G. Adam Shapiro, DPM, FACFAS
Diplomate, Am. Board of Foot & Ankle Surgery
Board Certified in Foot Surgery

Joe K. Ades, DPM, FACFAS
Diplomate, Am. Board of Foot & Ankle Surgery
Board Certified in Foot Surgery &
Reconstructive Rearfoot/Ankle Surgery

James Robinson, DPM, FACFAS
Diplomate, Am. Board of Foot & Ankle Surgery
Board Certified in Foot Surgery
Board Certified, Am. Board of Podiatric Medicine

Francesca Zappasodi, DPM, AACFAS
Associate, Am. Board of Foot & Ankle Surgery
Board Qualified in Foot Surgery

Thank you for choosing Dr. Shapiro, Dr. Ades, Dr. Robinson, Dr. Zappasodi and the wonderful staff of Foot & Ankle Associates.

Since 1998, Foot & Ankle Associates has been here to provide the best possible medical and surgical foot and ankle care for adults and children. Along with specialized training and the newest technology, we offer kindness and respect for every patient. We look forward to getting to know you, giving you the care you need, and getting you back up to speed.

Our knowledgeable, sensitive, and well-trained staff will be happy to assist you in every way.

Our mission is to provide the best possible comprehensive foot and ankle care in a comfortable, respectful, and professional environment.

To expedite your Check In process, please complete the enclosed paperwork prior to your appointment.

For your first visit with us, it is important that you bring the following information with you:

1. A list of your medications both prescription and over-the-counter.
2. Please bring your insurance card at the time of your visit
3. In order to communicate with your primary care physician, it is important that you bring your physician's name and phone number to your visit, as well as any written referral information.
4. Payments for services not covered by your insurance plan or from any insurance co-payment, co-insurance, and/or deductible are expected at the time of service. If you have any questions or concerns regarding billing issues, please contact either your insurance carrier or our billing office at (704) 360-1103. For your convenience we accept cash, check, Visa/Mastercard.

For more information or directions to our offices, you can visit our website at www.footandankleassociates.com.

We look forward to your visit.

Morrison Plantation
143 Joe Knox Ave.
Suite 100
Mooresville, NC 28117
704.662.3660 ph
704.662.3595 fx

Gilead Medical Center
15419 Hodges Circle
Suite 200
Huntersville, NC 28078
704.892.5575 ph
704.892.6566 fx

Prosperity Commons
3220 Prosperity Ch. Rd.
Suite 101
Charlotte, NC 28269
704.971.7100 ph
704.971.7101 fx

www.footandankleassociates.com

PATIENT INFORMATION SHEET

How did you hear about Foot & Ankle Assoc? ☐ Sign ☐ Internet ☐ Yellow Pages

Other: ________ ☐ Insurance ☐ Family/Friend ☐ Primary Care Doctor

If you were referred by your primary care doctor or a family/friend please provide their name so that we may properly thank them:

Family/Friend Name ______________________ Primary Care Doctor Name ______________________

Last Name:		First Name:	Middle Initial:
Address:		City/State/Zip:	
Home Phone:		Cell Phone:	
Email Address:		Work Phone:	
Date of Birth:		SS No.:	
Gender:		Marital Status:	
Employer:			
Employer Address:		City/State/Zip:	
Emergency Contact:		Contact Phone:	
Name of Pharmacy:		Pharmacy Location:	
Primary Care Doctor:			

PERSON RESPONSIBLE FOR THE BILL, IF OTHER THAN ABOVE PATIENT

Name: ______________________ Relationship: ______________________

Address: ______________________ Phone: ______________________

City: ______________________ State: ____________ Zip: ____________

U S GOVERNMENT REPORTING

I WOULD PREFER NOT TO DISCLOSE THIS INFORMATION

Language: ☐ English ☐ Chinese ☐ French ☐ Spanish ☐ Hindi ☐ Japanese ☐ Portuguese ☐ German ☐ Type Unknown

Race: ☐ Amer. Indian ☐ Asian ☐ Black ☐ Native Hawaiian ☐ White ☐ Other ______________________

Ethnicity: ☐ Hispanic ☐ Non Hispanic ☐ Other ______________________

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Other

Use of Tobacco: ☐ Current Everyday ☐ Never Smoker ☐ Former Smoker ☐ Current Someday Smoker ☐ Smoker, Status Unknown ☐ Unknown if ever Smoked

Alcohol Use: ☐ Yes ☐ No If Yes, how often: Drinks perday: ______ Drinks perweek: ______

Drug Use: ☐ Yes ☐ No

MEDICAL HISTORY

Name of Primary Physician:________________________ Last Seen (Month/Year)____________

Preferred Pharmacy (Name/City)________________________ Phone ____________

Describe the reason for your visit today:________________________________

Have you ever been diagnosed and/or treated for any of the following? Please check below.

___ Diabetes (Do you take Insulin? Y / N) ___ Heart Problems ___ Circulation Trouble
___ Cancer/Tumors (Specify________________) ___ Mental Disease
___ Stroke ___ High Blood Pressure ___ Nerve Problems ___ Kidney/Bladder Disease
___ Arthritis ___Gout ___ Breathing Problems ___ Asthma
___ Anemia ___ Thyroid Disease ___ Stomach Problem ___ Bleeding Tendencies
___ Seizures ___ HIV (+) ___ Back Pain or Injury ___ Foot wound or ulcer
___ Blood Clots ___ High Cholesterol ___ Liver Problem (Specify________________)

List any medications you take:	Dosage/Frequency	What is it for?

Do you have any allergies? Please list.

____

Have you had any surgeries? Please List.

Year	Type of Surgery

Do you smoke? ____Yes____No How many packs per day?____for____years.

