PATIENT NAME:____ **D.O.B.**:_______/______/______

MAILING ADDRESS:____ **APT**__________

CITY:_____________________________ **STATE**:________ **ZIP CODE**:____________

PHONE NUMBER:_________________________ **CELL PHONE NUMBER:**____________________________

EMAIL:____

PREFERRED CONTACT METHOD: **PHONE CALL** **TEXT** **EMAIL**

EMERGENCY CONTACT:__________________________________ **PHONE:**___________________________

PRIMARY CARE PHYSICIAN:______________________________ **DATE LAST SEEN**:______/______/______

PHARMACY:____ **PHONE**:__________________________

PRIMARY INSURANCE:__________________________________ **POLICY ID**:_________________________

SECONDARY INSURANCE:________________________________ **POLICY ID**:_________________________

HOW DID YOU HEAR ABOUT OUR PRACTICE? (circle one)

Internet/Google **Friend/Family** **Doctor Referral (who?)**_____________________

Insurance Company **Facebook** **Other**________________________________

KNOWN MEDICAL HISTORY:____
____
____

SURGICAL HISTORY:____
____
____

LIST ALL ALLERGIES (MEDICATION, ENVIROMENTAL, FOOD, ETC.):____________________________________
____

LIST ALL MEDICATIONS (INCLUDING OTC & HERBAL SUPPLEMENTS):__________________________________
____
____

REASON FOR TODAY'S VISIT:____
____

WAS THERE ANY RECENT INJURY?____

HOW LONG AGO DID THE PROBLEM START?____

WHAT HAVE YOU TRIED FOR TREATMENT OF THE SYMPTOMS?____________________________________
____
____

I attest that the above information has been filled out to the best of my knowledge and as accurately as possible. I understand it is my responsibility to report any changes in contact/mailing information, medication changes, pharmacy changes, and changes with my physicians, and failure to do so may result in the delay of my care.

PATIENT SIGNATURE:___________________________________ **DATE:**________/______/____________

PATIENTS WITH INSURANCE: I have provided correct insurance information and understand that if I fail to do so I will be responsible for payment at time of service. I understand and agree that I am responsible for any co-payments, co-insurance, unmet deductibles, and non-covered services or supplies and understand that payment is due at the time of service. I understand that if InStride Summit Podiatry does not participate with my plan I will be responsible for payment in full if there are no out-of-network benefits. I authorize InStride Summit Podiatry to peruse a formal appeal or grievance on my behalf for any denied claim that they feel should not have been denied. If my insurance fails to respond in **60days** InStride Summit Podiatry reserves the right to collect full payment from me.
MEDICARE: Medicare will only pay for services that they determine to be "reasonable and necessary" under Section 1862(a)(1) of The Medicare Law. The following services are services that we know are not covered by Medicare: Routine Foot Care (debridement, cutting, or trimming of corns, toenails, or calloused tissues). Prescription Foot Orthotics/Custom Orthotics, Post-Operative Surgical Shoe(s).

CONSENT TO EXAMINATION, INSURANCE ASSIGNMENT, AND RECORDS AUTHORIZATION

I hereby consent and authorize InStride Summit Podiatry to examination and treatment as deemed necessary by its physicians. I hereby authorize InStride Summit Podiatry 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, attorney's, and adjusters. I hereby assign InStride Summit Podiatry and its physicians all payments for medical services rendered to myself or dependents.

SPECIMEN/LABORATORY INSURANCE CONSENT: I authorize InStride Summit Podiatry and give my consent to submit specimens (cultures, skin, tissue, aspirations, etc.) to the laboratories of choice for analysis 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 service, deductibles, and/or co-payments.

NO SHOW/CANCELATIONS/SERVICE FEES: There will be a **$25.00 service fee for all forms** that need to be filled out by InStride Summit Podiatry (including short term disability, FMLA, work forms, etc), payment is due upon receipt of the forms, you must allow 5-7 business days for completion of the forms**.** There will be a **$50.00 service fee** for any appointment canceled in less then 24 hours' or any missed appointments without prior communication to InStride Summit Podiatry (**NO SHOW**). **Same day cancellations are considered a cancelation with less then 24 hours notice and will be charged as such.** Failure to cancel, reschedule an appointment with a 24 hour notice, or failure to show up will result in a **$50.00 no show fee** that must be paid before scheduling another appointment or release of any records.

PATIENT RELEASE FORM: I, _________________, hereby authorize InStride Summit Podiatry and its physicians to release any or all of my patient health information to the following person(s) listed:

NAME:_____________________**RELATIONSHIP:**____________________**PHONE:**____________________

NAME:_____________________**RELATIONSHIP:**____________________**PHONE:**____________________

PARENT/GAURDIAN ACKNOWLEDGEMENT: I certify that I am the parent/legal guardian of ___________________________, and an adult, and such am authorized to sign on his/her behalf.

RECEIPT OF NOTICES 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 InStride Summit Podiatry's Notice of Privacy Policy as required by the Health Information and Portability Accountability Act (HIPAA).

