The Foot and Ankle Treatment Center
Dr. Donovan Gowdie

New Patient Information

Patient Name:_____ Sex: Male or Female Date of Birth: _____

What would you like to be called: _____ SS#:_____

Mailing Address: _____ City _____

Zip Code: _____ Marital Status: Single/Married/Divorced/Widow Height_____ Weight_____

Cell Phone:_____ Home: _____ Work: _____

Email: _____ Shoe Size/Width _____

Employer: _____ Occupation: _____

Emergency Contact:_____ Contact Phone: _____

Relationship to Patient: _____

Primary Care Physician: _____

Practice Name/Address:_____

Phone:_____ Fax:_____ Date of last visit:_____

Pharmacy Name:_____ Pharmacy Phone Number:_____

Pharmacy Address:_____

****PLEASE INCLUDE/BRING IN A COPY OF A PHOTO ID AND ALL INSURANCE CARDS****

How did you learn about **The Foot and Ankle Treatment Center**?

- I was referred by Dr. _____
- A friend or another patient referred me_____
- Insurance Website
- Internet Search: Google Yahoo Bing Other:_____
- I saw your practice sign/driving by
- Other Source:_____

Patient's Name:_____

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What is your chief complaint today?_____ Where?_____

When did this condition start? ___years ___months ____days ago

What is the nature of your pain? (Circle one): Stabbing Radiating Sharp Dull Aching Burning Itching Other_____

Is your condition getting better or worse? _____ Rate your pain: 0 1 2 3 4 5 6 7 8 9 10 (severe)

What seems to make your condition/pain worse? _____

What seems to make your condition/pain better? _____

Have you seen another physician for this problem? YES or NO If yes, doctor's name: _____

Has this condition affected your ability to work, exercise or perform other daily activities? YES/NO

If yes, how? _____

Is there a history of injury? YES/NO If yes, date of injury? _____ Is this a work-related injury? YES/NO

Women: Breastfeeding? YES/NO

Are you pregnant? YES/NO If yes, how many weeks are you? _____ Due Date: _____

Past Medical History (circle all that apply) ***NONE***

Cancer: lung skin breast cervical prostate

Neurological: stroke neuropathy vertigo seizures migraines

Skin: eczema psoriasis ulcers vitiligo dermatitis hives

Psychiatric: bipolar depression anxiety claustrophobia dementia

Respiratory: emphysema asthma shortness of breath COPD

Eyes/Ears/Nose/Mouth and Throat: cataracts glaucoma hearing loss

Genitourinary: STD HIV UTI kidney stones kidney/bladder infections

Hematologic/Immunologic: dialysis anemia sickle cell bleeding disorder

Gastrointestinal: stomach ulcers hernia hepatitis reflux/GERD gallbladder disease

Cardiovascular: heart attack coronary disease high blood pressure irregular heart rhythm

Musculoskeletal: lupus osteoarthritis rheumatoid arthritis fibromyalgia gout back pain

Metabolic: hypoglycemia diabetes hypothyroidism hyperthyroidism hyperlipidemia osteoporosis

Other: _____

Past Surgeries and Hospitalizations (circle all that apply) ***NONE***

Tonsil/Adenoids	Amputations	Other Vascular Bypass	Appendix
Gallbladder	Hysterectomy	Hernia	Angioplasty
Coronary/Heart Bypass	Other _____		

List or attach a complete list of all CURRENT MEDICATIONS, including vitamins/supplements:

Allergies: (circle) NONE Narcotics NSAIDS Penicillin Sulfa Aspirin Contrast Latex Iodine Shellfish Tape Gluten Intolerance Food Allergies Metal Other: _____

Patient's Name: _____

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Do you currently use illicit drugs (pain pills, marijuana, cocaine etc.)? YES or NO

Do you have a history of alcohol or drug abuse including prescription medications? YES or NO

Have you ever used tobacco? YES or NO If yes, amount per day _____
Age began: _____ Age quit: _____

Do you ever drink alcohol? YES or NO If yes, How often: _____ How much: _____

Is there a family history of any specific medical conditions or disease?

