

Sutera & Jones Surgical Podiatry,

A Division of Pace Foot & Ankle Centers, PLLC

Dr. Angelo Sutera, Jr ~ Dr. Scott E. Jones ~ Dr. Judy Tan

PRIMARY CARE OR FAMILY DOCTOR: _____

Last date seen by PCP: _____

NAME: _____ **BIRTHDATE** ___/___/___ **S.S#:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PHONE # HOME: _____ **WORK:** _____ **CELL:** _____

MAY WE LEAVE A MESSAGE CONTAINING PRIVATE INFORMATION ON YOUR VOICEMAIL? YES NO

-IF "YES", WHICH NUMBER MAY WE LEAVE THE VOICEMAIL? _____

EMAIL ADDRESS: _____

EMERGENCY CONTACT: _____ **PHONE #:** _____

GENDER: Male Female - **MARITAL STAU:** Single Married Divorced Widowed Legally Separated

INSURANCE INFORMATION: Please present your card(s) to a staff member to make a copy for our records

PRIMARY MEDICAL INSURANCE: _____

SECONDARY MEDICAL INSURANCE: _____

SUBSCRIBER'S NAME: _____ **RELATIONSHIP TO PATIENT:** _____

SUBSCRIBER'S DATE OF BIRTH: ___/___/___ **EMPLOYER:** _____

MEDICATIONS: Please list any medications that you are currently taking:

NAME: _____ **DOSE:** _____ **FREQUENCY:** _____

NAME: _____ **DOSE:** _____ **FREQUENCY:** _____

NAME: _____ **DOSE:** _____ **FREQUENCY:** _____

NAME: _____ **DOSE:** _____ **FREQUENCY:** _____

NAME: _____ **DOSE:** _____ **FREQUENCY:** _____

PHARMACY NAME AND PHONE# _____

HEIGHT: _____ Ft _____ In **WEIGHT:** _____ lbs **SHOE SIZE:** _____

PAST SURGICAL HISTORY: Please list any surgeries you have had **CHECK HERE IF NONE**

SURGERY: _____ **DATE:** _____

SURGERY: _____ **DATE:** _____

SURGERY: _____ **DATE:** _____

ALLERGIES: Please check ALL that apply **NO KNOWN ALLERGIES**

Aspirin Dyes Iodine Penicillin

Cortisone Food Local Anesthetic Sulfa

Dust, Molds Hay Fever Nuts Tape

Other: _____ Other: _____ Other: _____

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PAST MEDICAL HISTORY – Please check all that apply

NO MEDICAL PROBLEMS

- | | | |
|---|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Bone Disease | <input type="checkbox"/> Joint Implant | <input type="checkbox"/> Scar Enlargement |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Liver Conditions | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Eye Disorders | <input type="checkbox"/> Muscle Disease | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Neurologic Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Psychiatric Disorder | <input type="checkbox"/> Urinary Problems |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pacemaker | |

Please list any other medical conditions not listed above: _____

FAMILY HISTORY – Please check if any immediate family members have or have had any of the following:

PLEASE MARK WITH: F = FATHER M = MOTHER B = BROTHER S = SISTER

- | | | | |
|---|--|--|---------------------------------------|
| <input type="checkbox"/> Arthritis ____ | <input type="checkbox"/> Cancer ____ | <input type="checkbox"/> Heart Conditions ____ | <input type="checkbox"/> NONE |
| <input type="checkbox"/> Bunions ____ | <input type="checkbox"/> Diabetes ____ | <input type="checkbox"/> Hypertension ____ | <input type="checkbox"/> OTHER: _____ |
| <input type="checkbox"/> Birth Defects ____ | <input type="checkbox"/> Foot Disorders ____ | <input type="checkbox"/> Stroke ____ | <input type="checkbox"/> OTHER: _____ |

SOCIAL HISTORY – Do you use or have ever used any of the following:

- Drug Abuse: YES If Yes, please list _____ NO
- Smoking History: Never Former smoker/How pack years? _____ Current smoker/How many per day? _____
- Alcohol use: YES NO - Social Mild Moderate Heavy Quit Number of drinks per day? _____

PRIMARY CONCERN-Please check all that apply

- Painful foot- Left Right Both
- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Diabetes Checkup | <input type="checkbox"/> Neuroma | <input type="checkbox"/> Bunion | <input type="checkbox"/> Surgery Consultation |
| <input type="checkbox"/> Fungus Nails | <input type="checkbox"/> Plantar Fasciitis | <input type="checkbox"/> Hammertoe | <input type="checkbox"/> Orthotics |
| <input type="checkbox"/> Ingrown Toenail | <input type="checkbox"/> Heel Pain | <input type="checkbox"/> Achilles Tendinitis | <input type="checkbox"/> 2 nd Opinion |
| <input type="checkbox"/> Injury to Foot/Ankle | <input type="checkbox"/> Sprain or Strain | <input type="checkbox"/> Diabetic Shoes | <input type="checkbox"/> Work Related Injury |
| <input type="checkbox"/> Infection or Ulceration | <input type="checkbox"/> Plantar Warts | <input type="checkbox"/> Corns, Calluses | <input type="checkbox"/> Rash or Athlete’s Foot |
| <input type="checkbox"/> OTHER: _____ | <input type="checkbox"/> OTHER: _____ | | |

