NORTH FLORIDA
NFFAC
FOOT & ANKLE CENTER

Andrew K. Bartell DPM
Amanda M. Bartell DPM

8825 Perimeter Park Blvd Ste #401 • Jacksonville, FL 32216
465 Town Plaza Avenue Ste #A • Ponte Vedra, FL 32081
Phone: (904) 236-5023 • Fax: (904) 236-5073
Visit us online at www.nffac.com

Patient Information:

First Name: _____ Last Name: _____ M.I. _____

Suffix (Jr., Sr. III) _____ Alias Name (Name you prefer to go by): _____ Gender: __ M __ F

Address: _____ City: _____ State: _____ Zip code: _____

SS#: _____ Date of Birth: _____ Marital Status: __Married __Single __Other

Contact Information: Home: ( ) _____ Business: ( ) _____ Cell: ( ) _____

Preferred way to contact you: ___ Home __ Cell __ Work May we leave detailed messages at that number? _____

Employed: __ Yes ___ No Employer Name: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone #: ( ) _____

Pharmacy Name: _____ Pharmacy Phone#: ( ) _____

Primary Care Physician: _____ Physician Phone #: ( ) _____

Who Referred you to our office? _____ *If referred by a physician, please complete the following:*

Referring Physician Name: _____ *Physician Phone #:* _____

If you are a minor or under the supervision of a legal guardian, please complete the following information:

Parent/Guardian Name: _____ Relationship to Patient: _____

Address: _____

Contact Information: Home: ( ) Business: ( ) Cell: ( )

Responsible Party For Account (if different from patient):

Name: _____ Relationship to Patient: _____

Address: _____

Contact Information: Home: ( ) _____ Business: ( ) _____ Cell: ( ) _____

Insurance Information:

Primary Insurance Name: _____ Plan Type: _____

Policy #: _____ Group #: _____ Effective Date: _____

Insured Name: _____ Employer: _____

Date of Birth: SS #: Relationship to Patient:

Secondary Insurance Name: _____ Plan Type: _____

Policy #: _____ Group #: _____ Effective Date: _____

Insured Name: _____ Employer: _____

Date of Birth: SS #: Relationship to Patient:

_____ _____

Date Completed Completed By

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PATIENT E-MAIL REQUEST FORM

Patient Name:_____ Date of Birth:_____

Email Address:_____

How did you hear about us? Please check one of the options.

- Website
- Facebook
- Google
- Magazine Ad
- Walk-in
- Referred By:_____

Patient Authorization:

_____

Patient Signature: Date:

North Florida Foot and Ankle Center is requesting your Email information so as a patient with us we can include you in our Patient Portal, newsletters, campaigns, as well as so we could send you birthday cards and holiday cards. We would like to make sure all of our patients have access to our websites and any further information we can provide. **Signing this form, you are giving North Florida Foot and Ankle Center permission to send you updated information via email**. All the information contained on this form is maintained confidential.

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What is your primary concern today?

_____

_____

Height: ____ Weight: _____ Shoe Size: _____ Are you pregnant: __Yes __No If *yes*, delivery date? _____

Allergies: Are you or have you ever had a reaction to any of the following?

Drug:	Reaction:	Drug:	Reaction:
☐Aspirin	_____	☐Tape or Band-Aids	_____
☐Codeine	_____	☐Penicillin or Antibiotics	_____
☐Iodine	_____	☐Sedative	_____
☐Sulfa Drugs	_____	☐Other Not Listed:	_____
☐Local Anesthesia	_____		

Past Medical History

Alcoholism	Yes	No	Heart Attack	Yes	No	Pneumonia	Yes	No
Anemia/Sickle Cell	Yes	No	Heart Disease	Yes	No	Polio	Yes	No
Arthritis	Yes	No	Hepatitis or Jaundice	Yes	No	Rheumatic Fever	Yes	No
Asthma	Yes	No	High Blood Pressure	Yes	No	Seizures	Yes	No
Cancer or Tumor	Yes	No	HIV /AIDS	Yes	No	Skin Rash or Hives	Yes	No
Cholesterol	Yes	No	Kidney Failure	Yes	No	Stomach Ulcers	Yes	No
Diabetes	Yes	No	Measles	Yes	No	Stroke	Yes	No
Drug Abuse	Yes	No	Multiple Sclerosis	Yes	No	Thromophlebitis	Yes	No
Emphysema or Bronchitis	Yes	No	Mumps	Yes	No	Thyroid Disease	Yes	No
Epilepsy or Seizure	Yes	No	Pacemaker	Yes	No	Tuberculosis	Yes	No
Gout	Yes	No	PAD	Yes	No	Other:	Yes	No

