# Palo Verde Foot and Ankle
## Patient Registration

First Name:_____ MI:____ Last Name:_____

Social Security Number:_____

Date of Birth:_____Sex:_____E-Mail: _____

Mailing Address: _____

_____

** Medicare Patients: Please specify your permanent address*

Home Phone: _____ Work Phone:_____ Cell Phone:_____

Primary Care Physician: _____Phone No:_____Date Last Seen:_____

Primary Language: _____

Race: [ ] American Indian or Alaska Native [ ] Asian
[ ] Black or African American [ ] Native Hawaiian
[ ] Other Pacific Islander [ ] White

Ethnicity: [ ] Hispanic or Latino
[ ] Not Hispanic or Latino

Referral Source: [ ] Insurance [ ] Internet [ ] Newspaper [ ] Another Patient [ ] Provider [ ] Other_____

Emergency Contact:_____ Phone Number:_____

Marital Status: _____ Drivers License #_____

Employer:_____Occupation:_____

PRIMARY INSURANCE:_____ SECONDARY INSURANCE:_____

Name of Spouse (or Guardian): _____Date of Birth:_____

Spouse or Guardian Social Security Number: _____

Spouse or Guardian Employment:_____Phone:_____

Contact Preferences: [ ] Phone [ ] Mail [ ] E-Mail

Preferred Pharmacy:_____Location:_____

I hereby give Scott A. Crampton, DPM permission to examine, evaluate, and treat my lower extremity complaint. I also request and authorize the administration of drugs and/or local anesthesia as deemed necessary during my treatment by Scott A. Crampton, DPM.

Patient/Parent or Guardian Signature_____ Date _____

| NAME | | Today's Date | |
|---|---|---|---|
| Birth Date | / / | Age | Height | Weight | Shoe Size |

**PATIENT'S CURRENT CHIEF COMPLAINTS** Describe your problem below and its cause if you know:

Is problem work related? NO YES Date of Injury:

PAIN: Please indicate the severity of your pain or discomfort on a scale from 1 – 10

1 2 3 4 5 6 7 8 9 10

**My Pain/Discomfort is:**

- □ Aching Pain
- □ Burning Pain
- □ Dull Pain
- □ Itching
- □ Numbness
- □ Sharp Pain
- □ Shooting Pain
- □ Throbbing Pain
- □ Tenderness
- □ Tingling

How long ago did the problem/pain start:

_____ □ days, □ weeks, □ months, □ years ago

The pain from my problem:

- □ increases with walking and/or standing
- □ is worse at night
- □ is present with any activity
- □ other: _____

Previous medical treatments for this problem (if any): _____

_____

**PATIENT'S MEDICATIONS AND ALLERGIES**

ALLERGIES: Is there a history of skin or other outward reaction or sickness following an injection, oral or topical administration of:

| | *Reaction* | | *Reaction* |
|---|---|---|---|
| □ Adhesive tape/Latex | | □ Morphine | |
| □ Aspirin, Advil, Aleve *(circle which)* | | □ Novocaine | |
| □ Celebrex | | □ Other anesthetics *(list)* | |
| □ Codeine | | □ Penicillin | |
| □ Demerol | | □ Other antibiotics *(list)* | |
| □ Other narcotics *(list)* | | □ Sulfa drugs | |
| □ Empirin, Tylenol *(circle which)* | | □ Shrimp, Iodine, Merthiolate *(circle which)* | |
| □ Other pain remedies *(list)* | | | |

| List Current Medications: | Dose: | How Often? | For Treatment of: |
|---|---|---|---|
| | | □as needed □____times a day □____ times a week | |
| | | □as needed □____times a day □____ times a week | |
| | | □as needed □____times a day □____ times a week | |
| | | □as needed □____times a day □____ times a week | |
| | | □as needed □____times a day □____ times a week | |

| NAME | | DOB | |
|---|---|---|---|

## PATIENT'S PERSONAL MEDICAL HISTORY

Does foot pain limit your desired activities? □ Yes □ No

Any pain in calves or buttocks when walking? □ Yes □ No

Do you have any difficulty in walking? □ Yes □ No

Is the pain relieved by stopping and standing still? □ Yes □ No

Do you have or have you ever been treated for:

| | | | | |
|---|---|---|---|---|
| □ Alzheimer's | □ Epilepsy | □ High Blood Pressure | □ Osteoporosis | □ Thyroid Problem |
| □ Anemia | □ Glaucoma | □ Keloid/Thick Scar | □ Phlebitis | □ Tuberculosis |
| □ Arthritis | □ Gout | □ Kidney Disease | □ Poor Circulation | □ Unexplained Weight Loss |
| □ Asthma | □ Headaches | □ Liver Disease | □ Psychiatric Disorder | □ Vascular Disease |
| □ Cancer | □ Hearing/Ear Disorder | □ Lung Disease | □ Rheumatic Fever | |
| □ Chronic Light Stool | □ Heart Attack | □ Lyme's Disease | □ Sciatica | |
| □ Dark Urine | □ Heart Condition | □ Macular Deg. | □ Stomach Ulcer | |
| □ Diabetes | □ Hepatitis | □ Nerve Disorder | □ Stroke | |

□ Other(s): _____ □ NONE OF THESE

| I had surgery for: | On date of: | with complications of: |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## PATIENT'S FAMILY/SOCIAL MEDICAL HISTORY

List relationship to you of family members who have had:

