



GENTLE FOOT CARE

Treatment & Surgery of the Foot and Ankle

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Date: __/__/__

Patient Name _____ Date of Birth _____ Age ____ Sex: M F

Home Address _____ SSN: _____

City _____ State ____ Zip code _____

Home Phone _____ Preferred: Home Cell

Cell Phone _____ Email _____

Primary Language _____ Ethnicity _____

Do you have a legal guardian or Healthcare Power of attorney? Yes No

If Yes, NAME _____ Relationship _____ Phone Number _____

Emergency Contact _____ Relationship _____ Phone Number _____

Primary care provider _____ Phone Number _____

How were you referred to us? _____

Pharmacy Name _____ Phone Number _____

Address _____

Who is responsible for payment? _____

Occupation _____ Employer _____

Is there a family member or other person you would like for us to share your medical information?

Yes No Name _____ Relationship _____

What is the reason for your visit today? _____

Are you diabetic? Yes No

Family History

Do you have a family history of: Family Member (example: Mother, Father, Sister, Brother)

- Diabetes
- Cancer
- Heart Disease
- High blood pressure
- Stroke
- Rheumatoid Arthritis
- Other

Allergies: None

Medications _____

Anesthesia _____

Foods _____

Other Tape Latex Shellfish Iodine Other _____

Review of Systems: Please note or write in any symptoms that apply to you currently

Constitutional	Nausea <input type="checkbox"/> Recent Illness <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Night sweats <input type="checkbox"/> Anorexia <input type="checkbox"/> Fatigue <input type="checkbox"/> Insomnia <input type="checkbox"/> Weight loss/gain <input type="checkbox"/>
Eyes	Visual changes <input type="checkbox"/> Cataract <input type="checkbox"/> Glaucoma <input type="checkbox"/> Discharge <input type="checkbox"/> Injuries <input type="checkbox"/> Glasses or contacts <input type="checkbox"/>
Head, Ears, Nose, Throat	Head Injuries <input type="checkbox"/> Headache <input type="checkbox"/> Dizziness <input type="checkbox"/> Difficulty with Hearing <input type="checkbox"/> Pain <input type="checkbox"/> Discharge <input type="checkbox"/> ear Infections <input type="checkbox"/> Ventilation Tubes <input type="checkbox"/> Sinus <input type="checkbox"/> congestions <input type="checkbox"/> Sore throat <input type="checkbox"/> Discharge <input type="checkbox"/> Difficulty in swallowing <input type="checkbox"/> Dental defects <input type="checkbox"/> Swollen glands <input type="checkbox"/> Masses <input type="checkbox"/>
Lungs	Shortness of breath <input type="checkbox"/> Ability to keep up with peers <input type="checkbox"/> cough <input type="checkbox"/> Wheezing <input type="checkbox"/>
Heart	Cyanosis <input type="checkbox"/> Arrhythmia <input type="checkbox"/> Edema <input type="checkbox"/> Heart murmurs <input type="checkbox"/> Heart Trouble <input type="checkbox"/> Pain over heart <input type="checkbox"/>
Gastrointestinal	Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Abnormal bowel movements <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Jaundice <input type="checkbox"/> Reflux <input type="checkbox"/>
Genitourinary	Hematuria <input type="checkbox"/> Urethral or vaginal discharge <input type="checkbox"/> Sores <input type="checkbox"/> Pain <input type="checkbox"/> Venereal disease <input type="checkbox"/> Pregnant <input type="checkbox"/> Abortion <input type="checkbox"/>
Musculoskeletal	Back pain <input type="checkbox"/> Stiffness <input type="checkbox"/> Swelling <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Deformities <input type="checkbox"/> Difficulty in moving extremities or walking <input type="checkbox"/> Joint pains <input type="checkbox"/> Swelling <input type="checkbox"/> Muscle pains or cramps <input type="checkbox"/>
Skin	Skin cancer <input type="checkbox"/> Rashes <input type="checkbox"/> Calluses <input type="checkbox"/> Nail changes <input type="checkbox"/> Psoriasis <input type="checkbox"/> Cellulitis <input type="checkbox"/> Skin color change <input type="checkbox"/> Abnormal moles <input type="checkbox"/> Easy bruising or bleeding <input type="checkbox"/>
Neurologic	Headaches <input type="checkbox"/> fainting <input type="checkbox"/> Dizziness <input type="checkbox"/> Seizures <input type="checkbox"/> Numbness <input type="checkbox"/> Tremors <input type="checkbox"/>
Psychiatric	Nervousness/anxiety <input type="checkbox"/> Drug use or abuse <input type="checkbox"/> Psychosis <input type="checkbox"/> Suicidality <input type="checkbox"/>
Endocrine	Hypo-thyroid <input type="checkbox"/> Hyper-thyroid <input type="checkbox"/> Hyperglycemic <input type="checkbox"/> Diabetes <input type="checkbox"/>

Height ___ Ft. ___ In Weight _____ Pounds Shoe Size _____

Please List all prior surgeries:

Type of Surgery	Date

Please List all Medications you are currently taking (Include prescriptions, over the counter meds and herbal supplements):

Name	Dose	Reason

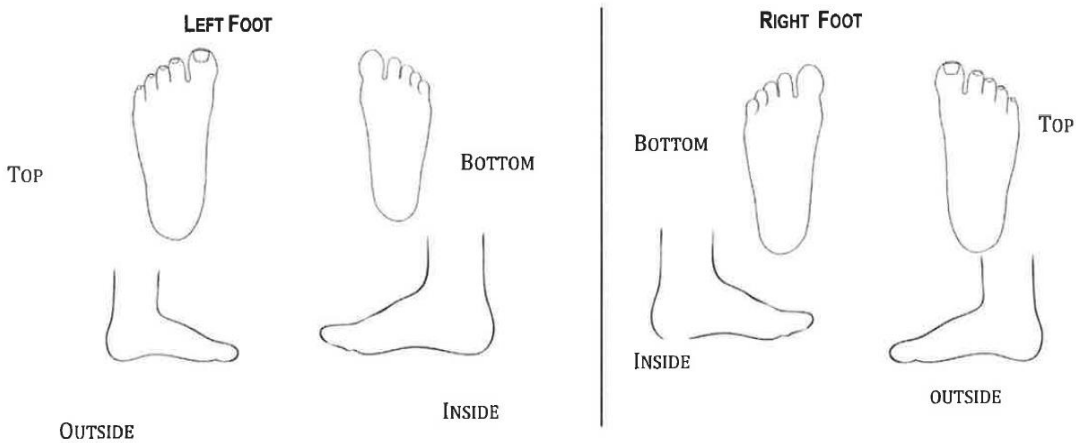
Medical Problems: Which of these following conditions are you currently being treated for or have been treated for in the past (Please Check)

- | | | |
|---|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart | <input type="checkbox"/> Liver problems | <input type="checkbox"/> Anemia or blood problems |
| <input type="checkbox"/> Disease/Murmur | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Depression/Anxiety |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Hepatitis ___ | <input type="checkbox"/> Ulcers/colitis |
| <input type="checkbox"/> Eye disorder/Glaucoma | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Swollen ankles |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Arthritis (rheumatoid or osteoarthritis) | <input type="checkbox"/> Ear Problems |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Heartburn (reflux) | <input type="checkbox"/> Psychiatric care |
| <input type="checkbox"/> Kidney/Bladder problems | <input type="checkbox"/> Seasonal allergies | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Neurological problems | <input type="checkbox"/> Infectious disease (HIV, AIDS) |
| <input type="checkbox"/> Lung Problems/cough/COPD | | |

Others/any additional information regarding your medical conditions:

Was this problem caused by an injury? No Yes If yes, please describe below

Where is the pain/problem located? Please mark on the picture below.



To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the Doctor and office staff of any changes in my medical status.

Signature _____ Date _____

Print Name _____

Relation to patient _____



Notification of Office Policies and Procedures

Reading the following policies and procedures annually will keep you informed about our office.

1. **Appointments:** To allow for greater access of care, our team of physicians are available by appointment during posted hours.
2. **Emergency/After Hours:** During a medical emergency, patients should call 911 or proceed to the nearest emergency room. For non-emergency, please call our answering service.
3. **Benefits:** Gentle Foot Care will reiterate the benefits that were disclosed to us by your insurance plan. We will then collect based on the benefit level all applicable copays, deductibles, coinsurances, and balances that apply at the time of service.
4. **Payment:** Gentle Foot Care requires a credit card on file for the following commercial insurance companies if there is no secondary coverage: Aetna, Anthem, Aultcare, Cigna, Coresource, Gateway Health, GEHA, Golden Rule, Humana, MedBen, Medical Mutual, Meritain, Mutual Health Services, Ohio PPO Connect, Optima Health, PAI, Physicians Mutual, UMR, and United Health Care.
 - *Copays are required at the time of service per insurance contract or you will be rescheduled.
 - *If deductible is not met, it is required that payment be made towards deductible amount on services rendered at the time of service and once explanation is received from insurance the balance due from patient will be charged to the credit card on file on the 1st business day of the month not to exceed \$250.00.
 - *We accept VISA, Mastercard, American Express, Discover, cash, and checks. We do not offer a payment plan.
5. **INSURANCE CLAIMS:** Gentle Foot Care files claims electronically for the patients for primary contracted plan and accepts payments via the patients assignment.
6. **MULTIPLE POLICIES:** When multiple policies exist, it is the policy holder’s responsibility to inform us of their primary plan. Delaying filing to the primary plan can result in violating timely filing limits, resulting in denial of service and full patient responsibility.
7. **INSURANCE NETWORKS:** Gentle Foot Care only files to carriers with whom we have a contractual relationship.
8. **NON-COVERED SERVICES:** Gentle Foot Care will not submit claims for non-covered OTC items.
9. **REFERRALS:** Gentle Foot Care may refer patients to other providers, facilities, and labs. Gentle Foot Care is not responsible for these entities. The patient should contact these non GFC providers, facilities, or labs directly regarding any billing inquires. The policy holder is also responsible for all insurance prior authorizations, and/or managed care referrals necessary for payment to Gentle Foot Care.
10. **RETURNED CHECKS:** A \$50.00 fee will be assessed on all returned checks. Any NSF or closed account will result in future services on a prepay cash or credit basis. The District Attorney’s Office will prosecute unresolved checks.
11. **REFUNDS:** Gentle Foot Care issues patients refunds by check within 30 days of a completed investigation of the potential overpayment as long as other outstanding accounts have been resolved.
12. **RETURNS:** Only unworn and non-custom items are returnable within 14 days of receipt if no visible signs or wear, tear, or odor. Custom items are specifically tailored to meet individual needs and are not returnable and/or refundable.
13. **MEDICAL RECORDS:** The cost for copied medical records and completion of disability forms will be charged to the patient and collected prior to replicating. The fees for these services are regulated by HIPPA.