Medications: *Please include any pills, injectables, and herbs taken on a daily basis.* ☐See enclosed list

_____

_____

_____

Past Surgical History: *Please list all surgeries from childhood.* ☐See enclosed list

_____

_____

_____

Social History:

☐ Married ☐ Single ☐ Other

Children? Yes No How Many? _____
Smoke? Yes No How Long? _____ How Many Packs A Day? _____
Drink? Yes No
Drug Use? Yes No Which? _____

Family History:

Alcoholism	__Yes	__No	High Blood Pressure	__Yes	__No
Anemia	__Yes	__No	HIV	__Yes	__No
Arthritis	__Yes	__No	Kidney Trouble	__Yes	__No
Asthma	__Yes	__No	Rheumatic Fever	__Yes	__No
Cancer or Tumor	__Yes	__No	Skin Rash or Hives	__Yes	__No
Diabetes	__Yes	__No	Stomach Ulcers	__Yes	__No
Drug Abuse	__Yes	__No	Stroke	__Yes	__No
Emphysema or Bronchitis	__Yes	__No	Thromophlebitis	__Yes	__No
Epilepsy or Seizure	__Yes	__No	Thyroid Disease	__Yes	__No
Heart Attack	__Yes	__No	Tuberculosis	__Yes	__No
Hepatitis or Jaundice	__Yes	__No	Other Not Listed:	_____	

Please indicate which family member: (example: M – Mother; F – Father; B – Brother; S – Sister)

_____

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Review Of Systems:

General Health: Poor Fair Good

Weight Changes	Gain	Loss
☐ Intentional		
☐ Unintentional		
Anxiety	Yes	No
Chills	Yes	No
Dehydration	Yes	No
Dizziness	Yes	No
Fever	Yes	No
Nausea and vomiting	Yes	No
Syncope	Yes	No

Respiratory:

Asthma	Yes	No
Breathing difficulty	Yes	No
Bronchitis	Yes	No
Chest tightness	Yes	No
Cold-like symptoms	Yes	No
Congestion	Yes	No
Emphysema	Yes	No
Pneumonia	Yes	No
Sleep apnea	Yes	No
Snoring	Yes	No
SOB/Dyspnea	Yes	No
Tuberculosis	Yes	No
Wheezing	Yes	No

Cardiovascular:

Ankle swelling	Yes	No
Chest pain	Yes	No
Cold extremities	Yes	No
Palpitations / Arrhythmia	Yes	No
Heart attack	Yes	No
Heart murmur	Yes	No
Hypertension	Yes	No
Intermittent claudication	Yes	No
Leg cramps	Yes	No
Pacemaker	Yes	No
Phlebitis	Yes	No
Varicosities	Yes	No

Gastrointestinal:

Abdominal changes	Yes	No
Appetite	Increased	Decreased
Constipation	Yes	No
Diarrhea	Yes	No
Gallbladder	Yes	No
GERD	Yes	No
Heartburn	Yes	No
Hepatitis	Yes	No
Stomach Ulcers	Yes	No
Vomiting	Yes	No

Endocrine:

Cold intolerance	Yes	No
Wounds take long to heal	Yes	No
Diabetes mellitus	Yes	No
Dry skin	Yes	No
Excessive hair growth	Yes	No
Extreme thirst	Yes	No
Hypoglycemia	Yes	No
Unexplained weight fluctuations	Yes	No
Unusual fatigue	Yes	No

Skin:

Acne	Yes	No
Athlete's Foot	Yes	No
Blisters	Yes	No
Dermatitis	Yes	No
Easy bruising	Yes	No
Eczema	Yes	No
Hypertrophic scars	Yes	No
Pruritus	Yes	No
Psoriasis	Yes	No
Rashes	Yes	No
Wounds	Yes	No

Musculoskeletal:

Generalized weakness	Yes	No
Joint Pain	Yes	No
Where? _____		
Leg Cramps	Yes	No
Limitation of motion	Yes	No
Where? _____		
Low back pain	Yes	No
Morning stiffness	Yes	No
Muscular tenderness	Yes	No
Neck pain	Yes	No
Osteoarthritis	Yes	No
Osteoporosis	Yes	No
Rheumatoid arthritis?	Yes	No

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OFFICE POLICIES AND PROCEDURES

We would like to take this opportunity to personally thank you for choosing North Florida Foot & Ankle Center to treat your podiatric needs and concerns. Below is a list of our office policies. Please take a moment of your time to review our policies and please do not hesitate to ask any questions. ***After reviewing the policies below, please initial next to each policy indicating you have read, understand, and will adhere to the written policies.***

_____ **Patient Treatment**
It is our primary goal to restore and maintain the health of your feet and ankles. We strive to provide you with the highest quality podiatric care. If you have any questions regarding your treatment, please feel free to consult with your physician who is providing your care. It is our responsibility to deliver the best health care possible. We highly value your confidence in our practice, and we will make a sincere effort to satisfy all your podiatric needs.

