Welcome to the Michigan Foot and Ankle Center, P.C.

We are pleased to welcome you to our practice. Please take a few minutes to fill out these forms as completely as you can. If you have questions, we will gladly help you. We look forward to working with you and thank you for allowing us to provide your podiatric care!

Identifying Information **Date:**_____

Name:_____

Identifying Gender:_____**Age:**_____**Date of Birth:** _____ **Marital Status:** _____

Height:_____ **Weight:**_____**Shoe Size:**____

Ethnicity: O African or African American O Asian O Caucasian or European American

O Native American or Alaskan American O Native Hawaiian or Pacific Islander O Other_____

Languages Spoken: _____**Employer:**_____

Contact Information

Address: _____ **County:** _____

City: _____**State:** _____**Zip:** _____

Phone Preferred: _____**Secondary Phone:** _____ **Office:** _____

Email: _____

Emergency Contact and Number: _____

Primary Care Physician: _____**Phone:**_____

Address: _____**Date of Last Visit:**_____

Pharmacy Name/Cross Streets: _____**Phone:** _____

Medical History

Reason for Visit Today: _____

_____

Has this problem been previously treated?_____

_____

List ANY surgeries you have had: _____

_____

List ANY allergies you have: _____

_____

Ongoing Medical Problem

Please Check Any That Apply

○ Anemia	○ Gastrointestinal Condition	○ Polio
○ Arthritis	○ Gout	○ Psychiatric Condition
○ Back Problems	○ Heart Problems	○ Radiation Treatment
○ Bleeding Tendency	○ Hemophilia	○ Respiratory Disease
○ Blood Disease	○ Hepatitis	○ Rheumatic Fever
○ Broken Bone (fractures)	○ High Blood Pressure	○ Scarlet Fever
○ Cancer	○ HIV Positive	○ Shortness of Breath
○ Chemotherapy	○ Kidney Disease	○ Stroke
○ High Cholesterol	○ Leg Cramps	○ Swelling of Foot/Ankles
○ Circulatory Problems	○ Liver Disease	○ Thyroid Problems
○ Diabetes	○ Mitral Valve Prolapse	○ Tuberculosis
○ Epilepsy	○ Osteoporosis	○ Venereal Disease
○ Eye Condition	○ Phlebitis (Blood Clots)	○ NONE OF THESE

Are you Pregnant or Nursing? Y N

Family History

Have any Family Members Ever Had the Following (Please List whom):

Diabetes:_____ **Foot Problems:** _____

Arthritis: _____ **Heart Disease:** _____

Stroke: _____ **High Blood Pressure:**_____

Cancer: _____ **Neuromuscular:**_____

Lifestyle

Do you smoke: Y N **Packs/Day:**____ **Years:** _____

Did you ever smoke: _____**Packs/Day:**_____**Years:**_____**Quit Smoking Date:** _____

Alcoholic Beverages: None Rarely Moderately Daily Quit

Recreational Drugs: None Rarely Moderately Daily Quit

Medications

Medication/Dosage	Medication/Dosage	Medication/Dosage

I authorize my insurance company to pay Michigan Foot and Ankle Center, P.C. all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize Michigan Foot and Ankle Center, P.C. to release all information necessary to secure the payment of benefits.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY MY INSURANCE COMPANY.

Signature: **Date:**

Whom may we thank for referring you?

NOTE: THERE WILL BE A $50 CHARGE (NOT COVERED BY INSURANCE) FOR MISSED OR CANCELLED APPOINTMENTS UNLESS 24 HOUR ADVANCED NOTICE IS GIVEN.

Your Protected Health Information Designees:

If you are not available at the time that we call, please list below those individuals with whom we can leave a message or discuss your medical information (i.e. lab/test results, prescription information.) This person (designee) will also be able to call the office on your behalf. Please print any names and phone numbers of such persons below.

_____

_____

_____

Check the following box if you do not want your health information discussed with anyone other than yourself. ☐

Check the following box if you will allow us to leave a confidential voicemail with the numbers your provided. ☐

Please indicate any friends or family members you would authorize to pick up prescriptions on your behalf:

_____

_____

Check the following box if you do not want to authorize anyone else to pick up your prescriptions. ☐

MICHIGAN FOOT AND ANKLE CENTER, P.C.

ACKNOWLEDGEMENT/GOOD FAITH EFFORT FORM

Patient Name: _____

❒ Acknowledgement

I acknowledge that I have received the Preamble form for Michigan Foot and Ankle Center, P.C.

_____

Patient or Personal Representative Signature Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

_____

❒ Good Faith Effort:

The above patient presented for treatment on this date:
and was provided with a copy of the practice's Preamble form. A good faith effort was made to obtain written acknowledgement of receipt of the Preamble form. However, an acknowledgement was not obtained because:

❒ Patient refused to sign.

❒ Patient was unable to sign or initial because: _____

_____

❒ There was a medical emergency and the practice will attempt to obtain an acknowledgement at the next available opportunity.

❒ Other: _____

_____

_____

Employee Name: Employee Signature:

Michigan Foot and Ankle Center, P.C.

Peter P. Galea, DPM, D.ABFAS, FACFAS
Joshua S. Faley, DPM, D.ABFAS, FACFAS
Katherine A. Morrison, DPM, D.ABFAS, FACFAS
Kalli E. Hewitt, DPM, AACFAS

HIPAA NOTICE
PREAMBLE

As part of your health care, Michigan Foot and Ankle Center, P.C., maintains paper and/or electronic records describing your health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment.

Please understand that this information will serve as:

* A basis for planning your care and treatment,
* A means of communication among the many health care professionals who may or may not contribute to your care.
* A source of information for applying your diagnosis and surgical information to your billing,
* A means by which a third-party payer can verify that services billed were actually provided, and/or,
* A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

Please note that as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a copy of the Michigan Foot and Ankle Center, P.C., Notice of Privacy Practices is posted in a noticeable and convenient location within the office. The Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Also understand that you have the right to request and keep a copy of this Notice for your own records.

This preamble is provided to all patients of Michigan Foot and Ankle Center, P.C., and we reserve the right to change our Notice and practices, in accordance with Section 164.520 of the code of Federal Regulation. Should Michigan Foot and Ankle Center, P.C., change its Notice, a copy of the revised Notice will be sent to the address that you have provided.

If you have any questions or concerns regarding your health information, this Preamble or the Notice of Privacy Practices of Michigan Foot and Ankle Center, P.C., please feel free to contact our HIPAA Privacy Officer at the address and/or phone number provided below.