



FOOT & ANKLE SURGICAL GROUP

PATIENT INFORMATION					
First Name		MI	Last Name		
Preferred Name		DOB	Sex <input type="checkbox"/> M <input type="checkbox"/> F	SS#	
Address			City	State	Zip
Cell Phone		Home Phone		Email	
REFERRAL (CHECK ONE)					
How did you hear about us? <input type="checkbox"/> Insurance <input type="checkbox"/> Online <input type="checkbox"/> Other Patient <input type="checkbox"/> Physician					
PRIMARY CARE PHYSICIAN					
Name/Practice Name				Phone	
EMERGENCY CONTACT					
Name		Phone		Relationship to Patient	
INSURANCE					
Primary Insurance		ID#	Group#		
Secondary Insurance		ID#	Group#		
Insurance Policy Holder (if different than patient)					
Name		DOB	SS#	Relationship to Patient	
Person Responsible for Payment (if different than patient)					
Name		DOB	SS#	Relationship to Patient	
CHIEF COMPLAINT					
Reason for visit today					
REVIEW OF SYSTEMS (CHECK ALL THAT APPLY)					
Constitutional <input type="checkbox"/> chills <input type="checkbox"/> fatigue <input type="checkbox"/> fever <input type="checkbox"/> recent weight change					
Eyes <input type="checkbox"/> blurry/double vision <input type="checkbox"/> dry eyes <input type="checkbox"/> light sensitivity					
Ears, Nose, Throat <input type="checkbox"/> bleeding <input type="checkbox"/> congestion <input type="checkbox"/> discharge <input type="checkbox"/> sores in mouth <input type="checkbox"/> sore throat <input type="checkbox"/> tinnitus/vertigo					
Cardiovascular <input type="checkbox"/> chest pain <input type="checkbox"/> cold feet <input type="checkbox"/> leg cramps <input type="checkbox"/> leg swelling					
Respiratory <input type="checkbox"/> cough <input type="checkbox"/> difficulty breathing <input type="checkbox"/> shortness of breath <input type="checkbox"/> wheezing					
Gastrointestinal <input type="checkbox"/> abdominal pain <input type="checkbox"/> change in appetite <input type="checkbox"/> constipation <input type="checkbox"/> diarrhea <input type="checkbox"/> nausea <input type="checkbox"/> vomiting					
Musculoskeletal <input type="checkbox"/> toe pain <input type="checkbox"/> foot pain <input type="checkbox"/> ankle pain <input type="checkbox"/> back pain <input type="checkbox"/> difficulty walking <input type="checkbox"/> loss of strength					
Skin/Integumentary <input type="checkbox"/> bruising <input type="checkbox"/> change in nails <input type="checkbox"/> hair loss <input type="checkbox"/> itching <input type="checkbox"/> rash <input type="checkbox"/> ulcer <input type="checkbox"/> wound					
Neurological <input type="checkbox"/> numbness <input type="checkbox"/> seizures <input type="checkbox"/> syncope <input type="checkbox"/> tremors <input type="checkbox"/> weakness					
Psychiatric <input type="checkbox"/> depression <input type="checkbox"/> mood changes <input type="checkbox"/> nervousness					
Endocrine <input type="checkbox"/> dryness of skin/hair <input type="checkbox"/> excessive hunger/thirst <input type="checkbox"/> excessive urination <input type="checkbox"/> intolerance to heat/cold					
Genitourinary <input type="checkbox"/> blood in urine <input type="checkbox"/> incontinence <input type="checkbox"/> pain with urination <input type="checkbox"/> genital sores					

