The Foot & Leg SPECIALTY CENTER

6543 Madison St. New Port Richey FL 34652
Phone 727-842-9504 Fax 727-842-9505
doctor@footlegspecialtycenter.com

Patient Name: _____ **Birth Date**:_____/_____/_____ **Age:**_____

Address: _____ **City:** _____**St**:_____ **Zip:**_____

Alternate Address: _____ **Email** (for online medical records)_____

Phone Number:_____ **Cell:** _____ **Gender :** _____

SSN#_____ **Marital Status:** _____ **RACE:** _____ **Ethnicity:**_____

Emergency Contact: _____ **Phone Number:** _____ **Relationship:**_____

How were you referred to our office? (Please circle): Google Facebook Insurance Family member _____ Doctor _____

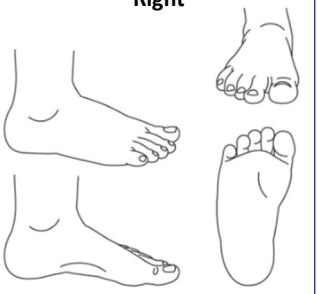
PRIMARY CARE DOCTOR: _____ Date last seen: _____

CARDIOLOGIST: _____ **DIABETIC DOCTOR**: _____

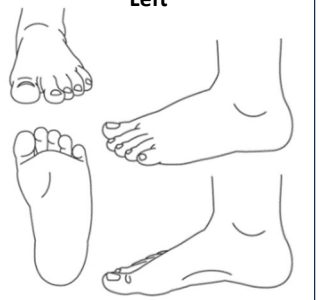
Chief Complaint (reason for visit):_____
Pain Scale (rate your pain level 1 to 10, 10 being the worst) _____
Please circle below in regards to your pain:

Nature	**Location**	**Course**
dull	left	intermittent
aching	right	constant
throbbing	ankle	random
sharp	foot	varied
stabbing	leg	progressive
burning	_____	sporadic
tingling		_____
numbness		
_____		

Right



Left



Right **Left**

Duration (how long have you had the problem?)_____

Onset (how did it start?)_____

Aggravating Factors (what makes it worse?)_____

Treatment (what has been done?)_____

Medications (Please list all medications you take, or attach your medication list)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

ALLERGIES (Please list allergies and reaction to them) Ie Penicillin-Hivers, Adhesive-rash, NSAIDs-difficulty breathing etc.

Vitals: Height_____ Weight _____ **Social history:** Do you drink alcohol: _____ Do you use illicit drugs:_____ Do you **smoke tobacco/tobacco products**? _____ If yes, how much: _____

Family history

Father_____

Mother_____

Siblings_____

Are you diabetic? _____ Your last A1c _____ Do you wear diabetic shoes? _____

Are you able to walk more than a block without a break _____

Past Medical History (circle or check mark those that apply)

Anemia	Thyroid disease	History of stroke	Please list others:
Alzheimer	Hepatitis	History of stents	
Arthritis	High blood pressure	High cholesterol	
Asthma	Kidney disease	Cardiac Pacemaker	
Cancer	Liver disease	Rheumatic fever	
Epilepsy	Heart failure	Stomach/GI issues	
Gout	Osteoporosis	Multiple Sclerosis	
HIV/AIDS	History of heart attack	Warts	

Past Surgical history (major surgeries only)

_____

_____

_____

_____

Policy Holder's name: _____ DOB _____

SIGNATURE of patient/patient representative: _____DATE: _____

Relationship of representative to the patient:_____

INSURANCE AUTHORIZATION AND ASSIGNMENT GUARANTY OF PAYMENT OF MEDICAL SERVICES

I hereby authorize Foot Leg Specialty Center to furnish information to insurance carriers, other physicians and any other facilities involving the treatment/care of illness/injuries and for services provided as a patient of Foot Leg Specialty Center. I also hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I authorize payment of benefits to the physician or supplier. I understand that I am financially responsible for all medical and related charges incurred by me and/or my dependent in my/his/her medical treatment provided by my physician or other persons or facilities acting with or in the place of my physician, whether or not such charges are covered by insurance, including any and all collection fees, costs and attorney fees incurred by the physician or facility in collecting my or my dependent's medical bill. This authorization applies to all occasions of service until it is revoked by me in writing. I also hereby authorize photocopies of this authorization form to be as valid as the original.