_____ **Appointments**
If you are unable to keep your appointment, we require that you contact our office. As a courtesy to other patients who are waiting for an appointment, we request that you call to cancel your appointment within 24 hours. Patients who fail to show for their appointments without proper notification will be responsible for a $25.00 non-refundable charge. Patients with 3 or more missed appointments without proper notification may be asked to transfer their records to another physician. Also, as a courtesy to the doctor and to other patients, we require that you be on time for your appointment. When you are late, you put the doctor behind schedule with their other patients. If you are more than 15 minutes late you will be required to reschedule your appointment.

_____ **Release of Records**
If you want your records released to another physician or facility you must sign a Release of Information form indicating who we are releasing records to, as well as which relevant information you would like us to release. If you wish to receive a copy of your records for your personal files, you must send us a written request. Please allow 30 business days to have your records available. Any x-rays taken within our office are our personal property which we are legally responsible to maintain with your records.

_____ **Referrals**
If your insurance company requires a referral, it ***is your responsibility for obtaining it***. The contract is between you and your insurance carrier. Therefore, we are not responsible to obtain your referral. If you present to the office without your referral you will be required to reschedule your appointment, or you may opt to pay out of pocket for services rendered. Referrals must be generated from your primary care physician or referring doctor.

_____ **Insurance Benefits**
Your insurance coverage is a contract between you and your insurance company. *We are not a party to this contact!* We will bill your insurance company (primary and secondary, if applicable) as a courtesy. Your insurance company does not guarantee payment for services rendered. Your insurance company makes the final determination of benefits and eligibility at the time claim is reviewed.

*You as the policyholder are primarily responsible to know your insurance benefits***.** The insurance **DOES NOT** guarantee payment of the benefits quoted and subsequently you will be responsible for any coinsurance or deductibles for services not covered by your insurance carrier. We may assist you, if time permits to verify your podiatric coverage available under your policy.

As part of your treatment, your physician may need to submit a culture to an outside laboratory due to possible infection. These charges are also subject to your deductible and any coinsurance.

By signing the line below, you hereby agree that you understand you are solely responsible to pay any portion of charges not covered by your insurance carrier.

Patient Signature: _____ Date Signed: _____

_____ **Required Payments**
You be will be responsible to pay any co-payment, deductible, coinsurance, or fees not covered by your insurance carrier at the time services are rendered. We do not accept letters of protection. Any outstanding balances greater than 60 days must be paid prior to being seen by the physician or you will be required to reschedule your appointment. You may choose to pay by cash, check, Visa, or MasterCard.

_____ **Monthly Statements**
You will receive a statement only if you have an outstanding balance on your account. The statement will reflect any balance pending with your insurance carrier as well as any outstanding balance for services not covered by your insurance company. We request that if you receive a statement, that you make payment within 30 days of receipt. **If your balance becomes delinquent past 60 days, your account will be referred to a collection agency and you will be responsible for any collection or litigation fees incurred.**

_____ Date Completed

_____ Completed By

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SUMMARY OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAYBE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ CAREFULLY.

Section I: Information that can be disclosed without patients consent.

1. We may release your medical information to other healthcare providers for purposes of treatment in order to give you safe and complete care.
2. We may share your medical information to other entities for purposes of payment. Such as:
    a. Your insurance company in order to process your claims and receive reimbursement for services rendered.
    b. Collection agency should your account become delinquent.
3. We may disclose all records directly to you upon written request.
4. We may disclose your records to Health and Human Services (HHS) for purposes of preventing or controlling disease, injury, or disability, such as reporting communicable disease, births, deaths, etc.
5. We may disclose your medical information to a public health authority or other appropriate government authority authorized to receive reports regarding suspected child abuse or neglect.
6. We may disclose patient information to drug company representatives or medical device company representatives regulated by the FDA for purposes of reporting adverse events involving the drug or device.
7. We may release your records for health oversight activities to federal or state agencies for purposes of audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure, or disciplinary actions.
8. We may disclose your records for purposes of judicial and administrative proceedings when ordered to do so by a court or administrative tribunal or upon receipt of a subpoena or discovery request.
9. We may disclose your records to law enforcement personnel that are required by orders, warrants, or subpoenas. Practice personnel may also disclose only the following limited information to law enforcement officials in response to their request made for purposes of identifying or locating a suspect, fugitive, material witness or missing person: name and address, date and place of birth, social security #, ABO blood type and Rh factor, type of injury, date and time of treatment, date and time of death, if applicable, and a description of distinguishing physical characteristics
10. We may disclose the records of deceased persons to coroners and funeral directors for the purpose of identifying a deceased person and determine cause of death.
11. We may release your records when it is necessary to prevent a serious and imminent threat to the health or safety of a person or the public. If a patient makes a statement admitting to participation in a violent crime that caused serious physical harm to a victim, and if the patient appears to have escaped from a correctional institution or from law custody. Disclosures must be limited to only the patient's statement and the following information: name and address, date and place of birth, social security #, ABO blood type and Rh factor, type of injury, date and time of treatment, date and time of death (if applicable), and a description of distinguishing physical characteristics.
12. We may disclose your records to any business associate – a third party who provides services for North Florida Foot & Ankle Center and in doing so, has access to your medical health information. Such as, transcriptionists, billing services, or clearinghouses.