PHARMACY			
Name	Address	Zip	Phone
MEDICATIONS			
Name/Dose/How Often		Problem Being Treated	
DRUG ALLERGIES			
Name of Medication		Type of Reaction	
MEDICAL CONDITIONS			
Acid Reflux	<input type="checkbox"/> Y <input type="checkbox"/> N	Emphysema/COPD	<input type="checkbox"/> Y <input type="checkbox"/> N
Allergies (seasonal)	<input type="checkbox"/> Y <input type="checkbox"/> N	Epilepsy/Seizures	<input type="checkbox"/> Y <input type="checkbox"/> N
Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N	Fibromyalgia	<input type="checkbox"/> Y <input type="checkbox"/> N
Anxiety/Depression	<input type="checkbox"/> Y <input type="checkbox"/> N	Gout	<input type="checkbox"/> Y <input type="checkbox"/> N
Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart Attack	<input type="checkbox"/> Y <input type="checkbox"/> N
Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart Disease/CHF	<input type="checkbox"/> Y <input type="checkbox"/> N
Atrial Fibrillation	<input type="checkbox"/> Y <input type="checkbox"/> N	Hepatitis	<input type="checkbox"/> Y <input type="checkbox"/> N
Back Problem	<input type="checkbox"/> Y <input type="checkbox"/> N	High Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N
Bladder Infections	<input type="checkbox"/> Y <input type="checkbox"/> N	High Cholesterol	<input type="checkbox"/> Y <input type="checkbox"/> N
Bleeding Disorder	<input type="checkbox"/> Y <input type="checkbox"/> N	HIV/AIDS	<input type="checkbox"/> Y <input type="checkbox"/> N
Blood Clots/DVT/PE	<input type="checkbox"/> Y <input type="checkbox"/> N	Kidney Disease/Dialysis	<input type="checkbox"/> Y <input type="checkbox"/> N
Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N	Liver Disease	<input type="checkbox"/> Y <input type="checkbox"/> N
Chronic Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Migraines	<input type="checkbox"/> Y <input type="checkbox"/> N
Dermatitis/Psoriasis	<input type="checkbox"/> Y <input type="checkbox"/> N	Neuropathy	<input type="checkbox"/> Y <input type="checkbox"/> N
Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N	Pacemaker	<input type="checkbox"/> Y <input type="checkbox"/> N
Peripheral Arterial Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Pneumonia	<input type="checkbox"/> Y <input type="checkbox"/> N
		Polio	<input type="checkbox"/> Y <input type="checkbox"/> N
		Rheumatic Fever	<input type="checkbox"/> Y <input type="checkbox"/> N
		Sickle Cell Disease	<input type="checkbox"/> Y <input type="checkbox"/> N
		Skin Disorder	<input type="checkbox"/> Y <input type="checkbox"/> N
		Sleep Apnea	<input type="checkbox"/> Y <input type="checkbox"/> N
		Stomach Ulcers	<input type="checkbox"/> Y <input type="checkbox"/> N
		Stroke	<input type="checkbox"/> Y <input type="checkbox"/> N
		Thyroid Disease	<input type="checkbox"/> Y <input type="checkbox"/> N
		Tuberculosis	<input type="checkbox"/> Y <input type="checkbox"/> N
		Ulcers (foot)	<input type="checkbox"/> Y <input type="checkbox"/> N
		Other	
SURGICAL HISTORY			
Type of Surgery		Date of Surgery	
SOCIAL HISTORY			
Marital Status		Employer	Occupation
Height		Weight	Shoe Size
Alcohol <input type="checkbox"/> Never <input type="checkbox"/> Occasional (how often):			
Tobacco <input type="checkbox"/> Never <input type="checkbox"/> Former (when did you quit): <input type="checkbox"/> Current (how many packs/day, how many years):			
Current flu vaccination <input type="checkbox"/> Y <input type="checkbox"/> N		Current pneumonia vaccination (65 or older) <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NA	
Do you have an Advanced Directive Plan <input type="checkbox"/> Y <input type="checkbox"/> N			
FAMILY HISTORY			
Condition	Father	Mother	Sibling
Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Heart Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

FOOT & ANKLE SURGICAL GROUP

10561 Jeffrey's St. Suite 110
Henderson, NV 89052
Tel: 702-456-3668 * Fax: 702-456-6688

Douglas S Stacey D.P.M.
Gerald W. Torgesen D.P.M.
Philip J. Larsen D.P.M.
Troy S. McArthur D.P.M.

FINANCIAL RESPONSIBILITY POLICY

Your insurance policy is a contract between you and your insurance company, not our office. All fees are due at the time treatment is provided. As a courtesy, our office will bill your primary insurance for you. Insurance may pay all or part of your financial obligation to the Foot & Ankle Surgical Group. However, you are responsible to see that all accounts are completely paid within 90 days. At 90 days, if the undersigned fails to pay the FULL AMOUNT for goods or services rendered, a reasonable collection fee will be assessed and the account will be turned over to a collection agency.

As our patient, you are responsible for all authorizations or referral's needed to seek treatment in this office.

It is very important for you to understand that it is impossible for our office to know what your particular insurance plan will cover, what it will allow, or what it will pay for services we render to you. Many times your insurance company will not provide this information until after we receive the Explanation of Benefits (EOB) from them. Therefore, by becoming a patient of the Foot & Ankle Surgical Group you assume complete and total responsibility for all charges.

I understand and accept financial responsibility for payment of all accounts with the Foot & Ankle Surgical Group.

Signature of patient or responsible party_____

Patient's Name (Printed) _____

CONSENT TO TREATMENT

I hereby give permission for the doctors of Foot & Ankle Surgical Group to examine and render medical and / or surgical treatment, and to provide to referring/consulting physician, insurance companies, their representatives, or my attorney, information they may require regarding my condition while under treatment. I also agree to follow ALL prescribed treatment. I authorize photographs to be taken for medical education purposes. I also authorize the release of any information required or acquired in the course of examination or treatment.

