BARONNÉ FOOT CENTER

PATIENT INFORMATION

PATIENT NAME Last First M.I.		Social Security Number	
ADDRESS Street		DATE OF BIRTH	SEX Female Male
City State Zip	Home Phone	Cell Phone	Work Phone
EMAIL		Marital Status ☐ Single ☐ Widowed ☐ Divorced ☐ Married	
PREFERRED METHOD OF CONTACT (Check all that apply) ☐ Home Phone ☐ Cell Phone ☐ Work Phone			
RACE : ☐ African American ☐ Asian ☐ Hispanic ☐ Caucasian ☐ Native American ☐ Other		Ethnicity ☐ Hispanic ☐ Non-Hispanic	
EMPLOYER		PATIENT'S OCCUPATION	
PHARMACY NAME		PHARMACY PHONE	
HOW DID YOU HEAR ABOUT US ☐ Community Events ☐ Baronne's Patient/Friend/Family ☐ Employer ☐ High School/Sport ☐ Hospital/Urgent Care ☐ Insurance ☐ Magazine or Newspaper ☐ Physician ☐ Radio or Television ☐ Website or Online			

PERSON RESPONSIBLE FOR CHARGES

NAME	SOCIAL SECURITY NUMBER
ADDRESS Street	DATE OF BIRTH
City State Zip	CONTACT PHONE NO.
EMPLOYER	EMPLOYER PHONE NO.

REFERRAL INFORMATION

PRIMARY CARE PHYSICIAN	NAME OF REFERRING PHYSICIAN

INSURANCE INFORMATION

PRIMARY	SECONDARY
Insured Name: _____	Insured Name: _____
Insurance Name: _____	Insurance Name: _____
Policy ID #: _____	Policy ID #: _____
Group/Account #: _____	Group/Account #: _____
Social Security #: _____	Social Security #: _____
Relation to Patient: _____	Relation to Patient: _____

I hereby certify the above information is true and correct to the best of my knowledge. I understand that while Baronne Foot Center contracts with many insurance companies, it is my responsibility to verify with my plan that Baronne Foot Center is a participating provider. It is also my responsibility to find out what my coverage options are with my insurance plan. I hereby authorize Baronne Foot Center to submit insurance claim forms along with medical records necessary to obtain payment from my insurance company. I understand that I am responsible for all charges regardless of my insurance coverage. I acknowledge that photo IDs taken are used to assist in patient recognition per HIPPA guideline.

Patient Signature: _____ Date: _____

BARONNE FOOT CENTER

Privacy and Disclosure Statement

Your treatment, payment, enrollment or eligibility for benefits at Baronne Foot Center (BFC) is not dependent upon whether you sign this Privacy and Disclosure Statement. You have the right to revoke this Privacy and Disclosure Statement at any time by sending a written notice of revocation to: BFC at 127 Rue Louis XIV, Suite 101, Lafayette, LA 70508, Attn: Privacy Officer. Our Practice Manager and front office staff will be glad to discuss these acknowledgements and authorizations with you.

By signing below, I acknowledge that I have received the Notice of Privacy Practices of Baronne Foot Center which explains its legal duties and privacy practices with respect to my protected health information. I understand that if I have indicated my preferred method of contact is by cell phone, I may receive text message communications regarding my scheduled appointments, appointment reminders and missed appointment notifications. I understand that standard message and data rates may apply.

I understand if I choose to opt-out of receiving text message reminders, I am responsible of changing my preferred method of contact with Baronne Foot Center.

I hereby agree that Baronne Foot Center may disclose any and all of my protected health information to the following individuals, all of whom are involved in my care for any purpose related to my treatment or the payment of my care.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

IN CASE OF EMERGENCY NOTIFY:

Name: _____ Relationship: _____ Phone: _____

PATIENT PORTAL ONLINE ACCESS

I have been informed about the Patient Portal Online Access and authorize Baronne Foot Center to activate my patient portal account using the email address indicated on Patient Information Form. I understand that it is my responsibility to safeguard the email address and my patient portal password in order to maintain the security and privacy of my personal health information. I also understand that the patient portal is not to be used for urgent medical needs nor does it replace the need for me to keep my regular appointments with my doctor.

