MID FLORIDA FOOT AND ANKLE CLINIC

Podiatric Consultation: History and Physical

Name: _____ Gender: □ Male □ Female

Street Address: _____ Marital Status: □ S □ M □ W □ D

City, State, Zip: _____ Date of Birth: _____ Age: _____

Northern Address: _____ SS No: _____

Phone: _____

Cell: _____ Email Address: _____

Family Physician: _____ Dr. Phone: _____

Referred By: _____ Dr. Fax: _____

Date Last Seen: _____

Spouse Name: _____ SS No: _____

Sp's Employer: _____ Date of Birth: _____

Emergency Contact: _____ Phone number: _____

Responsible Party: _____ Date of Birth: _____

SS No: _____

Employer of Responsible Party: _____ Work Phone: _____

Ins. Company # 1 _____ ID No.: _____

Policy Holder: _____ Group No.: _____

Ins. Company # 2 _____ ID No.: _____

Policy Holder: _____ Group No.: _____

Signature: _____ Date: _____

ASSIGNMENT: I authorize the release of information necessary to process this claim and hereby assign my insurance benefits to be paid directly to Dr. Gabriel Delgado.

Personal History:

Date: _____ Patient: _____

Weight:_____

Height:_____

1. Medical History: ☐ None
   - ☐ Kidney Disease
   - ☐ Stent
     Location_____
   - ☐ Diabetes
   - ☐ Hypertension
   - ☐ Heart Disease
   - ☐ Asthma ☐ COPD
   - ☐ Hepatitis ☐A ☐B ☐C
   - ☐ Bleeding Disorder
   - ☐ Heart Attack
   - ☐ Cancer
   - ☐ Stroke
   - ☐ Peripheral Vascular Dx
   - ☐ Ulcers
   - ☐ Gout
   - ☐ Psoriasis
   - ☐ Thyroid ☐ Low ☐ High
   - ☐ Rheumatoid Arthritis
   - ☐ Osteoarthritis
   - ☐ Fibromyalgia
   - ☐ Leg Pain when Walking
   - ☐ High Cholesterol
   - ☐ Fracture _____
   - ☐ Other_____

2. Allergies: ☐ None
   - ☐ Antibiotics
   - ☐ Aspirin
   - ☐ Codeine
   - ☐ Cortisone
   - ☐ Morphine
   - ☐ Penicillin
   - ☐ Other_____
   - ☐ Sulfa
   - ☐ Tape
   - ☐ Local Anesthetic

3. Social Habits: ☐ None
   - ☐ Smoke
   - ☐ Former Smoker _____ Pk/PD
   - ☐ Use Alcohol _____ Amt.
   - ☐ Use Drugs _____

4. Prior Footcare: ☐ No ☐ Yes Date: _____ Dr. _____

5. Shoe Size: _____ Type of Shoe: ☐ Athletic ☐ Dress ☐ High Fashion Heels

6. Family Medical History ☐ None

Parents:

Siblings:

7. Past Surgeries and Hospitalization: ☐ None

8. Current Medications: ☐ None
   - ☐ Coumadin
   - ☐ Aspirin daily

Doctor Dose

ACKNOWLEDGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____
Patient Name (please print) Date

_____
Parent or Authorized Representative (if applicable)

_____

Signature

Consent to allow access to medical records

Please allow the following access to medical records:

Name:_____

DOB:_____

Relationship to Patient: _____

Mid Florida Foot & Ankle Clinic
Consent to Treatment and Financial Responsibility Agreement

Consent to Treatment. The undersigned consents to any medical or surgical treatment, x-ray examination, or any other diagnostic or therapeutic treatment or services rendered the patient by the staff of Mid Florida Foot & Ankle Clinic, and/or Gabriel F. Delgado, DPM, P.A., (collectively referred to herein as MFFA) under the general or special instructions of the physician. The undersigned also consents to admission of observers and/or assistants to the room where procedures, tests, or examinations are performed and to the disposal of any tissue or specimens removed in accordance with MFFA's policy.

Release of Medical Information. The undersigned hereby authorizes MFFA to release information and/or copies of his/her medical records to physicians, any guarantor of payment on his accounts, insurance companies (and other third party payors, including workers' compensation carriers and the patient's employers for which he has assigned benefits for his treatment and care). This includes authorization to release information pertaining to: (i) x-ray, pathologic or serologic test results (ii) care and treatment for this period of illness and (iii) disclose all or part of my medical record to past and future medical care providers. Such medical care providers may discuss with the MFFA staff and its representatives any treatment provided, procedures performed and complications therefrom, if any.

Medicare Patients. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct to the best of my knowledge. I authorize the holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I understand that the care and services received during my treatment are subject to professional medical review according to the Federal Law P.L.97-248, and that the information regarding my treatment including x-ray, pathologic or serologic test results may be forwarded to the appropriate peer review organization, who will ensure the confidentiality of information collected and maintained for purposes of professional review.

Agreement to Pay Charges. The undersigned promises to pay to MFFA the total charges, on demand, for services rendered or any co-payments or deductible for which the undersigned is liable. I also agree that all charges for services rendered that are not covered by any insurance program, sponsorship, or other third party coverage are due and payable at the time of service. **I hereby acknowledge that if MFFA has agreed to bill my insurance carrier or other third party payor, it has agreed to do so as a courtesy only and that MFFA has the right to demand payment in full from me at any time prior to full payment from any insurance carrier or other third party payor.** The statement of charges for services performed will be provided to me by MFFA on request. Any amounts paid by insurance companies, assigned to and received by MFFA, will be credited to the balance due. The assignment of insurance benefits does not alter the undersigned's obligation to pay. MFFA reserves the right to decline further services to the patient without notice and to accept periodic payments without waiving its right to demand payment in full as outlined above and the right to assign the amount due under this Agreement. Any overpayment by or for the patient will be first applied to other balances due then may be refunded to the paying party, or held on account at the request of the paying party. I hereby acknowledge having been told by MFFA that I may be billed for all services rendered. I further agree that, if I am more than thirty (30) days delinquent in the payment of any bill connected with this treatment, interest on the amount due may accrue at the maximum rate allowed by law. If the delinquent account is referred for collection, I agree to pay the attorney's fees, court costs and/or collection agency fees associated with the collection process.

