FOOT, ANKLE & LEG VEIN CENTER

*Walk with Comfort and Look Great Doing It!*

# Welcome to the office of Dr. Schoenhaus and Dr. Gold

Patient Name: _____

DOB: _____

SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

**Alternate Address**:

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Cell: _____

E-Mail: _____

Occupation: _____

Employer: _____

How did you hear about us?

_____

**This information is required for Electronic Health Records which is mandated by the Government to comply with Meaningful Use*

***Ethnicity***: __Caucasian __African American __Hispanic __Asian __Pacific Islander __American Indian __Other Race __Declined

***Language***: __English __Spanish __Other_____

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**INSURANCE INFORMATION:**

Primary Insurance: _____

Secondary: _____

**PRIMARY CARE PHYSICIAN:**

Dr: _____

City: _____ State: _____ Zip: _____

Phone: _____

Date of Last Office Visit: _____

Hgb A1C (Diabetics): _____

**EMERGENCY CONTACT:**

Name: _____

Relationship: _____

Phone: _____

**RELEASE OF INFORMATION:**

Name: _____

Relationship: _____

Phone: _____

Signature of Patient/Guardian: _____ Date:_____

# MEDICAL INFORMATION

Patient Name: _____ Height_____ Weight_____ Shoe Size_____

What are you being seen for today?
_____

Was this caused by and injury?_____ If yes, Date of Injury_____ Any previous treatments?
_____

**MEDICATIONS AND DOSES**

_____, _____,
_____,

_____, _____,
_____,

_____, _____,
_____,

Or _____See attached List

**PHARMACY**

Name:_____ Location:_____
Phone:_____

**ALLERGIES**

___Aspirin ____Latex _____Dyes _____Penicillin _____Lidocaine _____Codeine ____Shell Fish _____Sulfa ____**None**

**HAVE YOU HAD ANY OF THE FOLLOWING CONDTIONS**

___Arthritis ___Vascular Disease ___Kidney Disease ___HIV ___Depression

___Osteoporosis ___Hepatitis ___Neuropathy ___IBS **___No Past Illnesses**

___Bleeding Disorders ___Heart Disease ___Hypertension ___Reflux Disease

___Blood Clots ___High Cholesterol ___Epilepsy ___Stomach Ulcers

___Stroke ___Diabetes ___Lung Disease ___Thyroid Disease

Other:_____
____

**Past Surgical History**

___Heart Surgery ___Spine ___Cancer ___Vein Surgery **___No Past Surgeries**

___Pacemaker ___Joint Replacement ___Gynecological ___Vascular Surgery

Have you had any procedures done on your feet or legs? Yes____ No____

If yes, please explain_____

**Current Information**

Pregnant? ___Yes ___No Do you smoke cigarettes/cigars? ___Yes ___No

Do you have a history of drug use ___Yes ___No If yes, how many per day _____

Do you drink alcohol? ___Yes ___No Are you a former smoker ___Yes ___No

How many per day?_____

**Family Medical History**

Mother: _____ ___Alive ___Deceased Medical Illnesses: _____

Father: _____ ___Alive ___Deceased Medical Illnesses: _____

Sister: _____ ___Alive ___Deceased Medical Illnesses: _____

Brother: _____ ___Alive ___Deceased Medical Illnesses: _____

I authorize Foot, Ankle & Leg Vein Center and/or any healthcare professional to perform a physical examination, diagnostic testing, procedures and to prescribe a therapeutic regimen. I also authorize Foot, Ankle & Leg Vein Center and the staff to release and/or collect information including diagnosis acquired in the course of my exam to/from any healthcare facilities, physicians or insurance carriers.

Patient/Guardian Signature:_____
Date:_____

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# FINANCIAL POLICY

PLEASE read & understand Foot Ankle & Leg Vein Center's financial policy that is as follows:

**I understand that it is ultimately my responsibility to understand my insurance contract and what I will be responsible for financially.**

I understand and agree that **I am responsible** for any co-pay, co-insurance and deductible amounts that are part of my insurance contract.

'We have prepared this to help you understand the complexities of medical insurance, realizing how confusing it can be. To begin, we would like to highlight a misconception; medical insurance was not designed to pay for all medical care. Most contracts have limits and/or various degrees of payment.

All levels of payment by insurance companies, including allowed fees, usual and customary (UCR), are governed by the premiums paid. They have nothing to do *with the actual charges by a physician. Our fees are based upon a combination of our cost, our time, and our constant dedication to supplying our patients with the highest quality medical care.* The treatment recommended by our office is never based on what your insurance company will pay; your treatment should not be governed by your insurance contract.'

I hereby **accept responsibility** to pay for any service(s) provided to me that **is not covered by my insurance**, along with (DME products: ace bandages, shower bags, stockings, orthotics, walking boots, post-op shoe, creams, lotions, etc.). All products are non refundable. **Payments are due at time of service.** If the balance or payment arrangements are not paid within the first 30 days of the statement, then the account will be sent to a collection agency. At which time the current balance will incur an additional 35 % collection fee.

***Our office has a policy for our Medical Pedicure program of charging a $ 40 fee for missing an appointment or canceling within less than 48 hours hours.*** The reason for this is to encourage our patients to take their appointments as seriously as we do. That time is reserved for you and if you do not keep your appointment then other patients who need an appointment the schedule permits are being obligated to wait longer than necessary.

*Signing below means you have read and agree to all terms of this policy.

I hereby authorize payment of medical benefits billed to my insurance to Foot, Ankle & Leg Vein Center.

_____

Print Patient Name

_____

_____

Patient Signature Date

# Foot, Ankle & Leg Vein Center

**670 Glades Rd. # 320**
**BOCA RATON, FL 33431**
**561-750-3033 P**
**561-750-3443 F**


## CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plan for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

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**OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgement on this *Notice of Privacy Practices Acknowledgement*, but was unable to do so as documented below:

| Date: | Initials: | Reason: |
|---|---|---|
| | | |