PORTAL ACCEPTANCE

Patient Name: _____
DOB: _____

PORTAL DECLINE

Signature: _____
Date: _____

Signature of Patient/ Patient's Representative: _____ Date: _____

Printed Name of Patient/ Patient's Representative: _____

FINANCIAL POLICY

It is our goal to create and maintain a good doctor – patient relationship. To help you understand, and to meet your financial obligations to our practice, we have put together the following policies. We understand that sometimes it may be difficult to meet your financial obligations. If this should occur, we encourage you to discuss your account, and any payment arrangements with our medical assistant staff.

PROCEDURES. I understand that Baronne Foot Center will collect, prior to any surgery or procedure, deductibles and coinsurance up to an amount equal to payment in full for the planned procedure. Payment in full and expected coinsurance payment responsibility is determined by the anticipated surgical billing codes, details of your insurance policy, and agreement between your insurance company and Baronne Foot Center.

INSURANCE. As a courtesy to you, this office will file claims for all visits and procedures, whether they are delivered in the office, outpatient center, or the hospital. When we file a claim on your behalf, it is with the understanding that the benefits are assigned to Baronne Foot Center. You are responsible for payment of all co-pays, deductibles, co-insurances and non-covered services.

REFERRALS. We can assist you to determine if your insurance plan requires a referral. Referrals usually have an expiration date, and a limited number of visits. You should carefully monitor the dates and visits.

NO INSURANCE. Patients who do not have insurance are expected to pay for all services rendered at the time of service.

PAST DUE ACCOUNTS. Patients who fail to make payment arrangements or have not expressed interest in meeting their financial obligations, will be turned over to a collection agency. Patients with accounts in collections will be required to satisfy their financial obligations to us, and pay for any future services in advance, prior to being seen by our doctors.

NON-COVERED SERVICES. Medicare or your health insurance company may determine that your visit with our doctors is not "medically necessary" and will deny payment for our services. If this happens, it is your responsibility to pay for our services. We will do our best to inform you what services may not be covered by your health insurance.

RETAIL/ RETURN POLICY. Full payment of retail items is expected at the time of service. We do not accept returns on any of our products.

FMLA FORMS and MEDICAL RECORDS. FMLA forms take 5 - 10 business days to be processed. A fee of $15.00 will be charged for every form. We gladly send your medical records to other physicians (at no charge) upon your request.

MISSED APPOINTMENT. As a courtesy to our patients we use a reminder call service that will text or call two days prior to your scheduled appointment. We charge a **$30.00** missed appointment fee with our doctors and a **$20.00** missed appointment fee with our medical assistants, if the appointment is not canceled by 5 PM the day before.

Patient Statement:

I have been informed of the **Baronne Foot Center Patient Financial Policy.** I have read and understand my obligations; I understand that if Medicare or my health insurance company denies payment, I agree to be personally and fully responsible for payment.

_____ _____

PATIENT'S PRINTED NAME **Date**

_____

PATIENT'S SIGNATURE

MEDICAL HISTORY

Patient Name: _____ Date of Birth:_____ Height: ____ Weight: ___ Shoe Size: ____
Is this a work related injury? _____Yes _____No Car Accident? _____Yes _____No
Current Foot or Ankle problem: _____
_____
When did the problem start? _____
What has been done to treat the problem?_____

Primary Physician (First and Last Name): _____ Phone#: _____
Date Last Seen: _____ Other Physicians: _____

ALLERGIES and DRUG REACTIONS: (Penicillin, Novocaine, tape, foods, etc.).

