Ankle and Foot Associates of the Palm Beaches
A 6901 West Okeechobee Blvd. Suite C-11, West Palm Beach, Fl 33411
T (561)640-3838
F (561) 478-5259
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Caren L. Block, D.P.M.

**WELCOME**

Thank you for the opportunity of adding you to the growing family of satisfied patients of Ankle & Foot Associates of the Palm Beaches. Our goal is to provide you with the best medical care available in a relaxed warm atmosphere.

The information you gave us at the onset of your appointment was the first step to assist us in better serving you as our valued patient. Please complete the enclosed paperwork prior to your appointment and bring it with you along with your insurance ID card, a picture ID card and any other information as may be required in your insurance handbook.

Please arrive 20 minutes before your scheduled appointment time. If you cannot keep your appointment as scheduled, we expect our patients to grant us the courtesy of notifying us within 24-hours in order to give that time to another patient.

If you are being seen for a second opinion, or have seen another doctor for foot problems or past surgery, please bring your past medical records, x-rays, MRI's or any other diagnostic reports with you. This will assist the doctor in providing you with the best care and address your foot problems during your first visit so you can get on the road to recovery.

If your insurance requires an authorization, it will be your responsibility to furnish that at the time of your visit. As a courtesy to our patients, we will verify your insurance benefits prior to your appointment.

Payment for insurance co-pays, deductibles or coinsurance amounts as well as non-covered services by your insurance company are due at the time of the services are rendered. For your convenience we accept cash, personal checks, Visa, MasterCard and American Express.

Please do not hesitate to call our office if you have any questions. We look forward to treating you.

Sincerely,
Dr. Block & Staff

Ankle and Foot Associates of the Palm Beaches

# REGISTRATION FORM

(Please Print)

## PATIENT INFORMATION

Date____/____/____Home Phone (  )_____Cell Phone (  )_____Email_____

Last Name_____First Name_____Middle Initial____Date of Birth ____/____/____

Street_____City_____State_____Zip_____

Social Security #_____-____-_____Age____Sex **M** **F** Marital Status_____Primary Language_____

Ethnicity (circle one): American Indian Asian African American Pacific Islander White Hispanic

Occupation_____Work Phone(  )_____

Employer Name & Address_____

Pharmacy_____ Address_____City & Zip_____Phone (  )_____

In case of Emergency Contact_____Relationship_____Phone (  )_____

## FINANCIALLY RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT)

Relationship to patient_____Home Phone (  )_____Cell Phone (  )_____

Last Name_____First Name_____Middle Initial_____ Sex **M** **F**

Street_____City_____State_____Zip_____

Social Security #_____-_____-_____Age_____ Date of Birth _____/_____/_____Marital Status_____

Occupation_____Work Phone(  )_____

Employer Name & Address _____

## INSURANCE INFORMATION (COPY OF CARD(S) REQUIRED)

Primary Insurer_____Phone (  )_____Group #_____

Insured's Name_____Insured's ID #_____

Secondary Insurer_____Phone (  )_____Group #_____

Insured's Name_____Insured's ID #_____

## HOW DID YOU HEAR ABOUT US? (CIRCLE ONE)

Doctor Phone Book Friend ER Hospital

Family Insurance Plan Newspaper Internet Other_____

## FAMILY PHYSICIAN INFORMATION

Did your Family Physician or other specialist refer you? **Y** **N**

Did you independently come for an opinion? **Y** **N**

Referring/Family Physician_____Date last seen_____

Address_____City_____State____Zip_____Phone (  )_____

Name: _____ Chart #: _____

## MEDICAL HISTORY

WHAT BROUGHT YOU TO SEE THE DOCTOR? (Please provide a brief description of the nature of the illness/injury.)

WHEN DID YOUR SYMPTOMS BEGIN?

WHAT TREATMENTS HAVE YOU TRIED?

WHAT OTHER FOOT/ANKLE/LEG PROBLEMS DO/DID YOU HAVE?

| **ALLERGIES:** Do you have any allergies? | 1. | 2. | 3. |
|---|---|---|---|

**MEDICATIONS:** What medications are you currently taking?

| | | | |
|---|---|---|---|
| 1. | 6. | 11. | 16. |
| 2. | 7. | 12. | 17. |
| 3. | 8. | 13. | 18. |
| 4. | 9. | 14. | 19. |
| 5. | 10. | 15. | 20. |

## PAST MEDICAL HISTORY

Please indicate whether you have had any of the following medical problems.