I consent to treatment.

Signature of patient or responsible party_____

PATIENT PRIVACY ACKNOWLEDGEMENT

Our practice is dedicated to maintaining the privacy of your Individually Identifiable Health Information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time. If you would like to review our privacy practices in more detail please ask our staff. A copy is available in the waiting room. The Provider's Privacy contact Officer for Foot and Ankle Surgical Group is Dr. Philip J. Larsen D.P.M.

If you would like anyone to have access to your records, please list their names below:

x _____ x _____ x _____

I hereby acknowledge that I have been presented this notice of Privacy Practices, and consent to treatment.

Signature of patient or responsible party_____

Patient's Name (Printed) _____ Date _____

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CONTRACT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

Controlled substance medications {narcotics, tranquilizers, and barbiturates} are very useful, but have high potential for misuse and abuse. Therefore, they are clearly controlled by the local, state, and federal government. They are intended to relieve pain, to improve function, and/or ability to work, not simply to feel good. Due to the fact my doctor is now or may be prescribing such medication for me in the future to help manage pain, I agree to the following conditions:

1. I am responsible for my controlled substance medication. If the prescription is lost, misplaced, stolen, or if I use it up sooner than prescribed, I understand it will not be replaced.
2. I will not request nor accept controlled substance medication from any other physician or individual while I am receiving such medication from my doctor at the Foot & Ankle Surgical Group without informing my doctor immediately. Besides being illegal to do so under NRS 453.391, it may endanger my health. The only exception is if it is prescribed while I am admitted in a hospital.
3. Refills of controlled substance medications:
 - a) Will be made only during the hours of 8:00 a. m. to 4:30 p.m. Refills will not be made at night, on holidays, or on weekends.
 - b) **Will not be made** if I "run out early." I am responsible for taking the medication in the dose prescribed and for keeping track of the amount left.
 - c) Will not be made as an "emergency," such as on Friday afternoon because I suddenly realize I will run out "today." I must keep track of my medication and plan ahead. I will call at least 24 hours ahead if I need assistance with a controlled substance medication prescription.
4. I understand if I violate any of the above conditions, my controlled substance prescription and/or treatment at the Foot & Ankle Surgical Group may be ended immediately. If the violation involves obtaining controlled substances from another individual, as described above, I may also be reported to local medical facilities and other authorities.

I understand the main treatment goal is to improve my ability to function and/or work. In consideration of this goal and that I have been or may be given potent medication to help me reach that goal, I agree to help myself by following better health habits, specifically involving exercise, weight control, and the use of tobacco or alcohol. I understand that only through following a healthier lifestyle can I hope to have the most successful outcome to my treatment.

Patient Name (Print)

Signature of Patient (Parent or Guardian If Minor)

Date

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OFFICE POLICIES

PLEASE READ AND SIGN THE FOLLOWING POLICIES

- I certify that all of the information given by me is correct to the best of my knowledge.
- I hereby authorize direct payment of surgical/medical benefits to Foot & Ankle Surgical Group for medical services rendered. I understand that I am financially responsible for any balance unpaid by my health insurance. All patient balances that remain unpaid for more than 90 days can/ will be referred to a collection agency.
- I understand that if my insurance company does not pay for any medical services rendered, even after prior authorization is given to our office, I will be financially responsible for any remaining balance. Some medical procedures require prior authorization. Our office will obtain any necessary authorizations. A prior authorization from your insurance company is not a guarantee of a payment by your insurance company.
- All co-pays, coinsurance and deductibles are due at the time service is rendered.
- There will be a \$50.00 check fee for all returned/non-sufficient funds/closes account checks. If the check is not settled within 10 days of the date it is issued it may be referred to the District Attorney's Office for collections.
- All prescription refills will be processed within 48 hours of notification, and during Office Hours only. We are unable to refill prescriptions after hours, weekends, or holidays.
- There will be a \$20.00 fee for each time we fill out your FMLA and/Disability forms. We will not accept incomplete forms. Your portion must be complete before we can complete the physician's portion. The forms must be submitted to our office a minimum of one week prior to the date of required submission. We cannot be responsible for forms given to the physician; they must be given to a back office assistant.
- There will be a \$25.00 charge for all missed appointments and a \$50.00 charge for all surgical appointments.
- As Per NRS 629.051, all health care records will be maintained for a period no less than five (5) years, all health care records may be destroyed after five (5) years.

PATIENT SIGNATURE _____ Date _____

PARENT/GUARDIAN SIGNATURE _____ Date _____