The undersigned certifies that he/she has read and understands the foregoing, 1-15 statements and is either the patient or is dually authorized by the patient as the patient’s general agent to execute the above and accepts its terms.

Printed Name of Patient or legal representative

Signature

Relationship

Date



GENTLE FOOT CARE

Treatment & Surgery of the Foot and Ankle

Authorization from patient or legal representative

1. **CONSENT TO TREAT:** The undersigned consents to any initial or follow up evaluations, examinations, x-rays, laboratory procedures, other tests, medications, medical treatment, surgery, physical therapy, home instructions, orthotics, other durable medical equipment, photographing and/or videotaping and/or other services rendered to the patient by Gentle Foot Care and its providers. The undersigned agrees that it is their responsibility to contact and/or schedule with Gentle Foot Care for any follow up visits, other services, prescriptions, and items orders for the patient. The undersigned understands that Gentle Foot Care's providers exercise their care with responsible skill and diligence; but make no guarantee as to the results or cure that will be attained.
2. **ASSIGNMENT OF BENEFITS:** I hereby irrevocably assign, to transfer and convey to Gentle Foot Care and any practitioner providing care and treatment to me/my child, any and all benefits and all interests and rights (including causes and action, the right to enforce payment and the right to appeal an adverse benefit determination) to which I am entitled under an employee benefit plan sponsored by my employer, all policies, benefits, any third party reimbursements or prepaid health care plan or services or products that I receive from Gentle Foot Care.
3. **MEDICARE ASSIGNMENT:** I certify that the information given by me in applying for payment under XVII of the social security act is correct and agree to complete the Medicare screening form annually. I authorize the release of information concerning me to the social security administration or its intermediaries as well as any information needed for filing a Medicare claim. I request that payment and authorized benefits be made on my behalf. I assign benefits payable for services to Gentle Foot Care.
4. **AUTHORIZATION TO RELEASE INFORMATION:** I consent and authorize Gentle Foot Care and its agents to release my health information for the purpose of payment, treatment and healthcare operations to any of the following: Insurance Company and its affiliates, any practitioner, support staff or faculty involved in my plan of care or transfer of care. In addition, I understand that the potential uses and disclosures of my health information are detailed in the privacy notice. The HIPPA notice of Privacy Practices are available in the office and posted in the lobby. I have read/had the opportunity to read my HIPPA rights, which include Gentle Foot Care's fees for records.
5. **DESIGNATION OF AUTHORIZED REPRESENTATIVE:** I designate and appoint Gentle Foot Care (and its agents) as my authorized representative and authorize it to act on my behalf to 1) request and receive a copy of the summary plan description, to 2) Pursue a benefit claim, 3) appeal an adverse benefit determination and/or 4) file a legal action to recover benefits from my employee benefit plan, insurance policy and any third party reimbursement or prepaid health plan. I understand and agree that my authorized representative shall have full authority to act and receive notices on my behalf with respect to an initial determination of a claim for health benefits relating to treatment and healthcare services received by me/my child at Gentle Foot Care, any requests for documents relating to the claims and adverse determination of the claims.
6. **FINANCIAL AGREEMENT:** I hereby promise to pay for all products received or services rendered to me/my child to the extent I am legally responsible for such payment according to the language of the physician's insurance contract. I understand that I am responsible for all health insurance copayments, deductibles, coinsurances, OTC, convenience items, non-covered services, and any other amounts that apply at the time of service and at the pre-operative appointment. Regardless of the assignment of benefits, should the insurance misrepresent their coverage or delay payment of a claim greater than 60 days, as the designated responsible party I am responsible for all the monies owed to Gentle Foot Care. I also understand that the insurance policy is a contract between me and the insurance company, therefore the policy holder should contact the insurance carrier first when there are questions regarding the explanation of benefits.

The undersigned certifies that he/she has read and understands the foregoing statements 1-6 and is either the patient or dually authorized by the patient as the patient's general agent to execute the above and accepts its terms. This document shall remain in force until a written revocation by me is delivered to Gentle Foot Care.

Print name of patient or legal representative

Signature

Relationship to patient

Date