Arthritis _____ Foot Problems _____

Birth Defects _____ Heart Attack _____

Cancer _____ High Blood Pressure _____

Diabetes _____ Stroke _____

Number of childbirths _____

Are you currently pregnant? □ Yes □ No

Are you slow to heal after cuts? □ Yes □ No

Any abnormal bruising, bleeding or scarring? □ Yes □ No

Do you smoke now?
□ No □ Yes: _____ packs/day for _____ years

Did you ever smoke?
□ No □ Yes: _____ packs/day for _____ years

If you quit, when did you do so? _____

Alcoholic beverages? *(circle one)* none / rarely / moderately / daily / quit

Recreational drugs? *(circle one)* none / rarely / moderately / daily / quit

Palo Verde Foot and Ankle

# PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Palo Verde Foot and Ankle to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Palo Verde Foot and Ankle's Notice of Privacy Practices provides a more complex description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Palo Verde Foot and Ankle reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Palo Verde Foot and Ankle's Privacy Official at 3003 Hwy 95, Ste. 41, Bullhead City, AZ 86442.

With this consent, Palo Verde Foot and Ankle may call my home or alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Palo Verde Foot and Ankle may mail to my home or other alternative location any items that may assist in carrying out TPO, such as appointment reminder cards and statements as long as they are marked Personal and Confidential.

With this consent, Palo Verde Foot and Ankle may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that Palo Verde Foot and Ankle restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Palo Verde Foot and Ankle's use and disclosure of my PHI to carry out TPO. I also acknowledge, by my signature below, that I have received a copy of Palo Verde Foot and Ankle's Notice of Privacy Practices.

I may revoke consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Palo Verde Foot and Ankle may decline to provide treatment to me.

_____

Patient's Name

_____ _____

Signature of the Patient or Legal Guardian Date

_____

Print Name of Patient or Legal Guardian

# Cancellation/Missed Appointment Policy

Our goal is to provide quality medical care in a timely manner. In order to do so, we have had to implement an appointment/cancellation policy. This policy enables us to better utilize available appointments for our patients in need of medical care.

## Cancellation of an Appointment:

In order to be respectful of the medical needs of other patients, please be courteous and call Palo Verde Foot and Ankle promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance, and calling early in the day is appreciated. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

## How to Cancel Your Appointment:

To cancel appointments, please call 928-758-3338. If you do not reach the receptionist you may leave a detailed message with the answering service. If you would like to reschedule your appointment, please be sure to leave us your phone number and let us know the best time to return your call.

## No-Show Policy

A "no-show" is someone who misses an appointment without canceling it in an adequate manner. "No-shows" inconvenience those individuals who need access to medical care in a timely manner. A failure to present at the time of a scheduled appointment will be recorded in the the patient's chart as a "no-show". A "no-show" will result in a fee of $20.00 billed to the patient's account.

**SIGNATURE:**_____ **DATE:**_____

# Palo Verde Foot and Ankle

## PAYMENT POLICY:

Payment is required when office services are rendered unless prior arrangements have been made with this office. We will be glad to provide you with a receipt that you may provide to your insurance carrier for reimbursement.

## PRIVATE INSURANCE CARRIERS:

If this office does not receive payment from your insurance company within 60 days, all bills are due and payable in full unless prior arrangements have been made. Failure to comply with the above payment policies will result in your account being turned over to an outside collection agency. When this becomes necessary, your outstanding balance due will forward to a collection agency or attorney for collection of monies owed to Palo Verde Foot and Ankle. You, the patient/guarantor, agree to pay, in addition to the principal balance owed, all related collection and/or legal costs and fees. All bills are due and payable in full within 6 months after services have been rendered.

## MEDICARE PATIENTS:

This office participates in the Medicare program. This means that we will accept what Medicare approves (not pays). Medicare will pay for 80% of their approved amount. You or your supplemental insurance will be responsible for the 20% coinsurance, non-covered items, and insurance deductibles. If you have given up your Medicare for an HMO (i.e.: Pacificare, Desert Canyon, etc.) you also understand that you are responsible for obtaining your own referrals. In the event a referral is not obtained, you will be responsible for the bill.

## INSURANCE AUTHORIZATION:

I authorize and request that payment under my insurance policies be made directly to the provider for any services furnished to me. In the event these payments are directly mailed to me, the patient/guarantor, I understand it is my responsibility to forward these funds to the provider of service. I also authorize the provider to release any information needed for payment of my claims. I further permit copies of this authorization to be used in place of the original.

**SIGNATURE:**_____ **DATE:**_____

Palo Verde Foot and Ankle
3003 Hwy 95, Ste. 41
Bullhead City, AZ 86442
928-758-3338

## NOTICE REGARDING PRESCRIPTION NARCOTICS

It has become the policy of this office to limit the prescriptions for controlled substances to include:

1. Temporary or acute systems on an occasional or as-needed basis.
2. Conditions that are well documented by diagnostic test results.
3. Amounts not to exceed the 30-day supply (or 90-day supply for mail-in prescriptions) as written on the prescription.

We refer chronic pain conditions to a pain management specialist.

We may pull a pharmacy profile on patients who request narcotics on a frequent basis to insure these medications are not being obtained by other providers in addition to our practice.

We reserve the right to discontinue the provision of care to any patient who:

1. Attempts to fraudulently obtain narcotics from this practice.
2. Attempts to obtain narcotics from this practice and other providers.
3. Exceeds the dose limit prescribed.
4. Harasses the staff or the providers for narcotic medications and refilling of these prescriptions.

It is in the best interests of our patients that we make these provisions and any attempt to jeopardize the relationship of providers and patients is strongly discouraged.

By signing below, I acknowledge receipt and acceptance of the above listed provisions.

_____ _____

Patient Signature Date