Assignment of Insurance Benefits. The undersigned hereby assigns to MFFA reimbursement benefits on all insurance policies otherwise payable to him or her for this visit. The undersigned authorizes MFFA to submit insurance claims to insurance companies or plan administrators and to apply insurance proceeds to the MFFA bill and to make refunds to insurance companies if refunds are due under provision of such insurance policies. The undersigned hereby assigns all rights, as the insured, to bring an action against his insurance company for benefits due under the insurance policies. I hereby authorize and direct payment to the MFFA physician and any consulting physicians for services provided during my care. I understand that I am financially responsible to these physicians for charges not covered by my insurance company. The undersigned does hereby authorize MFFA to endorse any checks or other payment instruments to the undersigned and to apply the same to any account of the undersigned or any account for which the undersigned could be liable. The undersigned authorizes MFFA or its representatives to prepare and submit to his insurance carrier or plan administrator all the insurance claims, forms, questionnaires and all other statements or documents required by the insurance carrier or plan administrator.

Fraudulent Information. The undersigned certifies that he/she has read, understands and accepts the foregoing, received a copy thereof, and is personally empowered, or is duly authorized by the patient as the patient's general agent, to execute the above.

Office Policies. I understand that a physician, nurse practitioner or physician's assistant may treat me. **I understand that if I fail to keep a scheduled appointment, and do not cancel that appointment at least 24 hours in advance, I will be charged a $20.00 no-show fee. I understand that if I schedule a surgical procedure, including vein treatment, and do not cancel within one week, I will be charged a cancellation fee of $100.00. I understand that the fee for a non-sufficient fund/check is $25.00. I have been offered a copy of the current Notice of Privacy Practices for MFFA. I understand that this consent to treatment and Financial Responsibility Agreement replaces previous versions of this document that I have signed.**

Custom Orthotics Payment Policy. The undersigned hereby understands and agrees that when purchasing Custom Orthotics that payment of half of the fee is required at time of casting and the balance is due at time of dispensing regardless of any insurance authorizations/approval for these devices. The undersigned hereby understands that while there may be an authorization/approval from any insurance carrier for these devices that it is not a guarantee by the insurance carrier of payment. If any payment is received by MFFA from any insurance carrier for these devices and this creates an overpayment, a refund will be issued to the undersigned in these circumstances.

_____ _____

Patient (or Parent/Guardian/Representative) signature Date signed

_____ _____

Relationship to patient (if not patient signature above) Print Patient Name

A copy of this document is to be provided to the patient or representative at the time of treatment. Initial when completed: _____

Mid Florida Foot & Ankle Clinic: 1718 Mockingbird Lane: Lakeland, FL 33801: tel 863-646-1641, fax 863-802-5693

Do you have any of the following:

Yes☐ or No☐ Chills

Yes☐ or No☐ Fever

Yes☐ or No☐ Dizziness

Yes☐ or No☐ Headache

Yes☐ or No☐ Malaise

Yes☐ or No☐ Nausea & Vomiting

Yes☐ or No☐ Syncope (Fainting Spell)

Yes☐ No☐or Excessive Thirst

Yes☐ or No☐ Weight Loss (Unintentional)

Yes☐ or No☐ Ankle Swelling

Yes☐ or No☐ Foot Swelling

Yes☐ or No☐ Calf Cramping

Yes☐ or No☐ Calf Pain

Yes☐ or No☐ Calf Burning/walking

Yes☐ or No☐ Cold Feet

Yes☐ or No☐ Cold Hands

Yes☐ or No☐ Temp Change feet/hand

Yes☐ or No☐ Variocosities

Yes☐ or No☐ Athlete's Foot

Yes☐ or No☐ Blisters

Yes☐ or No☐ Burning Skin

Yes☐ or No☐ Contact Dermatitis

Yes☐ or No☐ Dry Scaling Skin

Yes☐ or No☐ Eczema

Yes☐ or No☐ Excessive Scar Tissue

Yes☐ or No☐ Itchy Skin

Yes☐ or No☐ Leg/Foot Ulcers

Yes☐ or No☐ Non-healing wounds

Yes☐ or No☐ Rash

Yes☐ or No☐ Anemia

Yes☐ or No☐ Swelling Feet

Yes☐ or No☐ Bleeding

Yes☐ or No☐ Lymph node problems

Yes☐ or No☐ Water Retention

Yes☐ or No☐ Arthralgia

Yes☐ or No☐ Joint Pain

Yes☐ or No☐ Heel Pain

Yes☐ or No☐ Joints Red or Swollen

Yes☐ or No☐ Weakness

Yes☐ or No☐ Numbness Legs or Feet

Yes☐ or No☐ Tingling Legs or Feet

Yes☐ or No☐ Paralysis

Yes☐ or No☐ Uncontrolled Movement

Yes☐ or No☐ Loss of sensation

Yes☐ or No☐ Skin overly sensitive to touch

Patient Signature: _____ DATE: _____