_____

_____

Review of Systems: (circle any symptom that you have had in the last 6 months) NONE

Neurological: frequent headaches limb weakness limb numbness dizziness tremors rigidity balance issues
Skin: rash/hives skin discoloration lesions ulcers itching nail problems easy bruising unusual hair loss
Respiratory: persistent cough shortness of breath wheezing can't breathe lying flat coughing up blood
Eyes/Ears/Nose/Mouth and Throat: sore throat stiff neck nose bleeds hearing loss ringing in ears
Gastrointestinal: nausea/vomiting difficulty swallowing abdominal pain heartburn/indigestion
Cardiovascular: palpitations irregular heart rhythm exercise intolerance leg swelling leg pain when walking
Musculoskeletal: joint pain/stiffness joint swelling muscle weakness back pain muscle spasms falling
Constitutional/Endocrine: fever chills weakness/fatigue weight loss weight gain insomnia snoring excessive urination excessive thirst cold or heat intolerance
Other:_____

To the best of my knowledge, I have answered the questions on this form as accurately as possible. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor and staff of any changes in my medical status. I, the undersigned or as parent, legal guardian or power of attorney of undersigned hereby authorize the physician(s) and their assistants to administer treatment as deemed necessary or the patient below for whom I am responsible.

_____

Print Name of Patient Signature of Patient/Parent/Guardian/Power of Attorney Date

_____

Signature of Doctor Date

Patient's Name: _____

Patient Acknowledgement Form

Consent for Treatment

I hereby consent to any treatments and diagnostic studies considered necessary by the Physician or other medical personal of The Foot and Ankle Treatment Center.

Information Release

I authorize the release of any medical information including information related to psychiatric care drug and alcohol abuse and HIV/AIDS confidential information necessary to process insurance claims or any medical information that is needed for a utilization review or quality assurance activities.

Assignment of Benefits

I assign all medical and/or surgical benefits including major medical benefits to which I am entitled to The Foot and Ankle Treatment Center provider and/or representative. This assignment will remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original.

Childproof Container Waiver

I waive The Foot and Ankle Treatment Center of any responsibility in dispensing medication to me. I understand that the medication is not in a childproof container. I understand I will be advised of the directions for taking the medication and the potential side effect(s).

External Prescription History

I authorize The Foot and Ankle Treatment Center and its affiliated providers to view my external prescription history via the RxHub service.

HIE Consent & Change Form

The Foot and Ankle Treatment Center Health Information Exchange (HIE) grants clinicians participating in your care access to your most up to date medical records. This consent is to establish if you would like to participate in TFAATC HIE.

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices.

Our practice will make a good faith effort to obtain written acknowledgments of receipt of the Notice of Privacy Practices provided to the individual. If written acknowledgement is not obtained, our practice must document its good faith efforts to obtain such acknowledgement and record the reason why the acknowledgement was not obtained.

Patient Responsibility

We believe that each patient has a responsibility:

1. To cooperate with the staff.
2. To provide accurate and complete health care information.
3. To indicate whether he/she understands the contemplated plan of medicine and nursing management, and the kind of compliance that is expected of him/her.
4. To keep appointments, if at all possible, or to notify the clinic if unable to do so.

Patient Rights

It is the objective of The Foot and Ankle Treatment Center and all professional and supportive personnel working on behalf of the patient to uphold rights of all patients. We believe:

1. That the individual dignity of man should be upheld at all times.
2. All patients should be provided supportive and rehabilitative care to their individual needs and environment.
3. An environment should be provided that contributes to the patient's care, safety, and sense of well-being.
4. Fair and humane treatment should be provided to all patients under all circumstances, regardless of considerations of race, color, creed, or national origin, or the source of financial payment for cure.
5. Each individual patient has certain rights of privacy regarding care and personal circumstances, medical information, and financial information concerning patients should be treated confidentially at all times. The patient has a right to ask questions and receive appropriate information regarding the nature and extent of his/her medical problem, the planned course of treatment, and the prognosis.
6. Each patient will be given the opportunity for informal participation in his/her health care. 7. The patient has the right to refuse treatment to the extent permitted by law, to be informed of the medical consequences of his/her actions, and to request consultation or referral. 8. The patient has the right to efficient and cost-effective care in order to hold his/her health costs to minimum.
9. When a neonate, child, or adolescent is a patient, his/her family and/or guardian may represent the patient in securing his/her rights as a patient and shall be given the care appropriate to his/her needs.
10. Each patient has the right to present complaints concerning the quality of patient care that he/she has received.
11. Each patient has a right to a copy of his/her medical records
12. Each patient has a right to formulate advance directives and to appoint a surrogate to make health care decisions on his/her behalf.

The above includes requisite information for services at The Foot and Ankle Treatment Center. My signature acknowledges my review, understanding, and consent of all items included herein.

_____

Patient/ Guardian Signature Date

Payment Policy

As a courtesy, The Foot & Ankle Treatment Center, verifies your benefits with your insurance company. A quote of benefits is not a guarantee of benefits or payment. Your claim will process according to your plan, if your claim processes differently from the benefits we were quoted, the insurance company will side with the plan and will not honor the benefit quote we received.

It is the policy of The Foot & Ankle Treatment Center that payment is due at the time of service unless other financial arrangements are made in advance. We require all patients to pay their copay payment at the end of each visit.

If you are a self-pay patient, we require you to pay for your office visit and x-rays (if needed) prior to seeing the doctor. At the conclusion of your visit with us you may owe a balance depending on what procedures were done during your visit. We require payment for any open balances at the end of each visit, unless a payment arrangement has already been put into place.

If you are covered by health insurance with specialist benefits, we will be happy to bill your insurance. Please provide your insurance information to the front office staff and we will verify your coverage as a courtesy. Accepting your insurance does not place all financial responsibilities onto this practice, and you will be held accountable for any unpaid balances by your plan.

Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our clinic by another physician does not necessarily guarantee that your insurance will cover our services. Please remember that you are 100 percent responsible for all charges incurred: your physician's referral and our verification of your insurance benefits are not a guarantee of payment.

Patient Signature:_____ Date:_____

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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Patient Address: _____

By signing below, you hereby authorize The Foot and Ankle Treatment Center to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purpose of treatment, payment, and health care operations. You may refuse to sign the authorization. Subject to certain exceptions, you have the right to inspect and copy the protected health information. A copy of the Notice of Privacy Practices is provided to you by us prior to you signing the Authorization. The terms of this notice may change from time to time: you may request a current copy of the Notice of Privacy Practices at any time.

Your "protected health information" means all health information and medical records, including demographic information, collected from you and created or received by your physician, another health care provider, a health plan, your employer or a health care claims clearinghouse. Additionally, this authorization includes release of all medical records. You may revoke this authorization and consent in writing at any time except to the extent that TFAATC has already taken action in reliance upon this authorization. This protected health information relates to your past, present or future physical or mental health or condition and identifies you, or there is a reasonable basis to believe the information identifies you.

If someone calls or visits and asks about you, can we acknowledge that you are here? Yes No

There are multiple ways for our office to communicate with you. Your preference will be discussed during the registration process and this will be documented within your electronic health record. *We utilize the following methods to contact patients: Telephone/ Messaging, Email, Patient Portal, and/or Written documentation.*

I hereby give permission to the person(s) listed below to authorize treatment, attend examinations, and to receive information about the care of the patient listed at the top of this form. This includes but is not limited to: information about the patient's general medical condition and diagnosis (including treatment and payment options), access to medical records (protected health information), prescription pick-up, and the ability to set appointments.

1. _____ Relationship to patient: _____
2. _____ Relationship to patient: _____
3. _____ Relationship to patient: _____

_____ _____

Patient Signature or Personal Representative Date

As a personal representative, I have authority to act on behalf of the individual because I am their:

_____