New Patient Information Form

Patient Info:

Last Name:		Home Phone:
First Name:	M.I.:	Work Phone:
Address:		Cell Phone:
City, State, Zip		Date of Birth:
E-mail Address:		

Policyholder Info: (Self/Parent/Spouse)

Last Name:		Home Phone:
First Name:	M.I.:	Work Phone:
Address:		Cell Phone:
City, State, Zip		Date of Birth:

Emergency Contact:

Name:	Relationship:
Phone:	

Primary Care Physician:

Name:	Phone:

Local Pharmacy Info:

Name:	Phone #: ( )
Address:	

PAYMENT AT TIME OF SERVICE

IT IS OUR OFFICE POLICY THAT PAYMENTS ARE DUE AT THE TIME OF SERVICE. IF WE HAVE A CONTRACT WITH YOUR INSURANCE COMPANY, WE WILL FILE YOUR INSURANCE. HOWEVER, **YOU** ARE RESPONSIBLE FOR ALL CO-PAYS, DEDUCTIBLES AND NON-COVERED SERVICES AT THE TIME OF SERVICE.

I UNDERSTAND AND AGREE THAT, REGARDLESS OF MY INSURANCE STATUS, I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT. I CERTIFY THAT THE INFORMATION PROVIDED ON THIS FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU OF ANY CHANGES IN THIS INFORMATION. A PHOTOSTATIC COPY OR OTHER REPRODUCTION OF THIS WILL BE VALID AS THE ORIGINAL.

DATE:_____ SIGNATURE: _____

AUTHORIZATION TO RELEASE INFORMATION:

I HEREBY AUTHORIZE CALLAHAN FOOT & ANKLE CLINIC TO FURNISH MY INSURANCE COMPANIES, HOSPITALS, REFERRING OR CONSULTING PHYSICIANS AND BILLING AGENTS ALL INFORMATION WITH REGARD TO MY MEDICAL CARE.

DATE:_____ SIGNATURE: _____

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS:

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE (IF APPLICABLE) AND/OR PRIVATE INSURANCE BENEFITS BE MADE ON MY BEHALF TO CALLAHAN FOOT & ANKLE CLINIC FOR ANY SERVICES FURNISHED ME BY CALLAHAN FOOT & ANKLE CLINIC. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO BE RELEASED TO THE CENTERS FOR MEDICARE AND MEDICAID SERVICES AND ITS AGENTS, ALSO ANY INFORMATION NEEDED TO DETERMINE THESE BENEIFTS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

I UNDERSTAND MY SIGNATURE REQUESTS THAT PAYMENT BE MADE AND AUTHORIZE RELEASE OF MEDICAL INFORMATION NECESSARY TO PAY THE CLAIM. IF OTHER HEALTH INSURANCE COVERAGE IS INDICAED ON ITEM 9 OF THE CMS-1500 CLAIM FORM OR ELSEWHERE ON OTHER APPROVED CLAIM FORMS OR ELECTRONICALLY SUBMITTED CLAIMS, MY SIGNATURE AUTHORIZES RELEASING OF THE INFORMATION TO THE INSURER OR AGENCY SHOWN. CALLAHAN FOOT & ANKLE CLINIC ACCEPTS THE CHARGE DETERMINATION OF THE MEDICARE CARRIER AS THE FULL CHARGE AND I AM RESPONSIBLE ONLY FOR THE DEDUCTIBLE, COINSURANCE AND NON-COVERED SERVICES. COINSURANCE AND DEDUCTIBLE ARE BASED UPON THE CHARGE DETERMINATION OF THE MEDICARE CARRIER.

