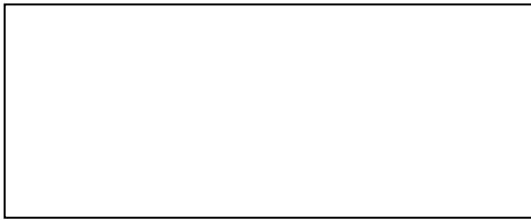


MEDICAL FORM



First Name _____ M.I. _____ Last Name _____ DOB _____

How long has this been a problem? _____ When does it occur? Morning Afternoon Evening Off and On All Day

TREATMENTS: Please list previous treatments (either prescribed or home remedies):

Is this visit related to an accident/injury? Y N If yes, date of injury _____

LIST CURRENT SPORTS/ACTIVITIES: _____

MEDICAL HISTORY: please indicate: S (Self) or F (Family Member-blood relation). If both, put both.

- | | | |
|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|
| ____ Alcohol/Drug addiction/dependency | ____ -GERD <input type="checkbox"/> Reflux <input type="checkbox"/> GI ulcers (v box) | ____ Phlebitis/DVT (blood clots in legs) |
| ____ Alzheimer's/Dementia | ____ -Headaches/Migraines | ____ -Pregnancy: are you currently pregnant? Due date: _____ |
| ____ -Anemia – type _____ | ____ -Hearing Problems | ____ -Rheumatic Fever/Scarlet Fever |
| ____ Arrhythmias – type _____ | ____ Heart Disease | ____ -Schizophrenia |
| ____ -Arthritis - type _____ | ____ -Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> Liver Disease v | ____ -Seizures/Epilepsy |
| ____ -Asthma <input type="checkbox"/> adult <input type="checkbox"/> childhood | ____ High Blood Pressure | ____ -STD's (sexually transmitted ds.) |
| ____ Bleeding/Clotting Problems | ____ High Cholesterol | ____ Sickle Cell Trait/Disease |
| - type _____ | ____ -HIV/Aids/ARC | ____ Stroke/TIA's |
| ____ -Cancer – type _____ | ____ Kidney/Renal Disease- type _____ | ____ Thyroid Problems <input type="checkbox"/> Hyper <input type="checkbox"/> Hypo |
| ____ Depression/Anxiety-disorder/ | ____ -Lung Disease/Pulmonary Embolus | ____ -Tuberculosis |
| Bipolar-depression/other | ____ -Lyme's Disease | ____ Other, Please Specify _____ |
| ____ Diabetes (how long _____) | ____ -Nervous Condition | ____ Other, Please Specify _____ |
| ____ -Emphysema/COPD | (type _____) | ____ None of the above |
| ____ -Glaucoma | ____ <input type="checkbox"/> Osteoporosis/ <input type="checkbox"/> Osteopenia (v box) | |
| ____ -Gout | | |

SURGICAL HISTORY: Y N If yes, please list the surgeries you have had:

HOSPITALIZATION: Y N If yes, please list: _____

PLEASE FILL OUT COMPLETELY

SMOKING: Do you or have you ever smoked? Y N
 If yes, how many years? _____ How long ago did you quit? _____

ALCOHOL USE:

Do you or did you ever drink alcoholic beverages? Y N
 How many drinks will you consume in a day? _____ Week? _____
 How long ago did you quit? _____

RECREATIONAL DRUG USE:

Do you or have you ever used illicit/recreational drugs? Y N
 If yes, which ones? _____ How long ago did you quit? _____

Age _____ Height _____ Weight _____ Shoe Size _____ Reason for visit _____

MEDICATIONS: Please list (or attach a list) of your current medications and their dosages:

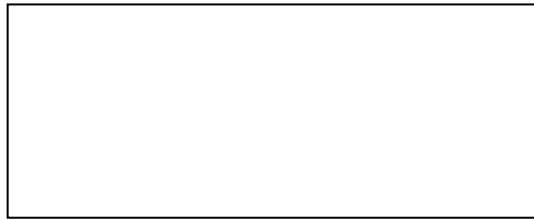
ALLERGIES: Do you have a history of allergies/skin reaction/sickness following the administration of any of the following:

	Y	N	**If yes, list REACTION		Y	N	**If yes, list REACTION
Adhesive tape	—	—	_____	Foods	—	—	_____
Anesthesia	—	—	_____	Iodine	—	—	_____
Aspirin	—	—	_____	Latex	—	—	_____
Caffeine	—	—	_____	Local Anesthetics	—	—	_____
Codeine	—	—	_____	Penicillin	—	—	_____
Cortisone	—	—	_____	Sulfa Drugs	—	—	_____
Demerol	—	—	_____	Other, please list:	_____		_____

Consent for Treatment: I certify that the information above is true and correct to the best of my knowledge. I have been informed that if I am uncertain about any question on the form I should ask the doctor or a member of the office staff for assistance. By signing below, I hereby authorize Foot and Ankle Specialists of the Mid-Atlantic, LLC to obtain medication history from community pharmacies and/or pharmacy benefit managers for the purpose of ongoing treatment. I give permission to Foot and Ankle Specialists of the Mid-Atlantic, LLC to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet, ankles, and lower legs.

