ADVANCED PODIATRY SPECIALISTS

ARMANDO GONZALEZ, DPM
3300 SW 33RD ROAD OCALA, FL 34474
PH (352)873-3332 FAX (352)351-4920

CARL SALVATI, DPM
812 NE 25TH AVE OCALA, FL 34470
PH (352)351-4444 FAX (352)351-4920

TIMOTHY GRAESER, DPM
915 NW 56TH TERR GAINESVILLE, FL 32605
PH(352)331-4333 FAX (352)331-8382

DEMOGRAPHICS

Date: _____
Name: _____
Birthdate: _____ Age: _____
Sex: Male Female
Married Single Divorced Widow
SS#: _____

Home Phone: (_____) _____-_____
Cell Phone: (_____)_____-_____
Preferred Contact Method: Home Cell
Text Notification Yes NO Email Notification Yes No
Address_____
City_____
State_____ Zip_____
Email: _____
Please List Who Referred You: _____

PATIENTS UNDER 18 YEARS OLD ONLY

Guardians Name: _____

Relation: _____

Phone: (_____) _____-_____

EMERGENCY CONTACT INFORMATION

Name: _____
Contact Number: _____
Relationship: _____

INSURANCE INFORMATION

Primary Insurance: _____
Policy Number: _____
Secondary Insurance: _____
Policy Number: _____

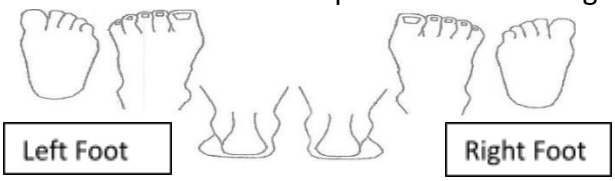
PHARMACY

Preferred Pharmacy and Location: _____

What is the problem/condition you are having?

_____

Please indicate the source of problem on the diagrams:



No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain
Current Pain Level: _____ Worst Pain Level: ____
Is this complaint due to an injury Yes No
Is this injury work related Yes No

Please indicate which problem(s) you are experiencing:	
Numbness/Burning/Tingling in Foot	Yes No
Cramps and Spasms	Yes No
Swelling of Leg(s)	Yes No
Leg Pain	Yes No
Ankle Pain	Yes No
Heel Pain	Yes No
Foot Pain	Yes No
Calluses	Yes No
Plantar Warts/Skin Lesions	Yes No
Wound/Ulcer	Yes No
Deformed/Fungal Toenails	Yes No
Ingrown Toenails	Yes No
Weakness in Leg/Ankle/feet	Yes No
Balance Problems	Yes No

PAST MEDICAL HISTORY

Diabetes	Neuropathy
Arthritis	RSD / CRPS
Osteomyelitis	Peripheral Vascular Disease
Fibromyalgia	
History of Pulmonary Embolism	Kidney Disease
	Venous Insufficiency
Heart Disease	Stent Placement in Lower Extremity
High Blood Pressure	
GERD/Gastric Ulcer	Implant: Pacemaker or Defibrillator
Skin Cancer	
Liver Disease	Other: _____

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PAST SURGICAL HISTORY

Please list any past surgeries:

_____
_____
_____

Did you tolerate anesthesia well? Yes No

FAMILY/SOCIAL HISTORY

Mother: Deceased Living
Medical History: _____

Father: Deceased Living
Medical History: _____

Do you use tobacco? Yes No
If **YES**:
Type: Pipe Cigar Cigarettes Chew
How Often: _____
If you are a FORMER TOBACCO USER:
How long ago did you quit? _____

Do you use Alcohol? Yes No
If **YES**:
How Often: _____

Do you have a history of Diabetes? Yes No
IF YES: Type I Type II Other: _____
Name of Monitoring Physician: _____
Date Last Seen by this Physician: _____

Name of Primary Care Physician: _____
Last Date Seen By PCP: _____

REVIEW OF SYSTEMS

Please ***circle*** any other significant medical history that you feel would be pertinent to your treatment at our facility:

General: Weight Gain-Loss; Change in strength or exercise tolerance; Fever; Chills; Fatigue; Lethargic; HIV/AIDS

HEENT: Headaches/Migraines; Dizziness; Traumatic Brain injury; Blurred Vision; Change in Vision; Hearing Loss; Ringing of Ears; Nose Bleeding; Trouble Breathing; Running Nose; Dental difficulties; Bleeding gums; Use of dentures/Implants; Neck Stiffness; Noted Masses on Neck; Frequent Sore Throat; Thyroid Problem; Trouble Swallowing

Lungs: Wheezing; Coughing of Blood; Chronic Cough; Shortness of Breath; Infection of Lungs

Heart: Chest Pain; Palpitations; Heart Valve Problems; Fainting; Infections of Heart

Abdomen: Loss of Appetite; Diarrhea; Nausea/Vomiting; Bloody Stool

GU: Frequent Urination; Urinary Tract Infection; Change in nature of urine.

