Queen City Foot & Ankle Specialists

Patient Information

Patient Name:
First: ________________________ Middle: __________________________ Last: ______________________________

Sex: Male Female **Date of Birth:** _____/_____/_____ **Shoe Size:** ______________________

Address: _____________________________________ City__________________ State: ______ Zip: ____________

Home Phone #: ___________________ Work #: _____________________________ Cell #: ______________________

Email ____

Race: American Indian Asian Black/ African American White Native Hawaiian/ Other

Ethnicity: Non-Hispanic/Latino Hispanic/ Latino

Primary Language: ____ **Do you need an Interpreter?** Yes / No

Marital Status: Divorced Married Partner Single Unknown / Other Widowed Legally Separated

How did you hear about our office? (Circle all that apply)

Direct Mailing Friend Insurance Company Internet Newspaper another Patient Doctor/HealthCare Provider Other

Name of referral source:
____

Primary Care / Referring Physician: ___________________________ Practice Name: ________________________

Emergency Contact Name: _________________________________Phone__________________________________

HIPPA Acknowledgment: I hereby acknowledge that I have been made aware that Queen City Foot and Ankle Specialists (QCFAS) has a privacy policy in place in accordance with the Health Insurance Portability and Accountability Act of 1966 (HIPPA) and has made this policy available to me. I am entitled to a copy of the privacy policy upon request.

How may we contact you? Phone Mail E-mail
Is it ok to leave a message with anyone other than yourself? Yes or No

I authorize the release of any previous exams, results or images in the event **QCFAS** is in need of them to help with the diagnosis or treatment of my conditions. I permit a copy of the authorization to be used in place of the original. I understand and acknowledge that I am personally responsible for the services rendered at this facility. **QCFAS** will bill my insurance carrier as a courtesy. In the event of non-payment, I understand I will be responsible for any outstanding balances.

I authorize **QCFAS** (**Dr. Roxanne Burgess**, whomever they designate) to examine, administer treatment and to perform such general procedures as she (they) may deem necessary in the diagnosis and/or treatment of my condition(s). I further certify that to the best of my belief and acknowledge the information provided on my personal health history is true, accurate and complete. I also authorize the physician designated to release information acquired in the course of my examination and treatment.
Signature **X** ____Date_________________
Printed Name of Patient or
Guardian____

Queen City Foot and Ankle Specialists

Past Medical History

Psoriasis Anxiety Arthritis Asthma History of Blood clots (Legs) Stroke

Sciatica Back Problems Parkinson's Disease Heart Disease Thyroid Disease

Heart Failure COPD Cancer High Cholesterol Malignant Melanoma Stomach Ulcers

Dementia/Alzheimer's Depression Diabetes (Last A1C__________)

IBS/Chron's Disease GERD (reflux) Poor Circulation Gout Kidney Disease Ulcers

HIV Hepatitis High Blood Pressure Heart Attack Migraine Varicose Veins

- **Please list your past surgeries with the date:-**

____

Social History

Are you a student? Yes, Part time Yes, Full Time No, not Currently a Student

Are you employed? Yes, Part Time Yes, Full Time No, Not Currently Employed

Employer (Company Name):_______________________________________ Occupation: ____________________

- Do you currently smoke or chew tobacco? Yes or No If no, have you in the past? Yes or No

How many packs per day? ______________________

- Do you drink alcohol, beer or wine? Yes or No If no, have you in the past? Yes or No

Family Medical History

Mother or Father diagnosed with the following conditions?

MOTHER: Deceased Diabetes Heart Disease Kidney disease Cancer Arthritis High BP

FATHER: Deceased Diabetes Heart Disease Kidney disease Cancer Arthritis High BP

Current Symptom Review:

Decrease in strength muscle weakness back pain knee joint pain joint pain in toes

Muscle aches arthralgias limb swelling stiffness of joints difficulty walking

not itching peeling skin rash skin wound discoloration of nails Chest pain

palpitations leg pain with exercise limb swelling varicose veins Dry Skin

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List any exercises or athletic activities:

____

Reason for your visit:

____

Percentage of waking hours you spend on your feet (circle one)
10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Do you have (Please circle) Artificial Joints, Replacement heart valves, or other implants?

