The Foot & Ankle Clinic

Tyson Tabora, D.P.M.
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Patient Name_____ Date Of Birth_____

FL Address_____City_____State___Zip_____

Out of State Address _____City_____State_____Zip_____

Primary Phone#_____Secondary Phone#_____

Last 4 of Social Security Number _____ Male_____Female_____

Email Address_____Employer Name_____

Emergency Contact Name_____Contact #_____

Family Doctor Name Printed_____

Pharmacy Name and Crossroads_____

Insurance Company Name_____

Policy Holder's name_____Date of Birth_____

I give permission to The Foot & Ankle Clinic to release any information requested by my insurance company. I also give permission for Dr. Tyson Tabora to perform general procedures in the diagnosis and/or treatment of my foot condition. I authorize payment of medical benefits of The Foot & Ankle Clinic for service provided.

Patient/Guardian Name Printed_____

Patient/Guardian Signature_____Date_____

How did you hear about our office?_____

What is the chief complaint for which you came to be treated? (Include foot, ankle and Leg)
_____
_____
_____

When did it start?_____
_____
_____
_____

Other_____

Have you seen a Podiatrist before?
If Yes, Name of Dr._____
Last Visit_____
Previous Foot Problems:
_____
_____
_____

Please indicate any family history of foot/ankle problems
Please check all that apply
Ankle Pain_____
Athlete's Foot_____
Bunions_____
Corns/Calluses_____
Flat Foot_____
Numbness Foot/Leg_____
Foot/ Leg Cramps_____
Heel Pain_____
Ingrown Toenail_____
Plantar Wart_____
Swelling ankles/Feet_____
Tired Feet_____

Allergies

_____Adhesive Tape
_____Aspirin
_____Codeine
_____Demerol
_____Iodine
_____Local Anesthetics
_____Novocaine
_____Penicillin
_____Other _____
_____**No Allergies**

Medications

Please list or attach a copy of **ALL** medications with **Dosage and Strength**_____

_____

_____

_____

_____

Medical History

_____Diabetic
_____Circulatory Problems
_____Epilepsy/Seizures
_____Stroke
_____High Blood Pressure
_____Low Blood Pressure
_____Stomach Ulcers
_____Heart Disease
_____Phlebitis
_____Respiratory Disease
_____Artificial Heart valve/joints
_____Blood Clots/DVT
_____Liver Disease
_____Bleeding Disorder
_____Arthritis
_____Hypothyroidism
_____Kidney Problems
_____Gout
_____Varicose Veins
_____Glaucoma
_____Other

Anxiety_____
Depression_____
High Cholesterol_____
Anemia_____
Hepatitis_____
AIDS/HIV_____
Cancer-Type_____

Surgical History

Please list any surgeries you have had

_____
_____
_____
_____
_____

Social History

Do you smoke?_____Amount_____Per day/Week
Are you a former smoker?_____Date you quit_____
Do you drink alcohol?_____Amount_____Per day/Week

Shoe Size_____**Width**_____

Height_____

Weight_____

Release of Medical Records and Information

This office is HIPAA compliant. We make every effort to protect your privacy. We feel it is important that you understand your patient rights to confidentiality. If you have any concern, please feel free to discuss them with our office manager.

Medical Records Information Release

I understand by signing this document I am authorizing the release of my medical information to my insurance carrier(s) needed for this or any related medical insurance claim. I authorize any holder of medical information or other information about me to release to the social security administration and the health care financial administration, its intermediaries carries and information needed for this or any related claim.

_____**Initials**

Medical Records Release to Hospitals/Physicians

I, the undersigned, authorize the release of my medical information to other physicians needed to provide my care. I further authorize release to hospitals and/or healthcare facilities as pertaining to my care. I understand that my records may be faxed to hospitals and/or physicians and that all reasonable efforts will be made to maintain confidentiality.

_____**Initials**

Medical Records Release to Family

I authorize Dr. Tabora to release information pertaining to my illness and/or treatment to_____. I authorize Dr. Tabora to leave medical information on my answering machine. I also authorize information to given to my spouse.

_____**Initials**

Medical Records

One copy of your medical records will be provided upon request at no charge. A pre-paid charge is required for any additional copies. There will be a charge of $1.00 per page. Please allow 10 days for copying all medical records.

_____**Initials**

Patient Rights to Confidentiality

I understand that The Foot & Ankle Clinic office complies with HIPAA regulations. All medical records are confidential and cannot be disclosed without the written consent of the person to whom they pertain. I further understand that under Florida law I have the right to my medical records. I further understand that I may request that my records be released to a physician and/or medical facility: however, this request must be in writing. I understand that by law this office may only release medical records that were generated by The Foot & Ankle Clinic. We cannot release medical records from other physicians, hospital or facility. I agree to accept responsibility for a copying fee as provided by Florida statutes. I understand that employees have no responsibility or liability regarding any aspect of this authorization. Furthermore, I have the right to complain to the practice or the State of HHS if I feel that my privacy rights have been violated. It is the policy of this office that no retaliation of any type will be taken against any patient that files a complaint.

Patient Name_____**Signature**_____

Financial Policy

Payment of Benefits to the Physician/ Provider

I, the undersigned, understand that Dr. Tyson Tabora has agreed to accept Medicare and/or Health Insurance for payment of my medical bills. By my signature below, I acknowledge and understand that I am fully responsible for any yearly deductible and/or coinsurance balance after Medicare or my health insurance payment hice is paid to Dr. Tyson Tabora. I understand that I am financially responsible for any changes that are not covered by my insurance plan. If I fail to give updated or current information and the claim is denied, I will be totally responsible for the entire balance.

Signature_____**Date**_____

Method of Payment

Payment is Required at the time service is rendered. Please present your insurance card(s) to our office staff for photocopying and benefit eligibility verification. You will be responsible for any copay or coinsurance amount at the time of your visit.

In the event your check is returned for any reason, your account will be charged $25.00. In the event it is necessary for your account to be placed with an outside collection agency or attorney, you will be assessed an additional 30% of the balance to recover the collection charges. We file your medical insurance as a courtesy. If your claim is not paid within 90 days, the claim will be transferred to patient responsibility. If timely payment is not received, the amount may be referred to a collection agency or attorney.

For your convenience, we accept MasterCard, Visa, American Express and Discover, as well as cash and checks.

Thank you for taking the time to review our financial policy. Your cooperation is greatly appreciated. If you should have any questions, or require and assistance, we will be pleased to be of service.

I have read this financial policy and understand my right and responsibilities.

Signature_____**Date**_____