Charlotte Foot & Ankle Specialists
2550 W Arrowood Road, Suite 102
Charlotte, NC 28273
704-504-4000 (o) / 704-504-3348 (f)

Patient Name: _____
(first) (middle) (last)

Address: _____ Apt #: _____ City: _____ State: ___ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ Age: _____ Sex: M F Social Security #: _____

Marital Status: S M D W Email: _____

Employer: _____ Job Title: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Medical power of Attorney? Y N Name of POA: _____ Phone: _____

Do we have your permission to leave a voice message (ie: appointment reminders) at the contact number? Y N

Do we have your permission to leave a voice message for normal test results at the contact number? Y N

Primary Care Physician: _____ Phone: _____

Address: _____ Date last seen: _____

Pharmacy Name: _____ Phone : _____

Address: _____

What is the reason for your visit today: _____

Where is your pain: _____ How long has it bothered you? _____

Treatments tried: _____ Did the treatments help? _____

Medications:

Medication	Dosage	Frequency	Medication	Dosage	Frequency

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Allergies:

Latex/Tape	Lidocaine	Penicillin
Shellfish/ Iodine	Sulfa	Other: _____

Medical Conditions: *Circle all that apply.*

Skin cancer	High cholesterol	Kidney/bladder disease	Gout
Cancer _____	High blood pressure	Hepatitis A B C	Opioid abuse
Type I diabetes	Anemia	Osteoporosis	Alcohol abuse
Type II diabetes	Sickle cell anemia	Emphysema/asthma	HIV/AIDS
Fibromyalgia	Clotting disorders	Rheumatoid arthritis	Other: _____
Stroke/seizures	Circulation trouble	Osteoarthritis	_____

Surgical History:

_____

_____

_____

Other Health Information:

Height: _____ Weight: _____ Shoe size: _____ Pregnant: Y N

Flu vaccine (this winter season): Y N Date flu vaccine: _____ Pneumonia vaccine (done every 5 years): Y N

Covid Vaccine (dates): _____

Do you smoke: Y N What do you smoke: cigarettes cigar marijuana

How long have you been smoking? _____ How many packs/day? _____

Do you drink? Y N How many drinks/day? _____

AUTHORIZATION FOR TREATMENT: I hereby authorize such examination, x-rays, treatments, medications, physical therapy and minor surgical procedures as may be prescribed by Charlotte Foot & Ankle Specialists.

_____ _____

Patient or responsible party's signature Date

Charlotte Foot & Ankle Specialists, PLLC
2550 W Arrowood Road, Suite #102
Charlotte, NC 28273

Please initial on each line before each paragraph acknowledging you understand our policies. Even if, it does not apply to your situation at this time.

_____For patients with insurance, **Co-payments, co-insurance, unmet deductibles and non-covered services or supplies are due at the time of service.** If your insurance fails to respond to the claim within **60 days,** Charlotte Foot & Ankle Specialists (CFAS) reserves the right to collect full payment from the patient.

_____If you have Medicare and have changed to an HMO Insurance policy (Medicare replacement plan) you must provide this information to the front desk. **Co-payments, co-insurance, unmet deductibles and non-covered services or supplies are due at the times of service.** If we do not participate with your HMO plan, you may be responsible for payment in full if there is not an out of network benefit. If you fail to disclose correct insurance information to us, you will be responsible for payment.

_____For patients without insurance or on a plan we do not participate with: CFAS financial policy require payment in full at time of service. **If you do not have your insurance card with you and we are unable to verify benefits, you will be responsible for paying at the time of service.**

_____If you are unable to pay your balance in full when due, you need to contact us immediately. Failure to make payment on your account as required every 30 days, will require further action to collect the balance in full and your credit rating will be affected. If regular monthly payments are not received and no payment arrangements have been made, we will no longer be able to extend credit to you for future visits. **An additional collection fee of 30% will be added to the outstanding balance at the time of transfer to a collection agency.**

_____ Please be aware that you will incur a $25 fee if you fail to show up for your scheduled visit or if you cancel or reschedule your visit less than 24 hours prior to the scheduled time.

_____Please be aware that we charge $15 for the completion of any patient forms (ie: FMLA, disability)

Medicare/Medicaid Patient's Certification: I certify the information given by me in applying for payment under Title XVIII and XIX of the Social Security Act is correct. I request payment be made directly to CFAS. I authorize CFAS to release any medical information including complete medical records, test results and billing information to my insurance company, and to other medical professionals and medical care institutions that I may be referred to for treatment. I understand that this information will be used to review, investigate or make payment of a claim and to review records for quality improvement initiatives, audit compliance, utilization management and complaint resolutions.

Assignment of Benefits: I hereby authorize payment directly to CFAS for all medical or surgical benefits otherwise payable to me under terms of my insurance.

_____ _____

Patient or Responsible Party's Signature **Date**

Thank you for complying with these policies so that we can keep your costs as low as possible!

We recognize how difficult it is to understand many of the points in today's insurance policies, with new plans and companies emerging constantly. Our office staff will make every attempt to follow the guidelines required by your insurance company. However, please understand the **contract is made between the insurance company and the patient.** Therefore, it is the **patient's responsibility** to know and understand the details of his/her specific coverage.

Thank you for choosing us as your foot care provider.
Discover, MasterCard, Visa and Debit Cards accepted