

DATE: _____

MECKLENBURG FOOT AND ANKLE & DIABETIC FOOT CLINIC

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ CITY _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____ EXT: _____

CELL PHONE: _____ SSN: _____

MARITAL STATUS: _____ NAME OF EMPLOYER: _____

HEIGHT: _____ WEIGHT: _____ SHOE SIZE: _____

AGE: _____ SEX: _____

TOBACCO USE Y/N: _____ IF YES HOW MANY? _____ HOW LONG? _____

IF QUIT WHEN AND HOW LONG? _____

MEDICAL PROBLEMS: _____ MEDICATION: _____

SURGERIES (DATE) & COMPLICATIONS: _____ ALLERGIES: _____

PHARMACY NAME: _____ PHARMACY NUMBER: _____

FAMILY HISTORY

MOTHERS AGE IF STILL LIVING: _____ IF DECEASED AT WHAT AGE: _____

MEDICAL PROBLEMS/AND OR CAUSE OF DEATH: _____

FATHERS AGE IF STILL LIVING: _____ IF DECEASED AT WHAT AGE: _____

MEDICAL PROBLEMS/ AND OR CAUSE OF DEATH: _____

SIGNATURE/HIPPA ACKNOWLEDGMENT: _____ DATE: _____

**Mecklenburg Foot & Ankle Associates
& Diabetic Foot Clinic.**

Financial Policy

1. All co-payments are due at the time of visit. Post-dated checks are not accepted. There will be a \$25.00 charge on all copays not paid within 10 days of your visit. Unpaid previous balances must be paid in full prior to any additional visit unless arrangements have been made with our financial department.
2. Co-insurance and unmet deductibles are due prior to scheduled surgeries and procedures. It is your responsibility to know what your copay, deductible and co-insurance is. We will verify your insurance benefits and we will notify you of any financial responsibility. **This is only a quote from your insurance that does not state your insurance will cover your charges.** You are ultimately responsible for payment of charges for services you receive from our office.
3. In accordance with you insurance member handbook, it is your responsibility to provide accurate insurance information and to present your insurance ID card at the time of your visit. If you do not have insurance or do not present a valid insurance card, you will be responsible for payment at the time of service. We will provide you with a copy of our billing form so that you can obtain reimbursement from your insurance company.
4. It is your responsibility to ensure that our physicians are in your insurance network. If your plan requires a referral, it is your responsibility to obtain this prior to being seen by our provider.
5. Cancellations for appointments and procedures must be received at least 24 hours prior to the scheduled appointment. Cancellations for scheduled surgery must be received at least 5 days prior to the scheduled surgery date and time. **Patients who fail to keep and fail to cancel a scheduled appointment may be charged a \$40.00 No Show Fee. There is a \$100.00 cancellation fee for scheduled surgeries that are cancelled less than 5 business days from the date and time of surgery unless cancellation is due to insurance denial or medical necessity.**
6. Medical records requests must be received in writing at least 72 hours prior to the date needed. Fees for medical records are set in accordance with allowable amounts as defined by the State of North Carolina. Fees must be received prior to record delivery. No more than 5 pages may be faxed.
7. **The returned check fee is \$30.00.**
8. **Administrative Services:** There is a \$25.00 charge for each required Administrative Service payable prior to service completion. This Administrative Service Fee covers specific administrative services such as forms completion for family medical leave and disability, letters for insurance authorizations for brand or non-formulary drugs, letters for employers, school, health clubs, and any other administrative item not covered by insurance.
9. Any account balance not paid in full within 60 days will be subject to a monthly finance charge of 1.5% per month (18% A.P.R) and a monthly cost of rebilling/account maintenance charge of \$5.00. These rates and charges are subject to change upon 30 days written notice. If any account balance should remain unpaid for 90 days the account is referred to a collection agency or attorney, the responsible party is responsible for paying the costs of collection and that such fees and costs may be added to the account balance.

<i>Patient Signature:</i>	<i>Date:</i>
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PATIENT PAIN DRAWING

Name: _____ Date: _____

Where is your pain now?

Mark the areas on your body where you feel the sensations described below, using the appropriate symbol. Mark the areas of radiation. Include all affected areas.

Aching
▲ ▲ ▲

Numbness
= = =

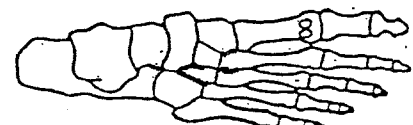
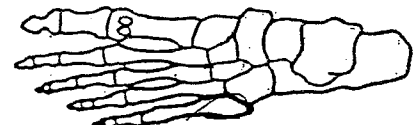
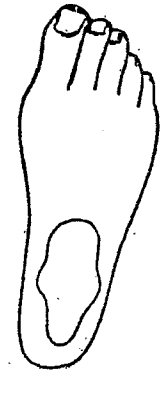
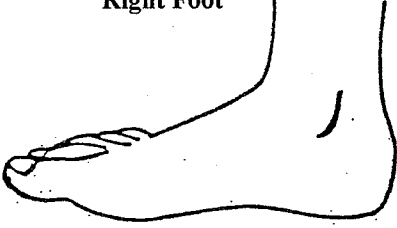
Pins & needles
○ ○ ○

Burning
X X X

Stabbing
/ / /

Left Foot

Right Foot



Comments: _____

Number or Word Pain Scale:

0 1 2 3 4 5 6 7 8 9 10
 NONE MILD MODERATE SEVERE

Faces Pain Rating Scale:

No pain Hurts More Hurts Worst