Signature of Responsible Party _____ Date _____

Relationship (if not Patient) _____



FINANCIAL POLICY

Welcome to Foot and Ankle Specialists of the Mid-Atlantic, LLC (FASMA) and thank you for selecting our practice. We are committed to providing you with the best possible care. If you have medical insurance, we want to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our policy.

1. Your insurance is a contract between you and the insurance company. It is your responsibility to understand the benefits of your plan for any and all services. We cannot guarantee payment of your claims that we file. We file as a courtesy to you and your insurance company will not give us a guarantee of coverage. If your insurance company pays only a portion of your claim or rejects your claim, you and/or the policyholder should make an inquiry to your insurance company. Payment delays or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred. Unfortunately, delays in reimbursement may make you subject to: a \$5.00 per month fee for balances older than 30 days plus a 10% administrative fee, a \$35.00 fee for returned checks, and a fee not to exceed 10% for the establishment of a payment plan.
2. We participate in a number of health insurance plans, including Medicare. All patients are required to pay their co-pay, co-insurance, deductibles, and any patient balances owed of all visits, at the time of their visit. Patients that do not pay their co-pay at time of visit will be charged an additional \$5.00 statement fee. In addition, HMO patients must present a valid referral/authorization from their primary physicians at check in. 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 entire charge for all services rendered. 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 insurance company for clarification of benefits prior to services rendered. In the event you do not satisfy your financial responsibilities, the practice may use a collection agency, may provide protected health information to that agency. If such agency is used, you will be responsible for a 35% balance-based collection fee and any additional costs related to satisfying that debt, including, but not limited to, court costs, and/ or reasonable attorney fees that may be incurred in the collection of an outstanding balance affiliated with satisfying your financial responsibility. It is our standard procedure to send all pathology samples to a lab that is owned and operated by FASMA. We might also use other pathology labs, as necessary. **MEDICARE PATIENTS** If Medicare has provided reimbursement for services rendered, and if your supplemental insurance does not respond within 30 days, then you become responsible for the balance.
3. In order for us to service your account and/or to collect any amounts you may owe, we, FASMA, and our agents may contact you by telephone at any phone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide us to use. Methods of contact may include using pre-recorded or artificial voice messages and/or use of an automatic dialing device, as applicable.
4. Missed appointments: You will be billed a \$40.00 charge for missed appointments not cancelled with at least 24 hours' notice.
5. If you believe your insurance company has made an error or not adequately addressed your claims you may contact the insurance company and/or file a grievance or appeal with your state: for Maryland, contact the Maryland Insurance Administration at 410-468-2244 and/or The Health Advocacy Unit of the Maryland Attorney General at 410-528-1840; for Pennsylvania, contact the Bureau of Consumer Services, Pennsylvania Department of Insurance at 1-877-881-6388; for North Carolina, contact the Consumers Services Division, N.C. Department of Insurance at 1-855-408-1212; for Virginia, contact the State Corporation Commission, Virginia Bureau of Insurance at 1-877-310-6560; and for the District of Columbia contact the Department of Insurance, Securities and Banking at 202-727-8000.

I, _____ (Print Name of Patient or Legal Representative--**Patient DOB** _____), have read and I understand the above financial policies. These policies are subject to change without prior written confirmation.

Signature of Patient or Legal Representative

Date

SUMMARY NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information according to the Health Information Portability and Accountability Act (HIPAA).

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To Government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law;
- To a collection agency and may provide protected health information to that agency in the event you do not satisfy your financial responsibilities.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please contact: our Privacy Officer, at 301-933-7133 or PrivacyOfficer@footandankle-usa.com.

