FOOT & ANKLE SURGICAL GROUP **PATIENT REGISTRATION**

PATIENT INFORMATION					
First Name	MI	Last Name			
Preferred Name	DOB	Sex □ M □ F	SS#		
Address	City	State	Zip		
Cell Phone	Home Phone	Email			

REFERRAL (CHECK ONE)

How did you hear about us? □ Insurance □ Facebook □ Google □ Yelp □ Other Patient □ Physician

PRIMARY CARE PHYSICIAN	
Name/Practice Name	Phone

EMERGENCY CONTACT		
Name	Phone	Relationship to Patient

INSURANCE		
Insurance Company	ID#	Group#
Is this a Workers' Compensation claim □ Y □ N	Claim#	Case Adjuster's Phone#

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	
Address	City	State	Zip	

CHIEF COMPLAINT

Reason for visit today

REVIEW OF SYSTEMS (CHECK ALL THAT APPLY)

Constitutional □ chills □ fatigue □ fever □ recent weight change

Eyes □ blurry/double vision □ dry eyes □ light sensitivity

Ears, Nose, Throat □ bleeding □ congestion □ discharge □ sores in mouth □ sore throat □ tinnitus/vertigo

Cardiovascular □ chest pain □ cold feet □ leg cramps □ leg swelling

Respiratory □ cough □ difficulty breathing □ shortness of breath □ wheezing

Gastrointestinal □ abdominal pain □ change in appetite □ constipation □ diarrhea □ nausea □ vomiting

Musculoskeletal □ toe pain □ foot pain □ ankle pain □ back pain □ difficulty walking □ loss of strength

Skin/Integumentary □ bruising □ change in nails □ hair loss □ itching □ rash □ ulcer □ wound

Neurological □ numbness □ seizures □ syncope □ tremors □ weakness

Psychiatric □ depression □ mood changes □ nervousness

Endocrine □ dryness of skin/hair □ excessive hunger/thirst □ excessive urination □ intolerance to heat/cold

Genitourinary □ blood in urine □ incontinence □ pain with urination □ 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	Y N	Emphysema/COPD	Y N	Peripheral Arterial Disease	Y N
Allergies (seasonal)	Y N	Epilepsy/Seizures	Y N	Pneumonia	Y N
Anemia	Y N	Fibromyalgia	Y N	Polio	Y N
Anxiety/Depression	Y N	Gout	Y N	Rheumatic Fever	Y N
Arthritis	Y N	Heart Attack	Y N	Sickle Cell Disease	Y N
Asthma	Y N	Heart Disease/CHF	Y N	Skin Disorder	Y N
Atrial Fibrillation	Y N	Hepatitis	Y N	Sleep Apnea	Y N
Back Problem	Y N	High Blood Pressure	Y N	Stomach Ulcers	Y N
Bladder Infections	Y N	High Cholesterol	Y N	Stroke	Y N
Bleeding Disorder	Y N	HIV/AIDS	Y N	Thyroid Disease	Y N
Blood Clots/DVT/PE	Y N	Kidney Disease/Dialysis	Y N	Tuberculosis	Y N
Cancer	Y N	Liver Disease	Y N	Ulcers (foot)	Y N
Chronic Pain	Y N	Migraines	Y N	Other	
Dermatitis/Psoriasis	Y N	Neuropathy	Y N		
Diabetes	Y N	Pacemaker	Y N		

SURGICAL HISTORY	
Type of Surgery	Date of Surgery

SOCIAL HISTORY		
Marital Status	Employer	Occupation
Height	Weight	Shoe Size
Alcohol use □ Never □ Occasional (how often):		
Tobacco use □ Never □ Former (quit how long ago):	□ Current (how many packs/day):	(how many years):
Current flu vaccination □ Y □ N	Current pneumonia vaccination (65 years of age or older) □ Y □ N □ NA	
Do you have an Advanced Directive Plan □ Y □ N		

FAMILY HISTORY			
Condition	Father	Mother	Sibling
Cancer	Y N	Y N	Y N
Diabetes	Y N	Y N	Y N
Heart Disease	Y N	Y N	Y 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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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. You 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_____

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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