1) _____ 3) _____ 5) _____
2) _____ 4) _____ 6) _____

MEDICATIONS. (List all medications with dosages)

1) _____ 5) _____ 9) _____
2) _____ 6) _____ 10) _____
3) _____ 7) _____ 11) _____
4) _____ 8) _____ 12) _____

MEDICAL HISTORY – Please check positive responses to your personal medical history. Example in ( )

☐ Accident/ Injuries
☐ Arthritis (RA,OA)
☐ Blood (sickle cell/anemia)
☐ Cancer
☐ Diabetes
☐ Digestive (reflux,Crohns, etc.)
☐ Ears/Nose/Throat
☐ Eyes (glaucoma)
☐ Gout
☐ Heart Disease/ Attack/ Pacemaker
☐ High Blood Pressure
☐ Immune Disease (HIV)
☐ Kidney Disease
☐ Liver Disease
☐ Lungs
☐ Nerves (neuropathy)
☐ OB-GYN
☐ Orthopedics (artificial joints)
☐ Psych (Depression/Alzheimer's)
☐ Seizures Epilepsy
☐ Skin (psoriasis, eczema, etc.)
☐ Stroke
☐ Thyroid or other endocrine
☐ Vascular/ Circulatory
☐ Other

Please explain any positive responses above: (ie. Hepatitis for liver disease).

_____
_____
_____

PAST SURGICAL HISTORY (procedures, year and any complications):

1) _____ 5) _____
2) _____ 6) _____
3) _____ 7) _____
4) _____ 8) _____

FAMILY HISTORY (diabetes, heart disease, gout, cancer, foot problems or other):

_____
_____
_____

SOCIAL HISTORY:

Occupation: _____ Tobacco: If yes, how much? _____
Alcohol: If yes, how much? _____ Illicit drugs: If yes, how much? _____
IMMUNIZATIONS: Last Tetanus: _____

Whom may we thank for referring you to our office? _____

I hereby give Baronne Foot Center permission to diagnose and administer treatment for my foot or ankle condition and authorize any release of information obtained in the course of my treatment.

SIGNED: _____ Date: _____

BARONNÉ FOOT CENTER

REVIEW OF SYSTEMS

Please check box if you have the following symptoms:

CONSTITUTIONAL:
- □ Chills
- □ Dizziness
- □ Fever

CV:
- □ Ankle swelling
- □ Calf cramping
- □ Change in color of extremity
- □ Change in temp of extremity
- □ Chest pain or tightness
- □ SOB

ENDOCRINE:
- □ Cuts take longer to heal
- □ Hyperglycemia
- □ Hypoglycemia
- □ Excessive urination
- □ Unusual fatigue

ENT:
- □ Change in hearing/ringing ears
- □ Difficulty swallowing
- □ Sinus infection/congestion
- □ Sore throat

IMMUNOLOGIC:
- Gouty attack
- Environmental allergies

EYES:
- □ Blurry vision
- □ Change in vision

GI:
- □ Abdominal cramping
- □ Diarrhea
- □ Reflux
- □ Nausea
- □ Vomiting

GU:
- □ Dysuria
- □ Blood in urine
- □ Frequent urination

INTEGUMENT:
- □ Blisters
- □ Dry or scaly skin
- □ Eczema
- □ Easily scar
- □ Hypersensitivity
- □ Itching
- □ Leg ulcers
- □ Non-healing wounds
- □ Rash

NEUROLOGICAL:
- □ Burning, tingling
- □ Hypersensitivity
- □ Numbness
- □ Paralysis
- □ Tremors
- □ Vertigo

LYMPH:
- □ Enlarged lymph nodes
- □ Leg swelling

MUSCULOSKELETAL:
- □ Back pain
- □ Decreased ROM
- □ Heel pain
- □ Joint pain
- □ Joint redness
- □ Joint swelling
- □ Morning stiffness
- □ Muscle tenderness
- □ Weakness

PSYCHIATRIC:
- □ Anxiety
- □ Depression
- □ Memory loss
- □ Panic attacks

RESPIRATORY:
- □ Asthma
- □ Breathing difficulty
- □ Cough
- □ Shortness of breath