Section II: Medical Information That Can Be Disclosed Only With Written Consent.

1. If you would like your records transferred to another healthcare provider that was not recommended as part of your treatment you must sign a Release of Information form.
2. Any insurance company that is not known to North Florida Foot & Ankle Center, then a written request made on letterhead must be submitted for verification.
3. A signed Release of Information form must be completed to release your medical records to any attorney as part of a personal injury lawsuit or claim.

Section III: Patients Rights to Your Medical Information

1. All patients have a right to receive a notice of the practice privacy policies and procedures on their first visit.
2. You have the right to restrict the use of your health information to carry out treatment, payment or health care operations and have the right to restrict disclosures made to family and close personal friends. All requests must be submitted in writing and must be submitted within reasonable time. North Florida Foot & Ankle Center reserves the right to

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whether they will grant the request. North Florida Foot & Ankle Center may terminate the agreement by advising you in writing that the termination will only be effective with respect to health information created or received after written notification to you.

3. You have the right to inspect and obtain a copy of your health information. You must submit a request in writing to have access to your health information. Upon receipt of the request, North Florida Foot & Ankle Center will provide you with an opportunity to inspect your health information within 30 days of the date of receipt for records maintained on site, and within 60 days for records maintained off site. The records must be in a readable format and North Florida Foot & Ankle Center must provide a convenient time and place for you to inspect your health information. *However, North Florida Foot & Ankle Center does reserve the right to charge a reasonable, cost-based fee for providing you with access to his/her information.*
4. You may request a list of anyone North Florida Foot & Ankle Center has shared your medical information with and when it was shared.
5. You have the right to request that North Florida Foot & Ankle Center amend your health information. Request for amendments or corrections to your health information may be submitted in writing. After reasonable investigation, the privacy officer will determine whether North Florida Foot & Ankle Center will grant of deny the request to amend and must respond in writing within 60 days from the date of the request.
6. No patient or perspective patient shall be asked to waive their rights under the HIPAA Privacy Rules. Practice personnel shall not intimidate or retaliate against patients who seek to inquire about, enforce, or complain regarding their rights under the HIPAA Privacy Rules.
7. You may make complaints regarding North Florida Foot & Ankle Center's policies, procedures and practices with respect to the HIPPA Privacy Rules. Complaints must be submitted in writing and must be reviewed and appropriate investigation shall be conducted to develop necessary information regarding the complaint. The privacy officer must respond within 15 days of receiving the written complaint and advice you in writing of their determination regarding the complaint and the measures, if any, which will be taken by North Florida Foot & Ankle Center to mitigate any improper use or disclosures of protected health information. If you feel that North Florida Foot & Ankle Center has not kept your privacy according to the law, you may forward your complaint to HHS at the following address:

   Office of Civil Rights
   U.S. Department of Health and Human Services
   200 Independence Avenue S.W.
   Room 509F, HHH Building
   Washington, D.C. 20201
   (202) 619-0257
   Email: ocrmail@hhs.gov
8. North Florida Foot & Ankle Center responsible to take necessary precautions to prevent disclosures of your health information in common areas accessible by the general public.
9. North Florida Foot & Ankle Center will keep and maintain all records, documents or information generated, created, or required to be kept for a minimum of 6 years. Records and information must be kept in a safe, secure location. All patient health information will be disposed of by means of shredding, incineration, or other methods to obliterate any identifying information in such records.

Please list who we may release your medical health information to. Whoever is listed below will be allowed to discuss any medical information pertaining to your treatment, as well as information pertaining to your account balance for services rendered.

Name: _____ **Relation:** _____ **Date:** _____
Name: _____ **Relation:** _____ **Date:** _____
Name: _____ **Relation:** _____ **Date:** _____

I hereby acknowledge receipt of Notice of Privacy Practices by North Florida Foot & Ankle Center and that I have read or had the opportunity to review and understood the privacy practices.

_____ _____
Date Completed Completed By