Do you drink? ____Yes____No How much?________________

Are you pregnant? ____Yes____No Are you claustrophobic? ____Yes____No

Is there any metal in your body? ____Yes____No Were you ever a welder?____Yes____No

What is your: Height?:____ft.____inches Weight?:______lbs. Shoe size?:______

Who may we thank for referring you to our practice? ________________________

CONSENT TO EXAMINATION AND TREATMENT, INSURANCE ASSIGNMENT, E-PRESCRIBE AND

I hereby consent to examination and treatment as deemed necessary by Foot & Ankle Associates (FAA) and its physicians. I hereby authorize FAA and its physicians to furnish patient health information concerning my relevant medical history to any of the following; other healthcare providers involved in my care, insurance carriers, attorneys and adjustors. I hereby authorize FAA to access and download my electronic prescription drug history. I hereby assign to the FAA and its physicians all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

AUTHORIZATION FOR MEDICARE BILLING

I hereby certify that the information given to me in applying for payment under Title XVII and XIX of the Social Security Act is correct. I hereby authorize any holder of medical or other information about me to be released to the Social Security Administration or its agents, Centers for Medicare and Medicaid Services (CMS), or its intermediaries or carriers any information needed for this or a related Medicare claim. I hereby request that payment of authorized benefits be made on my behalf and hereby assign the benefits payable for physician services to the physician if he/she chooses to accept assignment. Medicare requires notification via an Acknowledgement of Benefit Notification (ABN) for non-covered services, including Durable Medical Equipment.

SPECIMEN / LABORATORY INSURANCE CONSENT

I authorize and give Foot & Ankle Associates (FAA) my consent to submit specimens (culture, skin tissue, etc.) to the laborator(ies) of choice for analyses and study. This authorization includes submission for payment to my insurance company, including Medicare and Medicaid, and/or me for charges incurred and agree to full responsibility and payment of any non-covered medical services.

PATIENT DISCLOSURE

Please indicate any additional parties you authorize Foot & Ankle Associates (FAA) to speak with regarding your care, medical information and account. This authorization may be revoked at any time in writing.

Name: ______________________________ Relationship: ______________________________

Name: ______________________________ Relationship: ______________________________

Can we leave a message regarding your health information on your answering machine or voicemail? **YES** **NO**

PARENT / GUARDIAN ACKNOWLEDGEMENT

I certify that I am the parent or legal guardian of ______________________________, and adult, and as such am authorized to sign on his/her behalf.

RECEIPT OF NOTICE OF USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

I hereby acknowledge that I have been given the opportunity to read and receive a copy of Foot & Ankle Associates' Notice of Privacy Policy as required by the Health Information and Portability Accountability Act (HIPAA).

____

Signature of Patient or Guardian Date

____

Please Print Guardian Name Relationship to Patient

Foot & Ankle Associates

FINANCIAL POLICY

Thank you for choosing Foot & Ankle Associates as your provider. Our objective is to provide you with the highest quality care in the most cost effective manner. Your understanding of our financial policies is an essential element of your care and treatment. If you have medical insurance coverage, we will file the insurance claims on your behalf as a courtesy to you. If you have any questions, please do not hesitate to speak with our billing office.

MEDICARE PATIENTS: As a participating provider of Medicare Plan B (Physician Services), Foot & Ankle Associates will only bill you for your Medicare coinsurance, deductible and any services rendered but not covered by Medicare. All other services will be billed directly to Medicare. **You will be required to pay the co-pay and deductibles for authorized services at the time of service.**

NOTE: You will be informed of services not covered by Medicare prior to these services being rendered. Your signature upon the appropriate Medicare Waiver form represents your authorization for the physician to perform these services and your acceptance of the financial responsibility for these services.

If you have Medicare Part A only, then the services you will receive from our practice will not be covered by Medicare.

COMMERCIAL INSURANCE PATIENTS: Remember that your insurance contract is between you and your insurer. If your insurance company pays only part of your bill or rejects your claim, you are financially responsible for the balance and are to pay it upon receipt of your statement. **You will be required to pay the co-pay and deductibles for authorized services at the time of service.**

HMO/MANAGED CARE INSURANCE PATIENTS: Many HMO/Managed Care plans require that you obtain a referral in order to receive care from a specialist. ***It is your responsibility for obtaining this referral from your primary care physician if required by your insurance.*** Unauthorized services will be the financial responsibility of the patient. **You will be required to pay the co-pay and any deductibles for authorized services at the time of service.**

Foot & Ankle Associates will attempt to verify benefits for some specialized services, however, you remain responsible for charges for all service rendered, deemed non covered, or denied for any reason.
You must inform the office of all insurance changes and authorization/referral requirements prior to being seen. In the event, the office is not informed, you will be responsible for any charges denied by your insurance.

PATIENT WITHOUT INSURANCE COVERAGE: Patients without insurance are required to pay for all services related to their visit in full at the time of service. Ingrown toenail procedures will require a $275 deposit prior to being seen. All other office visits will require a $175 deposit prior to being seen. Any other services provided such as x-rays, durable medical equipment, over the counter items, etc will be payable upon checkout.

Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due to the office.

There will be a charge of $15 for any FMLA paperwork, Disability Forms or Employer Requests for Leave of Absence Forms to be completed. Please allow 5-7 business days for completion of paperwork.

CANCELLATION POLICY: ***If you cancel OR do not show for your appointment, you must give a 24 hour notice or a $55 cancellation fee will be charged.***

We accept VISA, MasterCard, Cash or Check. ***Foot & Ankle Associates will charge a $25 fee for all returned checks.***

______________________________ Patient/Guardian Signature

____________________ Date