# PATIENT INTAKE FORM

**BP:_____/______**

**PULSE:_____**

**PAIN LEVEL_____/10**

**HEIGHT:_______**

**WEIGHT:_____**

DATE: ___/____/____

PATIENT NAME: _______________ _____________ ___ DATE OF BIRTH: ___/___/___ AGE: ___ SEX: M F
LAST FIRST MI

HOME ADDRESS: _________________________________ CITY/STATE: __________________ ZIP: __________

MAY WE LEAVE A MESSAGE?

HOME PHONE #: (____) ____-______ YES NO

WORK PHONE #: (____) ____-______ YES NO

CELL PHONE #: (____) ____-______ YES NO

E-MAIL: ____________________________ YES NO

PRIMARY LANGUAGE: ______________ RACE:__________________________ ETHNICITY:_____________________

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO

IF YES, NAME: _____________________ RELATIONSHIP: _____________ PHONE #: (____) ____-______

EMERGENCY CONTACT: _____________________ RELATIONSHIP: ______________ PHONE #: (____) ____-______

PRIMARY CARE DOCTOR: _____________________________ PHONE: __________________________

PHARMACY: ______________________ LOCATION: ____________________ PHONE #: (____) ____-______

AMERICAN FOOT & ANKLE CLINIC OF TAMPA BAY

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?

_____ NO _____ YES NAME(S) ________________________________________________

WHO IS RESPONSIBLE FOR PAYMENT? ________________________ RELATIONSHIP TO PATIENT? _____________

ADDRESS: ___________________ CITY/STATE: _____________ ZIP: _______ PHONE #: (____) ____-_____

WHO REFERRED YOU TO US?____________________________________________________

**VACCINATIONS**

Pneumonia______ Chicken Pox_______ Shingles________Tetanus______ Influenza_______

Hemoglobin A1c ( Diabetic Patients) __________

**MEDICAL HISTORY**

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

| NAME | DOSE | HOW OFTEN DO YOU TAKE? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

PLEASE LIST ALL PRIOR SURGERIES:

| TYPE OF SURGERY | DATE | TYPE OF SURGERY | DATE |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**FAMILY HISTORY**

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES: TYPE 1 OR TYPE 2 ☐ CANCER ☐ HEART DISEASE

☐ HIGH BLOOD PRESSURE ☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE

☐ RHEUMATOID ARTHRITIS ☐ OSTEOARTHRITIS ☐ PERIPHERAL ARTERIAL DISEASE (POOR CIRCULATION)

AMERICAN FOOT & ANKLE CLINIC OF TAMPA BAY

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| ACID REFLUX | Y | N | FIBROMYALGIA | Y | N | NEUROPATHY | Y | N |
| ANEMIA | Y | N | GOUT | Y | N | OPEN SORES | Y | N |
| ARTHRITIS | Y | N | HEART ATTACK | Y | N | PNEUMONIA | Y | N |
| ASTHMA | Y | N | HEART DISEASE/FAILURE | Y | N | POLIO | Y | N |
| BACK TROUBLE | Y | N | HEPATITIS | Y | N | RHEUMATIC FEVER | Y | N |
| BLADDER INFECTIONS | Y | N | HIV+/AIDS | Y | N | SICKLE CELL DISEASE | Y | N |
| ABNORMAL BLEEDING | Y | N | HIGH BLOOD PRESSURE | Y | N | SKIN DISORDER | Y | N |
| BLOOD CLOTS | Y | N | KIDNEY DISEASE | Y | N | SLEEP APNEA | Y | N |
| BLOOD TRANSFUSION | Y | N | LIVER DISEASE | Y | N | STOMACH ULCERS | Y | N |
| BRONCHITIS/EMPHYSEMA | Y | N | LOW BLOOD PRESSURE | Y | N | STROKE | Y | N |
| CANCER | Y | N | MIGRAINE HEADACHES | Y | N | THYROID DISEASE | Y | N |
| DIABETES: TYPE 1 OR TYPE 2 (CIRCLE) | Y | N | MITRAL VALVE PROLAPSE | Y | N | TUBERCULOSIS | Y | N |
| OTHER CONDITIONS: | | | | | | | | |

**SOCIAL HISTORY**

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE

☐ CURRENT USE - TYPE ________________ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? ________ ☐ SMOKE ___ PACKS/DAY FOR ___ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? ________ TYPE ____________________

☐ CURRENT USE - TYPE _____________ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

EMPLOYER: ___________________________________ OCCUPATION: ______________________________________

**YOUR MEDICAL HISTORY**

ALLERGIES: ☐ NONE KNOWN ☐ MEDICATIONS ____________________________________________

☐ ANESTHESIA _____________________________ ☐ FOODS ________________________________________

☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER ________________________________________

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**CURRENT PROBLEM**

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? ______________________________

HOW LONG AGO DID THIS PROBLEM FIRST START? ________ DAYS / WEEKS / MONTHS / YEARS

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)