DATE:_____ SIGNATURE: _____

MISSED APPOINTMENT POLICY

IT IS THE POLICY OF CALLAHAN FOOT & ANKLE CLINIC TO CHARGE **$50.00** (FIFTY DOLLARS) FOR MISSED APPOINTMENTS AND APPOINTMENTS THAT HAVE NOT BEEN CANCELLED WITHIN 24 HOURS. THESE CHARGES WILL BE YOUR RESPONSIBILITY AND BILLED DIRECTLY TO YOU. PLEASE HELP US TO SERVE YOU BETTER BY KEEPING YOUR REGULARLY SCHEDULED APPOINTMENTS.

DATE:_____ SIGNATURE: _____

EMAIL AND TEXT MESSAGE USAGE CONSENT

Friedman and Greenhut DPM PA staff representative shall be referred to as "Provider" throughout this consent.

Providers will use reasonable means to protect the security and confidentiality of the email and text information sent and received. However, because of the risks identified below, Provider cannot guarantee the security of the email and text communication, and is not liable for the improper disclosure of confidential information that is not caused by the Provider's intentional misuse.

RISKS OF USING EMAIL/TEXT TO COMMUNICATE WITH YOUR DOCTOR AND STAFF

Transmitting patient information by email or text message has a number of risks that patients should consider before using email to communicate with your doctor or staff. These include, but are not limited to the following risks:

- Can be circulated, forwarded and stored in numerous paper and electronic files
- Can be immediately broadcast worldwide and be received by unintended recipients
- Senders can easily type in the wrong email address or phone number
- Is easier to falsify than handwritten or signed documents
- Backup copies may exist even after the sender or the recipient has deleted his or her copy
- Can be intercepted, altered, forwarded or used without authorization or detection
- Can be used to introduce viruses
- Can be used as evidence in court
- Employers and online services have a right to archive and inspect emails transmitted

PATIENT OBLIGATIONS WHEN CONSENTING TO EMAIL/TEXT

Use email or text messaging for general patient information only. Do not use it for medical emergencies or time sensitive matters or for non-general medical information. Follow up with the Provider if you have not received a response within 5 business days. Take precautions to preserve confidentiality. Use screen savers and safeguard your computer password. Inform Provider of any changes to your email and phone number. Withdraw consent to email/text patients through hard copy written communication. Understand that I may also communicate with a provider via telephone or during a scheduled appointment and text/email is not a substitute for the care that may be provided during an office visit. Appointments should be made to discuss any new issues as well as any sensitive information.

TYPES OF EMAIL/TEXT TRANSMISSIONS THAT PATIENT AGREES TO SEND AND OR RECEIVE

The types of information that can be communicated via email/text with the Provider include:

- Appointment scheduling requests
- Billing
- Insurance questions
- Patient education

The Provider will not engage in email/text communication that is unlawful, such as unlawfully practicing across state lines. If you are not sure if the issue you wish to discuss should be included in an email/text, you should call the office to schedule an appointment.

HOLD HARMLESS

I agree to indemnify and hold harmless the Provider, Friedman and Greenhut DPM PA, doing business as Callahan Foot and Ankle and its trustees, officers, agents, website designer and maintainers from and against all losses, damages, expenses, costs, including reasonable attorney fees relating to and or arising from any information loss due to technical failure, my use of the internet to communicate with the Provider and the use of the Provider's website, any arrangement you make based on information obtained by the site, any products or services obtained through the site and any breach by me of these restrictions and conditions. The provider does not warrant that the functions contained in any materials provided will be interrupted or error free, that defects will be corrected, or that the Provider's website or server makes such site available is free of viruses or other harmful components.

TERMINATION OF THE EMAIL/TEXT RELATIONSHIP

The Provider shall have the right to immediately terminate the email/text relationship with you, if determined in the sole Provider discretion, that you have violated the terms and conditions set forth above or otherwise breach in this agreement, or have engaged in the conduct which the Provider determines to be unacceptable. The email/text relationship between the provider and the patient will terminate in the event the Provider, in their sole discretion, no longer wishes to utilize email/text to communicate with their clients.

