SKYLAKE MEDICAL ASSOCIATES

1380 NE MIAMI GARDENS DR. STE 280
NORTH MIAMI BEACH, FL 33179
T: 305.735.2022

Patient Name: _____ D.O.B.:_____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Northern Address: _____

Home Phone:_____ Cell Phone: _____

Business Phone: _____ Sex: M F

Social Security #: _____ Marital Status: S M D Sep W

Email: _____

Emergency Contact: _____ Emergency Contact Phone: _____

Primary Insurance: _____ Secondary Insurance: _____

Primary Care Physician: _____ PCP Phone: _____

Referral: *how did you find out about us?* _____

Race:	Language:	Ethnicity:
White ____	English___ Dutch___	Unknown___
American Indian/Alaska Native____	Spanish___ Chinese___	Hispanic or Latino___
Asian ____	French___ Japanese___	Non-Hispanic/Latino___
Black/African American ____	Russian___ Italian___	
Native Hawaiian/Pacific Islander____		

Family History

Mother living: ___ Mother deceased:___ Cause of death:_____ Age: ____

Father living: ___ Father deceased:___ Cause of death:_____ Age: ____

How many children do you have: ___Boys ___Girls?

Any family history of diabetes? ___No ___Yes If yes, who? _____

Any family history of foot problems? ___No ___Yes If yes, who? What type of foot problems?

_____

Medical History

Please circle "Yes" or "No" if you have had any of the following.

AIDS/HIV	Yes	No	Rheumatoid Arthritis	Yes	No	Vericose Veins	Yes	No
Anemia	Yes	No	Arthritis	Yes	No	Claudication	Yes	No
Bleeding Disorder	Yes	No	Back Problems	Yes	No	(Leg cramps from walking)		
Cancer	Yes	No	Gout	Yes	No	Hepatitis or Jaundice	Yes	No
Hemophilia	Yes	No	Asthma	Yes	No	Liver Disease	Yes	No
Swollen Neck Glands	Yes	No	Emphysema	Yes	No	Heart Burn	Yes	No
Angina	Yes	No	Respiratory Disease	Yes	No	Ulcers	Yes	No
Artificial Heart Valve	Yes	No	Shortness of Breath	Yes	No	Weight Loss-unexplained	Yes	No
Chest Pain	Yes	No	Tuberculosis	Yes	No	Numbness or tingling	Yes	No
Circulatory Problem	Yes	No	Chemical Dependency	Yes	No	(in feet or legs)		
Heart Disease	Yes	No	Psychiatric Care	Yes	No	Seizures	Yes	No
High Blood Pressure	Yes	No	Diabetes	Yes	No	Fainting	Yes	No
Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No	Neurological Problems	Yes	No
Rheumatic Fever	Yes	No	Eye Problems	Yes	No	Venereal Disease	Yes	No
Stroke	Yes	No	Sinus Problems	Yes	No	Kidney Problems	Yes	No
Swelling Ankles/Feet	Yes	No	Headaches	Yes	No	Rash	Yes	No
Heart Attack	Yes	No	Phlebitis	Yes	No			

Allergies

__ Adhesive tape

__ Anticoagulant Therapy

__ Aspirin

__ Codeine

__ Cortisone

__ Demerol

__ Iodine

__ Latex

__ Local Anesthesia

__ Novocain

__ Penicillin

__ Seafood

__ Sulfa

OTHER:

_____

_____

Podiatric History

Describe the chief complaint for which you came to be treated (include foot, ankle, knee, thigh, and hip complaints). _____

_____

_____

_____

_____

How long has chief complaint been present? ___ wk ___mo ___yr

On a scale of 1-10, how bad is the pain?

1 2 3 4 5 6 7 8 9 10

Foot Disorder

Please indicate which foot problems you now have or had in the past.

Ankle Pain	yes	no	Heel Pain	yes	no
Athlete's Foot	yes	no	Ingrown Toenails	yes	no
Bunions	yes	no	Plantar Warts	yes	no
Corns/Calluses	yes	no	Infection	yes	no
Deformed Toes	yes	no	Ulcer/Wound	yes	no
Fungus Nails	yes	no	Tired Feet	yes	no

Medical History (cont.)

Cigarette/Tobacco use? yes no

(Circle one) Current or Former user?

Time smoked: _____

How much alcohol do you consume?

___ daily ___weekly ___monthly

Surgeries I've had:

_____

_____

_____

_____

_____

Medications:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Preferred Pharmacy Name: _____ Pharmacy Phone#:_____

(or Pharmacy Location:_____

CONSENT

I certify that the above information is correct to the best of my knowledge. I give permission to Physician at Skylake Medical Associates to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my pain and / or condition.

Signature _____ Date _____

Review of Systems

For new patients, established patients who may be having a new problem, or our patients who haven't been seen for a while, we need to update our records as to your general medical health. In each area, if you are not having any difficulties, please circle "No." If you are experiencing any of the symptoms listed, **PLEASE CIRCLE YES**. If you have any questions about this, please ask one of the technicians or the doctor.