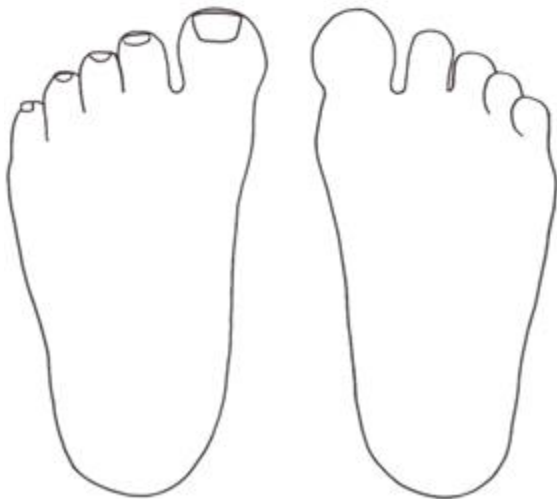
WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? ______________________________

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ YES (DESCRIBE) ______________________ ☐ NO

IF YES, WAS IT A WORK-RELATED INJURY? ☐ YES ☐ NO

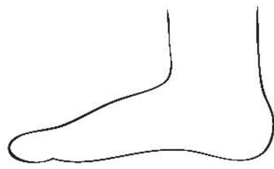
WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW:

**LEFT FOOT**



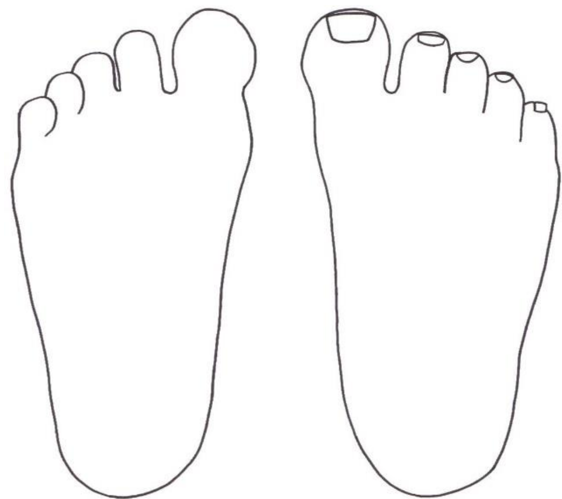
BOTTOM OF FOOT TOP OF FOOT

INSIDE OF FOOT

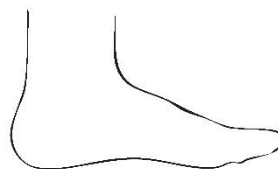


OUTSIDE OF FOOT

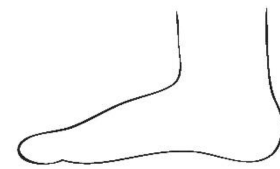
**RIGHT FOOT**



BOTTOM OF FOOT TOP OF FOOT



OUTSIDE OF FOOT



INSIDE OF FOOT

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

________________________________ ________________________________

PRINT NAME OF PATIENT, PARENT OR GUARDIAN DATE

________________________________

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

________________________________ ________________________________

SIGNATURE DATE

AMERICAN
FOOT & ANKLE
CLINIC OF TAMPA BAY

## Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, American Express, cash or check.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you or may not pay at all. Therefore, all charges for your care and treatment are due at the time of service.
- 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 complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.
- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

**Signature of Patient/Responsible Party:** ______________________________

Printed Name of Patient/Responsible Party ______________________________ Date: __________

________ Patient initials to indicate copy received.

# HIPAA (HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT) CONSENT

**PATIENT CONSENTS TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS**

I understand that as part of my healthcare, Dr. Guillermo Donate originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans or 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 health professionals who contribute to my care, such as

referrals. A source of information for applying my diagnosis and treatment information to my bill.

A means by which a third---party payer can verify that services billed were actually provided.

A tool for routine healthcare operations, such as assessing quality and reviewing the competence of staff.

I have been provided with a "*Notice of Patient Privacy Practices*", that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges: I have the right to review the "*Notice*" prior to acknowledging this consent.

I have the right to restrict or revoke the use or disclosure of my health information for other uses or purposes.

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.

**Restrictions:**

Please tell us with whom we may discuss your/patient's treatment, payment or healthcare operation, also please be sure to include their phone number(s) so we may contact them in the event that it may be necessary. Example: spouse, children, other relatives, friends or caregivers (names):

______________________________________________________________________________

______________________________________________________________________________

**Messages or Appointment Reminders:**

May we leave a message at your home using doctor's/practice name: Yes____No_

May we leave a message at your work using doctor's/practice name: Yes____No_

Do not leave a message: ______

Messages will be of a non-sensitive nature, such as appointment reminders, upcoming events, etc.

I understand that as part of treatment, payment, or healthcare operations, it may become necessary to disclose health information to another entity, i.e., referrals to other healthcare providers. I consent to such disclosure for these uses as permitted by law.

I fully understand and **accept/decline** (please circle one) the information of this consent.