PLEASE DESCRIBE PAIN (IF ANY)- Sharp Dull Throbbing Burning Radiating Numbness

LOCATION ON FOOT OR ANKLE- Top Bottom Inside Outside Toes Webs Nails

HOW LONG HAS THIS BEEN A CONCERN FOR YOU- ____ Days ____ Weeks ____ Months ____ Years

PREVIOUS TREATMENT- Check all that apply

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Rest | <input type="checkbox"/> Oral Medication | <input type="checkbox"/> Orthotic or Foot Support | <input type="checkbox"/> Foot Surgery |
| <input type="checkbox"/> Ice | <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Previous Medical Treatment | <input type="checkbox"/> Cortisone Injection |
| <input type="checkbox"/> Change in Shoe Gear | <input type="checkbox"/> Other: _____ | | |

LAST SEEN BY PODIATRIST: ____/____/____ **NAME OF PREVIOUS PODIATRIST:** _____

FEMALES- Are you currently pregnant? YES NO

I certify that the above information is correct

Patient Signature: _____ **Today’s Date** ____/____/____

Sutera & Jones Surgical Podiatry, P.C.

Thank you for choosing our office to provide you with medical care. We are committed to serving you with quality and affordable health care.

Your complete understanding of the following office payment policy is an essential element of your care and treatment. Please feel free to ask us any questions that you may have. After reviewing this, kindly sign in the space provided.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured with a plan that we participate with, payment in full is expected at each visit. If you are issued by a plan we participate with, but do not have an up-to-date insurance card, you will be responsible for any unpaid charges. Knowing your insurance benefits is YOUR responsibility. Please contact your insurance company with any questions you may have regarding coverage.
2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles can be considered a violation of our contract with your insurance.
3. **Non-covered services.** Please be aware that some and perhaps all of the services you receive may be non-covered or considered not necessary by Medicare or other insurers. We will inform you of this prior to treatment and if agreed upon, payment in full for providing these services will be expected at the time of the visit.
4. **Proof of insurance.** All patients must complete or update our personal information form prior to seeing the doctor. We must obtain a copy of your current insurance card and driver's license to verify proof of insurance. We must have the subscriber's name and date of birth, if you are not subscriber. Many insurance companies will reject claims if the subscriber's information is not complete. If you or the subscriber's insurance changes, you must notify the front desk immediately upon check-in. We have no other way of determining changes to your insurance and is your responsibility.
5. **Referrals\Authorizations.** We are required to follow the guidelines of your managed care plan which mandates a referral from your primary care physician prior to seeking podiatric care. Therefore, you are financially responsible for the services received, unless your referral is presented or is current at the time of this visit. Full credit will be given if a valid and timely dated referral is presented to our office within 48 hours. Please remember that obtaining a referral is YOUR RESPONSIBILITY and not a requirement of our staff. If you do not wish to be responsible for a visit without the proper authorization, you have the option to reschedule your visit until the referral is obtained or received.
6. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. You are responsible for complying with their request and failure to reply to them will usually lead to a rejected claim. This rejection will lead to your accountability for payment for the services rendered. Please be aware, any balance of your claim from what your insurance company paid, or if the claim is denied, is your responsibility. Your insurance benefit is a contract between you and your insurance company.
7. **Coverage changes.** If your insurance changes, please notify us BEFORE your next visit so we can make appropriate changes to help receive your maximum benefits.
8. **Patient billing.** Invoices are sent every 4-6 weeks. Your prompt payment will assist us in keeping the cost of healthcare down. Payment arrangements can be made on a case by case basis. We realize that temporary financial problems may affect timely payment of your account. If problems do arise, we encourage you to contact us promptly for assistance in managing your account. We accept the following payment methods: Cash, Check, VISA, Master Card, American Express, and Care Credit. There is a service fee of \$25 for all returned checks. Please be aware that if a balance remains unpaid, we may refer your account to collections.
9. **Missed appointments.** Please allow 24 hours for cancelation or rescheduling of appointments. Repetitive broken or cancelled appointments and/or a pattern of not keeping appointments may result in our practice providing you with means to transfer health care to another qualified provider.
10. **Privacy statement.** Any information disclosed in your records will remain confidential and will not be used for any other reason except in proving quality care and treatment, as well as to submit your claim to your insurance company and contact you as needed.

I have read and understand the policies and agree to abide by its guidelines.

PATIENT NAME(print): _____

TODAY'S DATE: ____/____/____

PATIENT SIGNATURE: _____

SIGNATURE OF RESPONSIBLE PARTY (if not the patient): _____

RELATIONSHIP TO PATIENT: Parent Spouse Power of Attorney Caregiver

Sutera & Jones Surgical Podiatry

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient’s rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health

Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____