FORWARDING EMAIL

I understand that there may be times in which the Provider must forward the information I have provided via email to a third party for treatment and payment purposes. I expressly provide my consent by placing my initials below:

Please initial if you agree: _____

PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I have discussed with the Provider and acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of the email/text message between the provider and me and consent to the condition therein. In addition, I agree to the instructions outlined herein as well as any other instruction that the Provider may impose to communicate with patients by the email/text. Any questions I may have had were answered.

_____ _____

Patient signature Date

ACKNOWLEDGEMENT OF RECEIPT
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices.

_____
Patient Name (please print)

_____
Parent, Guardian or Patient's Legal Representative

_____ _____
Signature Date

FAMILY MEDICAL RELEASE

I, _____, hereby authorize Friedman & Greenhut, DPM, PA to release/receive the following information via phone or in person:

_____ Appointments (schedule/cancel)
_____ Office Notes
_____ Financial Records
_____ Prescriptions

To/From the following individuals:

_____ _____
Name Relation

_____ _____
Name Relation

_____ _____
Patient Signature Date

Patient Name _____ Date _____

Referring Physician Name & Phone _____

History & Medical Information

1. Why are you here? _____
   _____
2. When did pain/discomfort begin (date)? _____
   Describe pain/discomfort ☐ Burning ☐ Numbness ☐ Sharp ☐ Other_____
3. What makes the pain/discomfort better? _____
4. Have you had a physical trauma? ☐ No ☐ Yes _____
5. Have you had an accident? ☐ No ☐ Yes _____

6. Occupation _____ Is your problem work related? ☐ No ☐ Yes
7. Past Medical History:

☐ Anemia	☐ Gout	☐ Kidney Disease	☐ Osteoarthritis
☐ Bleeding Disorder	☐ Heart Failure	☐ Lung/Respiratory Disorders	☐ Other Arthritis
☐ Cancer _____	☐ Hepatitis	☐ Mitral Valve Prolapse	☐ Rheumatic Fever
☐ Diabetes	☐ High Cholesterol	☐ Nerve Disorders	☐ Stroke
☐ Epilepsy	☐ HIV/AIDS	☐ Neurological Disorders	☐ Thyroid Disorders
☐	☐ High Blood Pressure	☐ Prostate Disorders	☐ Other _____

8. Are you currently pregnant? ☐ No ☐ Yes
9. Surgical History: Have you had surgery? ☐ No ☐ Yes, describe below
   Surgery / Date _____
   _____
10. Social History: (Only check what is pertinent to you)

☐ Tobacco Use	☐ Alcohol Use	☐ Exercise Habits_____
☐ Caffeine Use		☐ Drug Use (recreational, IV)

11. Family History: (list relationship of family member(s) who have had these problems)

☐ Diabetes_____	☐ Heart Disease_____	☐ Kidney Disease_____
☐ Hypertension_____	☐ Stroke_____	☐ Mental Illness_____
☐ Rheumatology_____	☐ Bleeding Disorders_____	☐ Cancer _____
☐ Other _____	☐ Other_____	☐ Other _____

12: Height _____ Weight _____ Shoe Size _____

Patient Name _____ Date _____

Review of Systems

Please check any of the following that you are currently experiencing or have recently experienced.