I, _____ (Print Name of Patient or Legal Representative--**Patient DOB** _____),
acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read or had the opportunity to read if I so chose and understood the Notice. This authorization may be revoked by me at any time in writing. By signing below, I hereby authorize Foot and Ankle Specialists of the Mid-Atlantic, LLC to obtain Medication History related to the patient above, from Community Pharmacies and/or Pharmacy Benefit Managers for the purpose of Continued Treatment. In addition, I authorize the following people access to my personal health information upon request (including leaving a detailed message):

Spouse Other: Name/Relationship: _____

Leave a detailed message on these voicemails/cell: _____

Signature of Patient or Legal Representative

Date

REVIEW OF SYSTEMS

Patient Name: _____ **Patient DOB** _____

Please check any of the following that you are currently experiencing or have recently experienced

GENERAL/CONSITUTIONAL:	KIDNEY/URINARY/BLADDER:	PSYCHIATRIC:
<input type="checkbox"/> Fatigue?	<input type="checkbox"/> Frequent or painful urination?	<input type="checkbox"/> Depression?
<input type="checkbox"/> Weakness?	<input type="checkbox"/> Blood in urine?	<input type="checkbox"/> Stress?
<input type="checkbox"/> Fever?	MUSCULOSKELETAL:	<input type="checkbox"/> Anxiety?
<input type="checkbox"/> Chills?	<input type="checkbox"/> Low back pain?	ENDOCRINE:
<input type="checkbox"/> Night Sweats?	<input type="checkbox"/> Pain in your leg?	<input type="checkbox"/> Thirsty?
<input type="checkbox"/> Malaise?	<input type="checkbox"/> Foot pain?	<input type="checkbox"/> Night sweats?
EYES:	<input type="checkbox"/> Joint pain?	<input type="checkbox"/> Swollen glands?
<input type="checkbox"/> Pain?	<input type="checkbox"/> Bone pain?	<input type="checkbox"/> Recent weight gain? **How Much?:
<input type="checkbox"/> Redness?	<input type="checkbox"/> General muscle aches and pains?	<input type="checkbox"/> Recent weight loss? **How Much?:
<input type="checkbox"/> Loss of vision?	<input type="checkbox"/> Swelling in the legs?	HEMATOLOGIC/LYMPHATIC (BLOOD):
<input type="checkbox"/> Double or blurred vision?	<input type="checkbox"/> Joint swelling?	<input type="checkbox"/> Anemia?
<input type="checkbox"/> Dryness?	<input type="checkbox"/> Joint stiffness?	<input type="checkbox"/> Clots?
EARS, NOSE, & THROAT:	<input type="checkbox"/> Change in gait?	<input type="checkbox"/> Bleeding problems?
<input type="checkbox"/> Ringing in your ears?	<input type="checkbox"/> Difficulty with climbing stairs?	ALLERGIC/IMMUNOLOGIC:
<input type="checkbox"/> Loss of hearing?	<input type="checkbox"/> Loss of leg strength?	<input type="checkbox"/> Healing issues?
<input type="checkbox"/> Frequent sore throats?	<input type="checkbox"/> Limping?	<input type="checkbox"/> Reactions to dyes?
<input type="checkbox"/> Hoarseness?	<input type="checkbox"/> Shoes wear out quickly?	<input type="checkbox"/> Reactions to foods?
<input type="checkbox"/> Difficulty in swallowing?	<input type="checkbox"/> Shoes wear out unevenly?	<input type="checkbox"/> Reactions to medicine?
<input type="checkbox"/> Pain in jaw?		OTHER/NOTES
<input type="checkbox"/> Nose bleeds?	INTEGUMENTARY/SKIN:	
CARDIOVASCULAR:	<input type="checkbox"/> Sensitive skin with sun exposure?	
<input type="checkbox"/> Chest pain?	<input type="checkbox"/> Rashes?	
<input type="checkbox"/> Palpitations?	<input type="checkbox"/> Warts on feet?	
<input type="checkbox"/> Swollen legs or feet?	<input type="checkbox"/> Moles/lumps/bumps?	
<input type="checkbox"/> Fainting?	<input type="checkbox"/> Extremely dry skin/cracking?	
RESPIRATORY:	<input type="checkbox"/> Open skin sores?	
<input type="checkbox"/> Shortness of breath?	<input type="checkbox"/> Unusual areas of discoloration?	
<input type="checkbox"/> Cough?	<input type="checkbox"/> Calluses?	
GASTROINTESTINAL/STOMACH	<input type="checkbox"/> Nail problems?	
<input type="checkbox"/> Black stools?	<input type="checkbox"/> Noticeable hair loss on legs or feet?	
<input type="checkbox"/> Blood in stools?	NEUROLOGIC:	
<input type="checkbox"/> Increasing constipation?	<input type="checkbox"/> Headaches?	
<input type="checkbox"/> Persistent diarrhea?	<input type="checkbox"/> Dizziness?	
<input type="checkbox"/> Heartburn?	<input type="checkbox"/> Fainting or loss of consciousness?	
<input type="checkbox"/> Nausea?	<input type="checkbox"/> Numbness or tingling or burning? **Where?:	
<input type="checkbox"/> Vomiting?		
<input type="checkbox"/> Stomach pain?		
<input type="checkbox"/> Yellow jaundice?		