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Heart Disease | | | Arthritis | | |
| Heart Valve Replacement | | | Gout | | |
| Heart Attack | | | Fibromyalgia | | |
| Chest Pain | | | Osteoporosis | | |
| Pacemaker | | | Leg Pain | | |
| High Blood Pressure | | | Back Pain | | |
| High Cholesterol | | | Weakness in Extremities | | |
| Stroke | | | Numbness in Extremities | | |
| Shortness of Breath | | | Balance Problems | | |
| Lung Disease | | | Dizziness | | |
| Asthma | | | Headaches/Migraines | | |
| Sleep Apnea | | | Changes/Loss of Vision | | |
| Liver Disease | | | Stomach Ulcer | | |
| Hepatitis | | | Tuberculosis | | |
| Bleeding Disorder | | | HIV | | |
| Clotting Disorder | | | Thyroid Condition | | |
| Anemia | | | Pregnant | | |
| DVT (Blood Clot) | | | Kidney Disease | | |
| Fractures *(When/Where?)* | | | Diabetes Type I___ Type II___ | | |
| Joint Replacement *(Which?)* | | | Skin Conditions *(What Kind?)* | | |
| Cancer *(What Type?)* | | | Other(s) *(Please Specify):* | | |

## FAMILY HISTORY

Please check if any of your family members have/had any of the following medical problems.

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Bleeding Disorder | | | Gout | | |
| Cancer | | | Arthritis | | |
| Heart Trouble | | | Bunion | | |
| High Cholesterol | | | Bunionette | | |
| High Blood Pressure | | | Flat Feet | | |
| Stroke | | | High Arched Feet | | |
| Diabetes | | | Pigeon-Feet | | |

Other *(Please Specify):*

## SOCIAL HISTORY

| | Yes | No | What kind, how much & how often? |
|---|---|---|---|
| Do you smoke? | | | |
| Did you ever smoke? | | | |
| Caffeine? *(tea/coffee)* | | | |
| Alcohol use? *(Currently using or used in the past)* | | | |
| Illicit drug use? | | | |
| Do you exercise regularly? | | | |

## PAST SURGICAL HISTORY

| Procedure | Date | Surgeon | Complication |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |

**HEIGHT:** _____ **WEIGHT:** _____ **SHOE SIZE:** _____

I certify that to the best of my knowledge that the information provided is true and accurate and I have disclosed all pertinent medical history.

SIGNATURE OF PATIENT (or Guardian) _____ DATE: _____

Ankle and Foot Associates
of the Palm Beaches

**Assignment: Medicare Signature on File**

I request that payment of authorized Medicare benefits be made on my behalf to Ankle and Foot Associates of the Palm Beaches for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I request payment of authorized Medicare benefits be made to this provider and also authorize any holder of medical information about me to release to the below named Medicare insurer any information needed to determine benefits payable for services from this provider.

I understand my signature below requests that payment be made and authorizes release of medical information necessary to pay the claim. My signature authorizes releasing of the information to the insurer or agency, electronically or by mail. In Medicare assigned cases, this office agrees to accept the "charge determination" of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the "charge determination" of the Medicare carrier.

Patient Name (please print) Date

X _____ _____

Patient Signature

X _____

Patient Medicare Number

_____

Ankle and Foot Associates
of the Palm Beaches

**Patient Financial Policy**

We are dedicated to providing the best possible care and service to you and regard your complete understanding our financial policies as an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept Visa, MasterCard, Discover, cash or check.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all-insurance changes and authorization referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are certain elective surgical procedures that we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.
- Past due accounts are subject to collection proceedings. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due this office.
- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

Printed Name: _____ Date: _____

Signature: _____

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Caren L. Block, D.P.M.

**Patient Name:** _____

**The Practice:**

**a.** Is required by federal law to maintain the privacy of your Personal Health Information (PHI) and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

**b.** Under the Privacy Rule, may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.

**c.** Is required to abide by the terms of this Privacy Notice.

**d.** Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.

**e.** Will distribute any revised Privacy Notice to you prior to implementation.

**f.** Will not retaliate against you for filing a complaint.

**EFFECTIVE DATE**

This notice is effective as of 11/15/04

**PATIENT ACKNOWLEDGEMENT**

By signing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and agreement to its terms.

**Print Name:** _____

**Signature:** _____

**Date:** _____

**Notice of Privacy Practices Effective November 15, 2004**
This notice describes how healthy information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

**Our commitment to your privacy**
Our practice is dedicated to maintaining the privacy of your healthy information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

**Use and disclosure of your health information in certain special circumstances**
The following circumstances may require us to use or disclose your healthy information:
**1.** To public health authorities and health oversight agencies that are authorized by law to collect information.
**2.** Lawsuits and similar proceedings in response to a court or administrative order.
**3.** If required to do so by a law enforcement official.
**4.** When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
**5.** If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
**6.** To federal officials for intelligence and national security activities authorized by law.
**7.** To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
**8.** For Workers Compensation and similar programs.

**Your rights regarding your health information**
**1.** Communications. You can request that our practice communicate with you bout your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
**2.** You can request a restriction in our use or disclose of your health information for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals in your care or the payment of your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except with otherwise required by law, in emergencies, or when the information is necessary to treat you.
**3.** You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the Office Manager.
**4.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the Office Manager. You must provide us with a reason that supports your request for the amendment.
**5.** Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practice.
**6.** Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the Office Manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
**7.** Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies,
please contact us at location on Page One.