SIGNATURE of patient/patient representative: _____ DATE: _____

REQUEST FOR CONFIDENTIAL INFORMATION

I hereby request Foot Leg Specialty Center to contact me by: the phone numbers, email and address I have listed on the first page.
I understand that Foot Leg Specialty Center is not required by law to agree to this request but every attempt will be made to abide by my restrictions unless I am in need of emergency treatment. This agreement is valid until revoked by me in writing. I also authorize Foot Leg Specialty Center to speak with the following people in regards to my diagnosis and/or treatment options or any other related healthcare issues:
Name:_____ Relationship_____ Phone:_____

SIGNATURE of patient/patient representative: _____ DATE: _____

NOTICE OF PRIVACY PRACTICES / PATIENT RIGHTS AND RESPONSIBILITIES ACKNOWLEDGMENT

I acknowledge that I am aware of Foot Leg Specialty Center's Notice of Privacy Practices and consent to the use of disclosure of my Protected Health Information (PHI) by Foot Leg Specialty Center for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, to conduct health care operations of Foot Leg Specialty Center and as required by law. I also acknowledge that I was offered the entire notice and that I understand I may obtain a full version of the notice at any time. I understand my rights as a patient of this practice concerning my PHI, as it is outline in this notice and in addition I have received a copy of Foot Leg Specialty Center's Patient Rights and Responsibilities. I am aware that Foot Leg Specialty Center reserves the right to change the privacy practices that are described in this Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by contacting the office.

SIGNATURE of patient/patient representative: _____ DATE: _____

NOTICE OF NO SHOW/CANCELLATION OF APPOINTMENTS/BALANCE/SELF PAY

We understand there are times when you must miss an appointment due to emergencies or obligations for work, family, etc. However, when you do not call to cancel an appointment, you could be preventing another patient from getting much needed treatment. If an appointment is not cancelled at least 24 hours in advance you may be charged a **$25.00 cancellation/no show fee**. If you are more than 15 minutes late to your appointment you may have to reschedule your appointment. This fee will NOT be covered under your insurance policy. Surgeries require a large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office. If your surgery is not cancelled at least 2 days in advance you may be charged a **$50.00 cancellation/no show fee**. We require that patients with self-pay balances have their account balances to zero ($0) PRIOR to receiving further services provided by our doctor and staff. Patients whom have questions about their bills or who would like to discuss a payment plan, may call and ask to speak to our billing staff. Patient balances over $100.00 must make payment arrangements PRIOR to any future appointments being made. If you are a self-pay patient; you will be required to pay for the office visit before services are rendered.

SIGNATURE of patient/patient representative: _____ DATE: _____

CONSENT FOR TREATMENT

I voluntarily consent to any and all health care treatment and diagnostic procedures provided by the Foot and Leg Specialty center, Omair Zafar DPM and its associated physicians, and other personnel. I am aware that the practice of medicine and other health care professions is not an exact science and I understand that no guarantees have been or can be made as to the results of the treatments or examinations at Foot and Leg Specialty Center. I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment, treatment and health care operations consistent with Foot and Leg Specialty center notice of privacy practices, financial policy notice and release of information. I authorize payment of medical benefits to Foot and Leg Specialty center or their designee for services rendered. I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.

SIGNATURE of patient/patient representative: _____ DATE: _____

I certify that the information I have provided is correct. I understand that I am responsible for my deductible, co Payments, co-insurance or Non-covered services that will be collected at the time of service.

SIGNATURE of patient/patient representative: _____ DATE: _____