Gyn: Change in menses; Pain with Menses; Vaginal discharge; Pelvic pain; Menopausal

Dermatologic: Callus; Wound; Rash/Itching; Change in Mole; Deformed Toenails; Infection of Skin

Musculoskeletal: Pain in muscles or joints; limitation of Joint or Joint Stiffness; Foot/Ankle Swelling; Infection of Bone

Neurologic: Weakness; Tremor; Seizures; Memory Loss; Trouble with Balance; Numbness or Loss of Sensation

Psychiatric: History of Depression; History of Anxiety; Trouble Sleeping; Thoughts of Suicide

Other: _____
_____

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

X_____ _____
Patient / Guardian Signature **Date**

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Name: _____ **Date: _____**

Date of Birth: _____

Medication List/Allergies Passport

Please fill this form out completely and bring it with you when you visit any Medical Professional/Pharmacy. Include all medications (prescribed and over the counter) and vitamins that you are currently taking. ALL MEDICATIONS ARE IMPORTANT TO YOUR VISIT.

Medications (PRINT)

Name	Dose	How often	Prescribing Doctor
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

Drug Allergies **Yes ☐ No ☐**

Allergen (Drugs)	**Severity** (Mild, Moderate, Severe)	**Reaction** (Anaphylaxis, Rash)		**Onset** (Childhood, Adult, Unknown)
1.				
2.				
3.				
4.				
5.				

HIPAA NOTICE OF PRIVACY PRACTICES

My signature on this document acknowledges that I have read the Advanced Podiatry Specialists HIPAA Notice of Privacy Practice.

LIFETIME AUTHORIZATION

INSURANCE ASSIGNMENTS AND AUTHORIZATION TO RELEASE INFORMATION

I. RELEASE OF INFORMATION- I, the below named patient, do hereby authorize any physician examining and/or treating me to release to any third payer (such as insurance company or governmental agency, e.g.-Blue Cross Blue Shield of Florida or Medicare) any medical, psychiatric condition, alcohol or drug related condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determine a claim for payment for such treatment and/or diagnosis.

II. PHYSICIAN INSURANCE ASSIGNMENT- I, the below named patient, hereby authorize payment directly to any physician examining or treating me or any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for these services.

III. MEDICARE/MEDICAID- Patient's certification authorization to release information and payment request. I certify that the information given by me in applying for payment under TitleXVII/XIX of the Social Security Administration Division of Family Services or its intermediaries or carriers any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

IV. I PERMIT A COPY OF THIS AUTHORIZATION AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE. The assignment will remain in effect until revoked by me in writing.

V. CONSENT TO DISCUSS MEDICAL CONDITION OR RELEASE RECORDS: I, the below named patient do authorize Timothy Graeser DPM, Armando Gonzalez DPM or Carl M. Salvati, DPM. to discuss my medical condition with, or release my medical records, to the below named person(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: Primary Care / Specialist

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand it's my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance or third-party payor within a reasonable period of time not to exceed 60 days. If the amount is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

Patient Signature: _____ Date_____

SUBSCRIBER (if different from patient) Name: _____

CONSENT FOR TRANSFER OF BIOLOGICAL SPECIMEN

Florida law (Section 817.5655, Florida Statutes) prohibits the sale or transfer of a person's biological specimen from which DNA can be extracted to a third party without the express consent of such person.

During the course of your care at Advanced Podiatry Specialists, it may be medically necessary to obtain a blood, urine, stool, tissue or other type of biological specimen for analysis. This analysis **will not** involve the examination of your DNA to identify the presence and composition of genes in your body. After the analysis has been performed and the sample is no longer needed, it will be stored as medical waste and then transferred to a third party for disposal in accordance with all local, state and federal requirements.

