



CHIEF COMPLAINT / HISTORY / CONSENTS

PODIATRIC HISTORY

What is the chief complaint for which you came in to be treated? (include foot, ankle, knee, thigh & hip complaints)

Have you ever been seen by a Podiatrist? No Yes, Name of Podiatrist: _____ Last Visit: _____

Please indicate which foot problem you now have or have had in the past:

- () Ankle Pain () Athlete's Foot () Bunions () Corns / Callouses
- () Heel Pain () Ingrown Toenails () Plantar Warts () Tired Feet
- () Swelling in Ankles/ Feet () Cramps, Numbness in feet/legs

MEDICATIONS

Please list all prescriptions, OTC medications & vitamins: _____

Which pharmacy would you like to use: _____ Phone: _____ City or Street: _____

Are you taking blood thinners? YES NO Do you take oral contraceptives? YES NO

ALLERGIES

- () No known drug allergies () Codeine () Penicillin
- () Adhesive / Tape () Iodine/Betadine () Sulfa
- () Aspirin () Local Anesthetics () Anti-inflammatories

MEDICAL HISTORY Please indicate if you have or have had any of the following:

- () AIDS/HIV () Varicose Veins () Hemophilia () Psychiatric Care
- () Anemia () Circulatory Problems () Hepatitis A,B or C () Stroke
- () Angina () Chemical Dependency () Venereal Disease () Tuberculosis
- () Arthritis () Diabetes () High Blood Pressure () Ulcers
- () Back Problems () Epilepsy () High Cholesterol
- () Bleeding Disorders () Gout () Kidney Problems
- () Cancer () Heart Disease () Phlebitis
- () Artificial Heart Valves or Joints

Please list any surgeries you have had: _____

Please list any hospitalizations other than for surgeries listed: _____

Primary Care Physician: _____ Phone: _____

Are you now or have you been within the past two years under any other doctor's care for any reason? Please Explain:

Consent For Treatment

I hereby request and consent to podiatric evaluation and other procedures (diagnostic x-rays if necessary) by a podiatrist at Foot & Ankle Concepts and/or qualified staff. I will have an opportunity to discuss with the Foot & Ankle Concepts medical provider and/or with other clinic personnel the nature and purpose of treatment indicated. I understand that results are not guaranteed. While in-office treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment. Please inquire if you have further questions. I do not expect the Doctor to be able to anticipate and explain all risks and complications, and wish to rely on the Doctor to exercise judgment during the course of any procedure which the Doctor feels at the time is in my best interest. I understand that Foot & Ankle Concepts will not be held responsible for any pre-existing medical conditions. I certify that the information contained in my health history is correct to the best of my knowledge. I will not hold my doctor or any staff member of Foot & Ankle Concepts responsible for any errors or omissions that I may have made in the completion of this form. I have read, or have had read to me, the full above consent and have also had an opportunity to ask questions about its content and by signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for any future care provided by this clinic and/or employed staff.

Financial Responsibility Policy

PATIENTS WITH INSURANCE: In order to file your claims in a timely manner, we need current, accurate insurance information for you and your dependents. We will do our best to confirm your eligibility and level of insurance coverage for care; however, per your insurance plan, it is ultimately your responsibility to know your own insurance benefits. Should your insurance carrier determine that any or all of our services are ineligible for payment, you will be billed directly for those services. Please be aware that most insurance plans will leave as your responsibility a co-payment, coinsurance, deductible, or balance for non-covered services.

PATIENTS WITHOUT INSURANCE: Payment is due in full at the time-of-service.

Foot & Ankle Concepts reserves the following right to charge for the following fees...

- Missed Appointment Fee: \$25 fee for any missed appointments not cancelled before 24 hours of the time of the appointment
- Late Fee: \$12 billed to your account for any balance owed past 60 days
- Administrative Fee: \$35 fee charged to your account when your balance is transferred to a third-party collector

If you have any questions about our financial policy, please contact our billing manager.

I have read and understand the Foot & Ankle Concepts consent and financial responsibility policy above.

Patient Name: _____

Guardian Name (if different than patient): _____

Patient / Guardian Signature: _____ Date: _____

Foot & Ankle Concepts Witness: _____ Date: _____