Medication History

- Please list **all medications, herbal supplements, and over the counter medications** that you are currently taking:

____

____

____

- Please list any drug **allergies** you have and the reaction you experienced:

____

____

Pharmacy Name: ____
City & Street: ________________________________ Phone Number: ________________________

We send all prescriptions electronically

Are you sensitive to Tapes or Adhesives? Yes or No

Do you have any problems taking Aspirin or Ibuprofen (Aleve, Motrin, and Advil? Yes or No

If yes, please describe:

____

____

Are all of your immunizations up to date? Yes or No
Have you had a current flu shot? Yes or No

Are you pregnant or breastfeeding? Yes or No

Do you have a Health Care Power of Attorney? Yes or No If yes, please provide the following information:

Name: ____ DOB: ____________________

Address: ____ Phone: ______________________

Office & Financial Policies

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our financial and office policies allows for a good flow of communication.

Prescription Refills
For medication refills, we require a notice of 2 business days. Please plan accordingly. **Initial _________**

Insurance Plans
We respectfully request that you keep us updated with your current insurance information. If you change insurance companies or if there is a change to your current insurance coverage, please present your card to us so that we may obtain a copy of it. If the insurance company you designate is incorrect, you will have 14 business days to provide with a copy of the correct insurance card.

If the correct card is not provided to us within 14 business days, we reserve the right to hold you financially responsible for the charges incurred. Initial ________

Financial Responsibility

1. According to your insurance plan, you are responsible for any and all **co-payments**, **deductibles**, and **coinsurances**.
2. **Co-payments** are due at the time of service. A **$5 service fee** will be charged in addition to your co-payment if the co-payment is not paid by the end of the next business day.
3. Self-pay patients are expected to pay for services in **FULL** at the time of the visit.
4. If previous arrangements have not been made with our billing department, any account balance over 90 days old will be forwarded to a collection agency.
5. Any account balance over 90 days old that has to be forwarded to a collection agency will be assessed a service fee of 35% of the total balance.
6. We accept cash, Visa, and MasterCard and AMEX in our office.
7. Checks will **only** be accepted for payment on invoices you have received from our office. A **$20 fee** will be charged for any checks returned for insufficient funds. ____ **Initial**

Forms

If you have any workers compensation, disability, or FMLA papers to be filled out, there is a **$5** charge per form. Payment is due when the forms are dropped off. We have a 3 to 5 business day turnaround time for forms. If a form is needed sooner than 3 business days, there is an additional **$15 rush fee per form. Initial** ________

I have read and understand the office and financial policies. I agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Printed Patient Name ____ Date ________________________

Signature of Patient or Responsible Party ____

Relationship____

Welcome to our New Patients

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 2015 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 **(Resigned from group 7/1/2017)**	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 (ret), 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 (ret.), John Iredale (ret.)
	Chapel Hill Foot & Ankle Associates, P.A.	Jane Andersen, Alan Bocko, Katherine Williams
	Charlotte Foot & Ankle Specialists, PLLC **(resigned from group 8/1/2017)**	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. **(Resigned from Group 1/1/17)**	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, Randell Contento
	Greensboro Podiatry Associates, P.A.	Martha Ajlouny, N'Tuma Jah (resigned 12/21/17), Jonathan Simpson (eff: 1/1/18)
	Hendersonville Podiatry	Russ Barone(ret), 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, David Collard, Thurmond Siceloff
	Myers Podiatric Clinic	William Myers
	Piedmont Foot & Ankle Clinic	Rick Hauser, Rob Lenfestey (ret.), Jason Nolan, Joel Kelly, Elizabeth Bass Daughtry, Jacob Panici, Brian Futrell (eff:3/1/18)
	Piedmont Podiatry Associates	Subodh Choudhary, Nicholas Canoutas, Cassandra Pike, Sarah Fitzgerald, Smitha Joseph (ret.)
	Queen City Foot & Ankle Specialists, P.C.	Roxanne Burgess, Alison Garten
	Raleigh Foot & Ankle **(Resigned from Group 1/1/2018)**	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
	Summit Podiatry	Derek Pantiel
	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 0**1/01/2015.**

________ I attest that to my best recollection, I have not been seen by any of the above divisions/physicians since **01/01/2015.**

Signature of patient: ____ Date: ______________________