PATIENT SIGNATURE:____________________________________**DATE:**________/______/______

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PATIENT NAME:_________________________________ **DATE OF BIRTH:**_____/_____/_____

SOCIAL SECURITY NUMBER:__________-________-____________

PHONE:__________________________

PLEASE CIRCLE INFORMATION TO BE RELEASED AND SPECIFIC DATE OF SERVICE IF APPLICABLE:

CLINICAL NOTES LAB REPORTS MEDICATION LIST

X-RAYS OPERATIVE NOTE

DATE FROM:___/______/______ **DATE TO:**_____/______/______

PERTAINING TO:____

I authorize InStride Summit Podiatry to release and/or obtain the requested health information to/from:

NAME/ORGANIZATION:____

ADDRESS:____

CITY:______________________**STATE:**______________ **ZIP:**________________

PHONE:___________________________________

FAX:______________________________________

CHECK THE PREFERRED METHOD FOR RELEASING THE REQUESTED INFORMATION:

- I will pick up
- I will have some one pick up for me
  - SPOUSE
  - PARENT/GUARDIAN
  - CHILD
  - OTHER:___________________________
- Fax to the number provided above **(only for release to healthcare providers)**

FEES: Medical Record copies will be provided to you at a fee of **$15.00 per request** (plus postage if mailing). Digital X-Ray copies will be provided to you on a CD for a fee **$10.00 per request** (plus postage if mailing).

I understand that if the person or entity that receives this information is not a healthcare provider or health plan covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law. I understand that I may revoke this authorization at any time by notifying InStride Summit Podiatry and completing a revocation of personal representative form. However, if I chose to do so, I understand that my revocation will not affect any actions taken by InStride Summit Podiatry before receiving my revocation. I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

PATIENT SIGNATURE:___________________________________ **DATE:**________/______/______

PATIENT PRINTED NAME:____

Welcome to our New Patients

Welcome to our practice! We appreciate the opportunity to be of service to you and hope that you will be pleased with our services. Our practice is a division of the **InStride Foot & Ankle Specialists, PLLC**. We have divisions across North and South Carolina, and we operate under one tax id number. As such, if you have seen any of the following physicians in the past three years, we need to know so that we will not file a new patient code for your visit today. Since the insurance carriers look at us as one large practice, if you have been seen at any of the following divisions, you will not be considered a new patient in our practice. **Visits prior to 2013 do not need to be disclosed**.

Please review the names of the divisions and podiatrists below and indicate if you have been seen at any of these divisions by putting a ✓ on the line to the left of the practice name. Thank you for disclosing this information to us – it will allow us to be in compliance with nationally mandated correct coding initiatives.

	Division	Podiatrist
___	Alta Ridge Foot Specialists	Robert van Brederode, William Broyles, Thomas Verla
___	Ankle & Foot Center of Charlotte	Scott Basinger
___	Brunswick Foot & Ankle Surgery, PA	Joseph Kibler
___	Carmel Foot Specialists	Barbara Kaiser, Richard Lind, Richard Miller, Kevin Molan, Tori Simmons-Lewis
___	Carolina Foot & Ankle Health Center	Millicent Brown
___	Carolina Foot Care Associates, PLLC	Ashma Davidson, Terry Donovan, William O'Neill
___	Carolina Podiatry Group	Brandon Percival, Julie Percival, William Harris
___	Central Carolina Foot & Ankle Associates	Melissa Hill, Gary Liao, Alan Sotelo, Phil Ward (retired), John Iredale (retired)
___	Chapel Hill Foot & Ankle Associates, P.A.	Jane Andersen, Alan Bocko, Katherine Williams
___	Charlotte Foot & Ankle Specialists, PLLC	Kristine Strauss
___	Coastal Carolina Foot & Ankle	Thomas Hagan, Tyler Hagan
___	Comprehensive Foot & Ankle Center, P.A.	Zack Nellas
___	Crystal Coast Podiatry	Thomas Bobrowski
___	Eastover Foot & Ankle, P.A.	Chris Fuesy, Ron Futerman, Kent Picklesimer
___	Family Foot & Ankle Center, P.A.	Patrick Dougherty, Doug Smith
___	Family Foot Care	Kevin McDonald
___	Foot & Ankle Center of Durham	Eric Simmons
___	Foot & Ankle of the Carolinas, PLLC	Eric Ward, Blaise Woeste
___	Gaston Foot & Ankle Associates, P.A.	David Kirlin, Ryan Meredith, Wagner Santiago
___	Greensboro Podiatry Associates, P.A.	Martha Ajlouny, N'Tuma Jah
___	Hendersonville Podiatry	Russ Barone, Pam Stover
___	James Mazur, D.P.M., P.A.	James Mazur
___	Kinston Podiatry	Dale Delaney
___	Matthews Foot Care	Brian Killian, Kevin Killian, David Ellenbogen
___	Mt. Airy Foot & Ankle Center, PLLC	Jim Shipley
___	Myers Podiatric Clinic	William Myers
___	Piedmont Foot & Ankle Clinic	Rick Hauser, Rob Lenfestey, Jason Nolan, Joel Kelly, Elizabeth Bass Daughtry
___	Piedmont Podiatry Associates	Subodh Choudhary, Nicholas Canoutas, Cassandra Pike, Sarah Fitzgerald, Smitha Jospeh (retired)
___	Queen City Foot & Ankle Specialists, P.C.	Roxanne Burgess
___	Raleigh Foot & Ankle	Alan Boehm, Robert Hatcher, Jordan Meyers, Kirk Woelffer
___	Ryan Foot & Ankle Clinic	David Garchar, Jeff Glaser, Michael Ryan, Scott Whitman, Matthew Borns
___	Salem Foot Care	Walter Falardeau, Scott Matthews
___	Upstate Foot Care	Hans Blaakman
___	Wake Foot & Ankle Center	Mike Hodos, Jim Judge
___	Wilson Podiatry Associates, PA	Kendall Blackwell

___ I attest that I have been seen in the above indicated division of the InStride since 01/01/2013.

___ I attest that to my best recollection, I have not been seen by any of the above divisions/physicians since 01/01/2013.

Signature of patient: ____ Date: ________________

Printed Name: ____ DOB: ________________