

**Which Provider are you seeing today?**

Dr. John DeLeonibus, DPM Dr. Eric Harmelin, DPM Dr. Mark Sussman, DPM Dr. Rikhil Patel, DPM

**Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI: \_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_/\_\_/\_\_ Gender: \_\_\_ Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ok to leave message with detailed Information:** YES OR NO

**Cell Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ok to leave message with detailed Information:** YES OR NO

**Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Visit Date with PCP: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID: \_\_\_\_\_\_\_\_\_\_\_\_\_ Group#: \_\_\_\_\_\_\_\_\_\_\_\_**

**Secondary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referred By (check one): □ Our Web-site □ Google □ Facebook □ Insurance □ Friend □ Other**

**□ Doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Who may we thank for referring you? \_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*** Co-pays and balances are due at the time of service. We will bill only two contracted insurance companies; however you are ultimately responsible for all charges whether the insurance company paid for your claim or not. We accept checks, cash, and most credit cards. The insurance companies you place on this forms are the carriers we will bill for your date of service. I hereby authorize AFAC and staff to disclose my individually identifiable health information to the insurance carrier(s). AFAC will use and disclose my health information in order to obtain payment to the doctor for services rendered and allow insurance companies to process claims. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

**Signature of Patient/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**



**Foot Care History**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Height: \_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_ Shoe Size: \_\_\_\_\_\_\_\_\_\_\_**

**Have you ever received treatment from a previous podiatrist? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What is the reason for your visit today?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Any past foot/ankle surgery or problems? If yes, please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have diabetes?** YES or NO **If yes:** TYPE I OR TYPE II **Controlled By:** Insulin/Orals/Diet

**Smoker: (Please Circle)** Everyday Smoker; Former Smoker; Non-Smoker

**Which Pharmacy do you use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Street: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Current or past medical conditions:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current medications:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize the Physicians at Annapolis Foot & Ankle Center to render treatment and/or therapy to myself that they deem medically necessary in order to treat my condition(s). My signature confirms that I have given AFAC all past and current health information and that it is accurate to the best of my knowledge.

**Signature of Patient/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**



**Notice of Privacy Practices Acknowledgement**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

 • Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

• Obtain payment from third-party payers.

• Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. (Please look on clip board or in binder for copy of HIPAA)

On occasion, it may be necessary to release clinical information to outside physicians, radiological institutions, laboratories or physical therapy centers that you have been referred to, by Southern Maryland Foot & Ankle, to aide in your coordination of care. We will not release your information to any third parties.

**Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:**

I agree that the practice may disclose certain pieces of my health information to a Personal Representative of my choosing, since such person is involved with my healthcare or payment relating to my healthcare. In that case, the Physician Practice will disclose only information that is directly relevant to the person’s involvement with my healthcare or payment relating to my health care.

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**



**Payment Policy & Insurance Billing Authorization**

We are committed to providing you with the best possible care. If you have medical insurance, we are eager to help you receive your maximum allowable benefits. To achieve these goals, we need your assistance in understanding our payment policy.

 **If Annapolis Foot and Ankle Center participates in your insurance plan**

 • Copayments are required at registration.

 • Payment for charges from earlier visits not covered by insurance is due at registration.

 **If Annapolis Maryland Foot and Ankle Center does NOT participate with your insurance plan**

 • Payment of all unpaid balances on your account is required at registration.

• Payment in full for your visit charges is required at discharge.

**If you do not have insurance**

 • Payment of all unpaid balances on your account is required at registration.

• Payment in full for your visit charges is required at discharge

Failure to pay bills promptly will result in l legal actions being taken to achieve collections. All collections and legal fees are the responsibility of the patient. A fee of 25% or greater may be addended to the bill if we are forced to take the account to collections.

\*I have read and understand the policy for medical services.

**Signature of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**