Constitutional			
☐ Fever	☐ Chills	☐ Sweats	☐ Weight Change
Head, Eyes, Ears, Nose and Throat			
☐ Wear Contact Lenses	☐ Dentures	☐ Wear Eyeglasses	
☐ Double Vision	☐ Cataract	☐ Dizziness	
☐ Difficulty Swallowing	☐ Neck Pain	☐ Sore Throat	
☐ Nosebleeds	☐ Problems with Eyesight	☐ Ringing in the Ears	
Cardiovascular			
☐ Chest Pain / Discomfort	☐ Cardiovascular Symptoms	☐ Heart Murmur	
☐ Swelling lower extremity	☐ Leg Pain with Exercise	☐ Palpitations	
Hematologic/Lymphatic			
☐ Bleeding Problem	☐ Swollen Glands	☐ Lymphoma	
☐ Anemia	☐ Skin Lump – Location _____		
Respiratory			
☐ Difficulty Breathing	☐ Wheezing	☐ Previous Pulmonary Disease	
☐ Exposure to TB	☐ Cough	☐ Pulmonary Symptoms	
Gastrointestinal			
☐ Nausea	☐ Vomiting	☐ Diarrhea	
☐ Decrease in Appetite	☐ Abdominal Pain	☐ Constipation	
Endocrine			
☐ Often Thirsty	☐ Frequent Urination	☐ Thyroid Disease	
☐ Urinary Symptoms	☐ Prostate Problems	☐ Prior Kidney Disease	
Musculoskeletal			
☐ Musculoskeletal Symptoms	☐ Feeling Weak	☐ Joint Pain, Arthralgia	
☐ Weakness of Limbs	☐ Prior Fracture		
Nervous System			
☐ Ataxia	☐ Speech Difficulties	☐ Headache	
☐ Neuropathy	☐ Confusion/Disorientation	☐ Fainting	
☐ Convulsions			
Skin			
☐ Rash	☐ Ulcer	☐ Lesions	☐ Sun Sensitivity
☐ Color Change	☐ Slow Healing	☐ Infections	☐ Cracking
☐ Eczema (Pruritus)	☐ Growth	☐ Hair Loss	
Allergic, Immunologic History			
☐ Dermatitis	☐ Rheumatoid Arthritis	☐ Lupus	☐ Collagen Vascular
Psychiatric			
☐ Nervousness	☐ Tension	☐ Depression	☐ Other

CALLAHAN FOOT & ANKLE CLINIC

UNIVERSAL MEDICATION FORM

Name _____ Date _____

Primary Care Physician: _____ Date Last Seen _____

Physician Phone Number _____

Allergic To:	Reaction:

List all prescriptions and over-the-counter (non-prescriptions) medications, such as vitamins, Aspirin, Tylenol and herbals (ex: Ginseng, Gingko Biloba, St. John's Wort, etc.). Include prescription meds taken as needed (ex. Viagra, Nitroglycerin, etc.). Please attach separate sheet or use back of page for additional medications.

DATE STARTED	NAME OF MEDICATION/DOSE	DIRECTIONS: USE PATIENT FRIENDLY DIRECTIONS. DO NOT USE MEDICAL ABBREVIATIONS.	DATE STOPPED	REASON FOR TAKING/MD NAME

CALLAHAN FOOT AND ANKLE CLINIC
2561 RIVERSIDE AVE
JACKSONVILLE, FLORIDA 32204

CONSENT FOR TRANSFER OF BIOLOGICAL SPECIMEN

Florida law (Section 817.5655, Florida Statutes) prohibits the sale or transfer of a person's biological specimen from which DNA can be extracted to a third party without the express consent of such person.

During the course of your care at CALLAHAN FOOT AND ANKLE CLINIC, it may be medically necessary to obtain a blood, urine, stool, tissue or other type of biological specimen for analysis. This analysis **will not** involve the examination of your DNA to identify the presence and composition of genes in your body. After the analysis has been performed and the sample is no longer needed, it will be stored as medical waste and then transferred to a third party for disposal in accordance with all local, state, and federal requirements.

It may also be the case that a biological specimen (such as blood, urine, hair, bodily fluids, etc.) from you may be deposited on medical instruments, bedding, clothing, or other objects. These objects may then be transferred to a third party for cleaning or disposal.

By signing this document, you affirmatively state that it is your intentional decision to consent to the transfer of any and all biological specimens collected by or deposited with CALLAHAN FOOT AND ANKLE CLINIC to a third party as set forth above. This consent does not authorize the sale or transfer of a biological specimen for the purpose of DNA analysis.

_____
Signature of Patient

_____
Printed Name of Patient

_____
Date