AREAS



RIGHT



LEFT

NEW MEXICO Foot & Ankle INSTITUTE

Patient Name_____ DOB: _____

YOUR PERSONAL MEDICAL HISTORY

Have you been treated for any of the following conditions? Please ☑ check all that apply: *More Info

__ Acid Reflux	__ Eye Problems *	__ Parkinson's Disease
__ Alcoholism	__ Fibromyalgia	__ Psychiatric Care *
__ Allergies	__ Headaches	__ Respiratory Disease *
__ Alzheimer's	__ Heart Condition *	__ Rheumatic Fever
__ Anemia	__ Hepatitis	__ Seizure Disorders/Epilepsy
__ Arthritis *	__ High Cholesterol	__ Sinus Problems *
__ Asthma *	__ HIV / AIDS	__ Sleep Apnea
__ Back Problems *	__ Hypertension/High Blood Pressure	__ Stomach Ulcers
__ Bleeding Disorders *	__ Low Blood Pressure	__ Stroke
__ Blood Clots / DVT / PE *	__ Hyperthyroidism	__ Tuberculosis (TB)
__ Cancer *	__ Hypothyroidism	__ Varicose veins
__ Circulatory Problems	__ Kidney/Bladder Problems *	__ Vertigo
__ Congestive Heart Failure (CHF)	__ Liver Disease *	OTHER: _____
__ Depression	__ Medical Implants *	**INFECTIONS:**
__ Diabetes *	__ Nerve System Disorder *	__ MRSA *
__ Drug or Chemical Dependency	__ Osteoporosis/Osteopenia	__ Hepatitis B *
__ Ear Problems *	__ Peripheral Arterial Disease	__ Hepatitis C *

SURGERIES /HOSPITALIZATIONS **Approx Date**

ALLERGIES: **YES / NO**

Please ☑ check all that apply

Adhesive Tape		Metal/Jewelry	
Anticoagulants		Novocaine	
Anti-inflammatory Meds		Peanuts	
Aspirin		Penicillin	
Codeine		Seafood	
Cortisone		Sulfa	
Iodine		Tylenol	
Latex		Motrin/Ibuprofen	

OTHER: _____

MEDICATIONS:

You can provide a list of your medications or list below

NAME OF MEDICATION	Strength/Mg	Take how often?

Do you participate in any exercise or physical activity on a regular basis? YES / NO If YES, what type and how often?

_____

NEW MEXICO Foot & Ankle INSTITUTE

Patient Name_____ DOB: _____

SOCIAL HISTORY

Please answer the following:

Occupation _____

Marital Status: Single Married Domestic Partner Divorced Widowed OTHER

History of STD's? YES / NO If yes, what type? _____

Use of Alcohol? YES / NO If yes, how much? _____

Use of Tobacco? YES / NO If yes, how much? _____

Use of Recreational Drugs? YES / NO If yes, type/frequency _____

FAMILY HISTORY

Has anyone in your immediate family been diagnosed with any of the following?

- Arthritis
- Cancer (Type) _____
- Diabetes
- Heart Disease
- High Blood Pressure
- Stroke

REVIEW OF SYSTEMS

Please circle all conditions and symptoms that you **currently** have)

GENERAL:	FEVER	FATIGUE	SLEEPING PROBLEMS	WEIGHT LOSS/GAIN
SKIN:	RASH	ITCHING	LESIONS/SORES	DRY SKIN
HEAD:	INJURY	HEADACHE	CHANGES	VISION PROBLEMS
EYES:	BLURRY VISION	DOUBLE VISION	PAIN OR ITCHING	GLASSES/CONTACTS
ENT:	RINGING EARS	HEARING LOSS	SINUS CONGESTION	HOARSENESS
LUNGS:	COUGH	SNORING	WHEEZING	SHORTNESS OF BREATH
HEART:	CHEST PAIN	IRREG HEART BEAT	MURMUR	PALPITATIONS
DIGESTIVE:	NAUSEA	VOMITING	CONSTIPATION	DIARRHEA
URINARY:	FREQUENCY	INCONTINENCE	BURNING	BLEEDING
MUSKULOSKELETAL:		JOINT PAIN	WEAKNESS	DEFORMITY
VASCULAR:	CALF PAIN	LEG CRAMPS	SWELLING	VARICOSE VEINS
NEURO:	NUMBNESS	SEIZURES	DIZZINESS	WEAKNESS
PSYCHIATRIC:		ANXIETY	DEPRESSION	NERVOUSNESS
ENDOCRINE:	DIABETES	THYROID	HAIR LOSS	EXCESSIVE SWEATING
HEMATOLOGY:	ANEMIA	BRUISE EASILY	BLEEDING TENDENCY	COLD FEET/HANDS
OB/GYN:	PREGNANT	BIRTH CONTROL	HORMONE THERAPY	MENOPAUSAL

VITALS

Current Height _____Current Weight _____Shoe Size _____

I hereby give permission to NMFAI and any qualified staff to evaluate, diagnose and treat my foot and/or ankle condition as may be deemed necessary.

_____

Patient or Authorized Signature: **Date:**