Constitutional

Weight loss	Yes	No
Weight gain	Yes	No
Fever	Yes	No
Fatigue	Yes	No

Dermatologic

Skin infections	Yes	No
Psoriasis (skin disease)	Yes	No
Spider veins	Yes	No
Blisters	Yes	No
Moccasin rash (Athlete's Foot)	Yes	No
Macerated webspaces	Yes	No
Rash	Yes	No
Bleeding	Yes	No
Bruising	Yes	No
Itching	Yes	No
Hypertrophy toenails (thick nails)	Yes	No
Foot ulcers	Yes	No

Neurologic

Paralysis (loss of ability to move)	Yes	No
Stroke	Yes	No
Tics	Yes	No
Tremors	Yes	No
Foot numbness	Yes	No
Seizures	Yes	No
Tingling feet and/or hands	Yes	No

Musculoskeletal

Joint pain	Yes	No
Joint swelling	Yes	No
Muscle pain	Yes	No
Pain after resting	Yes	No
Joint disability	Yes	No
Weakness	Yes	No
Back pain	Yes	No

Notice of Privacy Act

Patient Contact

We may contact you to provide appointment reminders, treatment information, billing and payment information, or for patient satisfaction surveys.

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to {Practice Name} all insurance benefits, if any, otherwise **payable to me for services** rendered, I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of my benefits. I authorize the use of this signature on all insurance claim submissions.

_____ (INITIALS)

Allowed Uses and Disclosures of Your Medical Information:

- Treatment – such as ordering diagnostic test
- Payment – such as submitting information to your insurance company
- Health Care Operations – such as quality assurance review, coordination of care, eligibility verification.

In addition to the above, your medication information may be used or disclosed for emergency treatment; when we are required by law to treat you, we attempt to obtain consent, and if we are unable to obtain consent due to substantial communication barriers and consent for treatment is implied under the circumstances or we created or received the information in treatment.

You have the right to:

- Request a restriction on certain uses and disclosures; however we are not required to agree to any requested restrictions.
- Receive confidential communication from us, upon written request.
- Inspect and request copies of your medical information.
- Request to amend copies of your incorrect or incomplete medical information.
- Receive an accounting of any disclosures made, upon written request.
- Receive a paper copy of the notice upon request.

We are responsible for:

- Maintaining the privacy of your medical information.
- Providing you this notice.
- Abiding by the terms of this notice.
- Providing written notice of any change to this notice. _____ (INITIALS)

Medicare and Insurance Authorization

I request that payment of authorized Medicare or insurance benefits be made to me on my behalf to Beaton Podiatry Center Inc dba Advanced Podiatry and Wound Care for any service furnished to me by that physician. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents; the information needed to determine these benefits or the benefits payable for any related services. I understand my signature request that payment be made and authorizes release of medical information necessary to pay the claim. If 'other health insurance' is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorized releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician, agency shown, or supplier agrees to accept the charge determination of the Medicare carrier as based upon the charge determination of the Medicare Carrier.

_____ (INITIALS)

Failure to Keep Scheduled Appointments

If you are unable to keep your scheduled appointment, we ask that you please notify our office; at least **24** hours prior to your appointment time. Should you fail to provide proper notice, you will be charged **$50.00** for the time that was allotted to you. By not contacting our office to cancel or reschedule your appointment, those in need of a time slot are unfortunately unable to see us. Thank you for your cooperation. I have read the above policies and I understand and agree to these policies. _____ (INITIALS)

Printed Name _____

Signature_____ Date _____

OUR FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require you to sign prior to any treatment.

All patients must complete our information packet and produce all insurance cards and id prior to seeing the doctor.

CUSTOM MADE PRODUCTS (SHOES, INSERTS, ORTHOTICS, ETC.) ARE NON REFUNDABLE.

24 Hours notice is required in the event you cannot keep your appointment. If notice is not given in a timely manner there is a mandatory $50.00 no show fee.

ALL returned checks have a $25.00 processing fee applied to the account.

Non insurance patients (self pay) **full payment is due at time of service.** We accept cash, check, credit card, etc.

Regarding insurance

We may accept assignment of insurance benefits**. ALL co pays, coinsurance and deductibles are due at the time of service.** In the event that your insurance is not in network you will be considered self pay. **The balance is your responsibility whether your insurance company pays or not.** Your insurance policy is a contract between you and your insurance company. We are not a third party to that contract. Please be aware that some, perhaps all, of the services provided may be non covered services and not considered reasonable under your insurance program.

Usual and customary rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Adult patients

Adult patients are responsible for their portion of payment at the time of service depending of self pay or insurance coverage.

Minor patients

The accompanying parent or guardian is responsible for full payment. For non accompanying minors, non emergency treatment will be denied.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. I have read the financial policy. I understand and agree to this financial policy:

Signed Name _____

Printed Name _____

Date _____