It may also be the case that a biological specimen (such as blood, urine, hair, bodily fluids, etc.) from you may be deposited on medical instruments, bedding, clothing or other objects. These objects may then be transferred to a third party for cleaning or disposal.

By signing this document, you affirmatively state that it is your intentional decision to consent to the transfer of any and all biological specimens collected by or deposited with ADVANCED PODIATRY SPECIALISTS to a third party as set forth above. This consent does not authorize the sale or transfer of a biological specimen for the purpose of DNA analysis.

_____

Print Name

_____

Signature of Patient

_____

Date

Medical Records Request Form

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Date: _____

Name(Print): _____
D.O.B.: _____

I hereby give authorization to release my medical records from:

Name of YOUR Primary Physician: _____
Phone: _____ Fax: _____

- ☐ **Labs**
- ☐ **Last office notes**
- ☐ **Medication List**
- ☐ **X-rays**
- ☐ **MRI's**
- ☐ **Operative Report**
- ☐ **All Medical Records**
- ☐ **Other: _____**

Fax (352) 331-8382

Patient Signature: _____ Date: _____

Practice Financial Policy

Thank you for choosing **Advanced Podiatry Specialists** as your health care provider. We are committed to building a successful physician-patient relationship, and the success of your medical treatment and care. Your understanding of our Practice Financial Policy and payment for services are important parts of this relationship. For your convenience, this document discusses a few commonly asked financial policy questions. If you need further information or assistance about any of these policies, please ask to speak with our Practice Manager.

When are payments due?

All copayments, deductibles, patient responsibility amounts, and past-due balances are due at the time of check-in unless previous arrangements have been made with our billing coordinator.

Which plans do you contract with?

Advanced Podiatry Specialists accepts most major insurance plans. However, with the frequent changes that happen in the insurance marketplace, it is a good idea for you to contact your insurance company prior to your appointment and verify if we are a participating provider as per your plan.

If we are not a provider under your insurance plan, you will be responsible for payment in full at the time of service. As a courtesy, however, we will file your initial insurance claim, and if not paid within 45 days, you will be responsible for the total bill. After your insurance company has processed your claims, any amount remaining as a credit balance will be refunded to you.

Do you charge a penalty for returned payments?

Any charges incurred by the practice collecting balances owed to us during the collection process may be charged to the patient. Returned checks, credit card chargebacks, or returned payments will attract a minimum $35 penalty in addition to the balance owed. Accounts with returned payments will be expected to make payments via cash, money order, or cashier's checks only.

Can you waive my copay?

We cannot waive deductibles, coinsurances, or copays that are required by your insurance. This is a violation of insurance rules.

Do you charge for completing forms?

Completing disability forms, FMLA forms, and other requested supplemental insurance forms requires time away from patient care and day-to-day business operations. A prepayment of $15.00 per form is required. Please understand that to complete forms, your medical record must be reviewed, forms completed and signed by the physician and copied into your medical record. Some of these forms can be quite complicated and tedious to fill out. Please provide us with pertinent information, especially dates of disability and return to work. We request that you allow 5 business days for this process.

What if I missed my appointment to see the physician?

We understand that on rare occasions, issues may arise, causing you to miss your appointment when you cannot notify our office before your office or surgical appointment.

Office Appointment: Should you experience any unforeseen circumstance that causes you to miss your appointment, please call our office at least 24 hours prior to having it rescheduled. For Monday appointments, cancellations must be made by noon on the preceding Friday.

Our highly skilled physicians are committed to your well-being and have reserved time just for you. Patients who miss more than three appointments without notifying our office 24 hours before the appointment time may be subject to a $20 missed appointment fee billed to the patient. This fee will have to be paid prior to your next appointment.
Surgical Appointment: Any patient who fails to keep an appointment or who cancels or reschedules a surgery less than 72 hours in advance of their appointment will be charged a fee of $100.00 per occurrence. For Monday appointments, cancellations must be made by noon on the preceding Friday.
I have read, understand, and agree to the above Financial Policy. I understand my financial responsibility to make payments for services provided to me and the courtesy extended by Advanced Podiatry Specialists to simplify insurance reimbursement for the services provided to me. I acknowledge that these policies do not obligate Advanced Podiatry Specialists to extend credit to me for services provided.

Patient or authorized representative signature: _____ Date: _____

Patient or authorized representative name: _____