______________________________ ______________________________

**Patient/Guardian Signature** **Print Name of Person Signing**

______________________________

**Date**

# Patient Bill Of Rights And Responsibilities

We want to encourage you, as a patient at The American Foot & Ankle Clinic of Tampa Bay, to speak openly with your health care team, take part in your treatment choices, and promote your own safety by being well informed and involved in your care. Because we want you to think of yourself as a partner in your care, we want you to know your rights as well as your responsibilities during your stay at our hospital. We invite you and your family to join us as active members of your care team

## Your Rights

• **You have the right** to receive considerate, respectful and compassionate care in a safe setting regardless of your age, gender, race, national origin, religion, sexual orientation, gender identity or disabilities.

• **You have the right** to receive care in a safe environment free from all forms of abuse, neglect, or mistreatment.

• **You have the right** to be called by your proper name and to be in an environment that maintains dignity and adds to a positive self-image.

• **You have the right** to be told the names of your doctors, nurses, and all health care team members directing and/or providing your care.

• **You have the right** to have a family member or person of your choice and your own doctor notified promptly of your admission to the hospital.

• **You have the right** to have someone remain with you for emotional support during your hospital stay, unless your visitor's presence compromises your or others' rights, safety or health. You have the right to deny visitation at any time.

• **You have the right** to be told by your doctor about your diagnosis and possible prognosis, the benefits and risks of treatment, and the expected outcome of treatment, including unexpected outcomes. You have the right to give written informed consent before any non-emergency procedure begins.

• **You have the right** to have your pain assessed and to be involved in decisions about treating your pain. • You have the right to be free from restraints and seclusion in any form that is not medically required.

• You can expect full consideration of your privacy and confidentiality in care discussions, exams, and treatments. You may ask for an escort during any type of exam.

• **You have the right** to access protective and advocacy services in cases of abuse or neglect.

• You, your family, and friends with your permission, have the right to participate in decisions about your care, your treatment, and services provided, including the right to refuse treatment to the extent permitted by law. If

you leave the clinic against the advice of your doctor, the clinic and doctors will not be responsible for any medical consequences that may occur.

• **YOU HAVE THE RIGHT** to agree or refuse to take part in medical research studies. You may withdraw from a study at any time without impacting your access to standard care.

• **YOU HAVE THE RIGHT** to communication that you can understand. The hospital will provide sign language and foreign language interpreters as needed at no cost. Information given will be appropriate to your age, understanding, and language. If you have vision, speech, hearing, and/or other impairments, you will receive additional aids to ensure your care needs are met.

• **YOU HAVE THE RIGHT** to make an advance directive and appoint someone to make health care decisions for you if you are unable. If you do not have an advance directive, we can provide you with information and help you complete one.

• **YOU HAVE THE RIGHT** to be involved in your discharge plan. You can expect to be told in a timely manner of your discharge, transfer to another facility, or transfer to another level of care. Before your discharge, you can expect to receive information about follow-up care that you may need.

• **YOU HAVE THE RIGHT** to receive detailed information about your physician charges.

• You can expect that all communication and records about your care are confidential, unless disclosure is permitted by law. You have the right to see or get a copy of your medical records. You may add information to your medical record by contacting the Medical Records Department 813-994-0213. You have the right to request a list of people to whom your personal health information was disclosed.

• **YOU HAVE THE RIGHT** to give or refuse consent for recordings, photographs, films, or other images to be produced or used for internal or external purposes other than identification, diagnosis, or treatment. You have the right to withdraw consent up until a reasonable time before the item is used.

• If you or a family member needs to discuss an ethical issue related to your care, call our office at any time. To reach us, call us at 813-994-0213.

• **YOU HAVE THE RIGHT** to voice your concerns about the care you receive. If you have a problem or complaint, you may talk with your doctor. You may also contact him at 813-994-0213 or email gdonate@americanfootandankle.com.

## YOUR RESPONSIBILITIES:

• You are expected to provide complete and accurate information, including your full name, address, home telephone number, date of birth, Social Security number, insurance carrier and employer when it is required.

• You should provide the hospital or your doctor with a copy of your advance directive if you have one.

• You are expected to provide complete and accurate information about your health and medical history, including present condition, past illnesses, hospital stays, medicines, vitamins, herbal products, and any other matters that pertain to your health, including perceived safety risks.

• You are expected to ask questions when you do not understand information or instructions. If you believe you cannot follow through with your treatment plan, you are responsible for telling your doctor. You are responsible for outcomes if you do not follow the care, treatment, and service plan.

• You are expected to actively participate in your pain management plan and to keep your doctors and nurses informed of the effectiveness of your treatment.

• You are expected to treat all staff, other patients, and visitors with courtesy and respect; abide by all clinic rules and safety regulations; and be mindful of noise levels, privacy, and number of visitors.

• You are expected to provide complete and accurate information about your health insurance coverage and to pay your bills in a timely manner.

• You have the responsibility to keep appointments, be on time, and call your health care provider if you cannot keep your appointments.