FOOT, ANKLE & LEG VEIN CENTER

Walk with Comfort and Look Great Doing It!

OFFICE USE ONLY
___ Dr. Schoenhaus ___ Med Info
___Dr. Gold ___ Notes
___Dr. Kane ___Chart

WELCOME TO OUR OFFICE

Patient Name:_____ **DOB:**_____**SSN:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Alternate 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_____

INSURANCE INFORMATION:

Primary Insurance:_____ **Secondary Insurance:** _____

PRIMARY CARE PHYSICIAN:

Dr._____ **City:**_____ **State:**_____

Phone:_____ **Date of Last Office Visit:** _____ **Hgb A1C (Diabetics):**____

EMERGENCY CONTACT:

Name:_____

Relationship:_____ Phone:_____

RELEASE OF INFORMATION:

Name:_____

Relationship:_____ Phone:_____

Do you have a Living Will/Advanced Directive? _____

Signature of Patient/Guardian: _____ **Date:**_____

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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/See attached

_____, _____, _____,
_____, _____, _____,

Have you had any of the following vaccines? ___ Flu Shot ___ Pneumovax ___ Shingles ____ COVID

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 have a history of drug use ___Yes ___No
Do you drink alcohol? ___Yes ___No
How many per day?_____

Do you smoke cigarettes/cigars? ___Yes ___No
If yes, how many per day _____
Are you a former smoker ___Yes ___No

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 any Self Pay Treatments with the Doctor and our Medical Pedicure Program that are "canceled "in less than a 24 hours from your scheduled appointment time or you should "No Show" there will be a $50.00 fee. 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 :_____

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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:

670 Glades Road, Suite 320, Boca Raton, FL 33431
P: (561)750-3033 F: (561)750-3443