ALL ABOUT FEET & LEGS, P.A.
Dr. Rosana Rodriguez
6 Saint Johns Medical Park Drive
Saint Augustine, FL 32086
PHONE: (904) 823-3301   FAX: (904) 823-3328

NEW PATIENT DEMOGRAPHICS

DATE: ________________

PATIENT NAME: ____ DOB: _______________

S.S.#: ______________________ GENDER: *MALE / FEMALE* HT: _______ WT: _______

MARITAL STATUS: _____________ OCCUPATION: ______________________________

PREFERRED LANGUAGE: _______________________ RACE: _______________________

HOME ADDRESS: ____

CITY/STATE/ZIP: ____

MAILING ADDRESS: ____
(IF DIFFERENT FROM ABOVE)

PHONE NUMBER: ____________________ ____________________ ____________________
(HOME) (CELL) (WORK)

EMAIL ADDRESS: ___________________________________ / ____ NO EMAIL ADDRESS

EMERGENCY CONTACT: _______________________ __________________ __________________
(NAME) (RELATION) (CONTACT NUMBER)

NEXT OF KIN: _______________________ __________________ _______________
(NAME) (RELATION) (CONTACT NUMBER)

PRIMARY DR: _______________________ PRIMARY PHARMACY: _________________________
DATE LAST SEEN: ____________________

PRIMARY INS: _______________________ ID# ______________________ GRP# ___________
SEC. INS. POLICY: _____________________ ID# ______________________ GRP# ___________

REASON FOR VISIT: _________________________________ REFERRED BY: ________________

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MEDICAL HISTORY

___**NO PREVIOUS DIAGNOSIS** ___**NO MEDICATION ALLERGIES**

MEDICATION ALLERGIES: ______________________________
ARE YOU ALLERGIC TO ADHESIVE TAPE: **YES** **NO**

DO YOU SMOKE: **YES** **NO** How Much: ____________ Duration: ______________
DO YOU DRINK ALCOHOL: **YES** **NO** How Much: ____________ Duration:____________
DO YOU USE STREET DRUGS: **YES** **NO** How Much: ____________ Duration: ____________

DO YOU TAKE BLOOD THINNERS? Y / N - MEDICATION: ______________________

DO YOU TAKE ANTIBIOTICS BEFORE ANY PROCEDURES? Y / N - ANTIBIOTIC: ____________

HAVE YOU EVER BEEN DIAGNOSED WITH:

__ Diabetes __ Low Blood Pressure __ High Blood Pressure __ High Cholesterol

__ Low Cholesterol __ Cancer __ HIV / AIDS __ Hepatitis __ Cardiac Disease __ COPD

__ Depression __ Asthma __ Arthritis __ Seizures __ Anemia __ Poor Circulation

__ Stroke __ Osteoporosis __ Tuberculosis __ Gout __ Kidney Disease ___ Sickle Cell

__ Hemophilia __ Emphysema __ Varicose Veins __ Blood Clots __ Syncope __ Thyroid

PHOTO CONSENT

__ I agree and authorize the use of the photos, films, &/ videos for treatment, medical record keeping and teaching purposes within office only.

___ **I DO NOT** AGREE NOR AUTHORIZE THE USE OF MY IMAGES

PATIENT NAME: ______________________ **SIGNATURE:** ____________________

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NEW PATIENT SURGICAL LOG

PATIENT NAME: ______________________________

DATE OF BIRTH: ______________________

___ **DENIES ANY SURGERIES**

SURGICAL PROCEDURE **ESTIMATED DATE**

1 ______________________________

2 ______________________________

3 ______________________________

4 ______________________________

5 ______________________________

6 ______________________________

7 ______________________________

8 ______________________________

9 ______________________________

10 ______________________________

11 ______________________________

12 ______________________________

13 ______________________________

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NEW PATIENT MEDICATION LOG

PATIENT NAME: ______________________________

DATE OF BIRTH: ______________

___ **NOT CURRENTLY TAKING ANY MEDICATIONS**

MEDICATION NAME	DOSAGE	FREQUENCY
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under Health Insurance Portability & Accountability Act of 1996 (HIPAA). I have certain right to privacy regarding my Protected Health Information (PHI). I understand this information can, and will be used to:

- Conduct, Plan, Direct my treatment, and Follow Up among the multiple healthcare providers who are involved in my treatment directly, and/or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments, and physician certifications.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses, and disclosures of my health information. I understand that **ALL ABOUT FEET & LEGS, P.A.** has the right to change it Notice of Privacy Practices at any time, and that I may contact **ALL ABOUT FEET & LEGS, P.A.** at any time at the addresses above to obtain a copy of the Notice of Privacy Practices.
I understand that I may request in writing that **ALL ABOUT FEET & LEGS, P.A.** restricts my private information to be used or disclosed to carry out treatment, payment, or other healthcare operations. I also understand you are not required to agree to my requested restrictions, but if it does agree than you are bound to abide by such restrictions.
I request and authorize **Dr. Rosana Rodriguez**, and the assistant of her choice to perform Medical Treatment. I understand I am responsible for any co-payment, co-insurance, or deductible at the time of service unless prior arrangements have been made. I authorize the release of any medical information, and records concerning my diagnosis, and treatment to any third party: (Insurance Companies, Gov't Agencies, or Physicians). This is necessary for the use of determining payment or continuing medical treatment.

MEDICARE PATIENTS: I certify that the information given by me in applying for payment under title XVII/XIX of the social security act is correct. I authorize any medical or other information needed for determining a claim for payment of treatment and/or diagnosis to be released to Social Security Administration, and its intermediaries and/or carriers.

PATIENT NAME: ______________________________ SIGNATURE: ______________________
RELATIONSHIP TO PATIENT: ______________________________ DATE: ________________

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PATIENT FINANCIAL POLICY

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

-As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.

-Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept Visa, Master Card, check or cash.

-Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company to pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.

-We have made prior arrangements with certain insurers and other health plans to accept assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay, co-insurance, deductible at time of service.

-If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send payment directly to you. Therefore all charges for your care and treatment are due at the time of service.

-All health plans are not the same and do not cover the same authorization you will be responsible for the complete charge. We will attempt to verify services. In the event your health plan determines a service to be not covered or you do not have any benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

-You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

-For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.

-There are certain elective surgical procedures for which we may require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to surgery.

-Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.

- There will be a $30.00 Fee for Missed appointments without a 24 hour advance notice if not due to an emergency.

PATIENT NAME:______________________ **PATIENT SIGNATURE:**______________________

WITNESS SIGNATURE: ______________________ **DATE:** ____________ **RELATION:** Staff

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MEDICAL RECORDS AUTHORIZATION

Patient Name: ______________________ DOB: __________ MR#__________

Patient Address: ____

Phone No: ____________________

I ☐ Request from ☐ Release to Physician Name: ______________________________

Phone #: ________________________ Fax #: ________________

Records Requested:

_____ Labs (Pathology) _____ Immunization records _____ All Records on file

_____ Office Visit/ Physical Exam _____ Diagnostic Testing (XRAY, CT, MRI) _____ Other :

I, ______________________, authorize the release/request of any medical records. I understand that the information disclosed in this authorization may contain sensitive information, including any or all records relating to sexually transmitted diseases, HIV or AIDS viruses, behavioral or mental health, drug and/or alcohol abuse. I understand I have the right to revoke this authorization at any time. If I choose to do so, I must provide a written authorization revocation and present it to this facility/office. I understand that the revocation will not apply to any documentation or information that has already been authorized and received prior to my revocation. I also understand that my revocation will not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy.

I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws and regulations. I understand authorizing this disclosure and authorization that it is completely voluntary. I need not sign this form to ensure healthcare treatment.

______________________________ ______________
Patient Signature Date

______________________________ ______________
Witness Date

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allaboutfeetandlegs@gmail.com

Authorization for Credit Card Use

PRINT AND COMPLETE THIS AUTHORIZATION AND RETURN.
All information will remain confidential

Name on Card: ______________________

Billing Address: ______________________
____

Email: ______________________

Credit Card Type: ____ Visa ____ Mastercard ____ Discover

Credit Card Number: ______________________

Expiration Date: ______________
Card Identification Number: ____ (last 3 digits located on the back of the credit card)
Amount to Charge: $ __________ (USD)

I authorize ***Dr. Rosana Rodriguez*** to charge the amount listed above to the credit card provided herein. I agree to pay for this purchase and/or service provided in accordance with the issuing bank cardholder agreement.

Cardholder – Please Sign and Date

Signature: ______________________
Date: ______________________
Print Name: ______________________

Credit Card Authorization: For your convenience in paying the balance on your account, we ask all patients to complete a Credit Card Authorization Form annually. You may specify a maximum dollar amount that we are authorized to charge each month. Non-covered services will be charged to this account if you are not present (such as for missed appointment fees $30, return check fees $30 and form completion fees $30). A copy of the credit card receipt will be mailed or emailed to you if we charge your account.