Print Form

SPACE COAST
FOOT & ANKLE CENTER
Specializing in Medicine & Surgery of the Foot & Ankle

New Patient Forms

Today's Date _____

Patient Details

Patient Name _____

☐ Male ☐ Female Social Security # _____

Date of Birth _____ Age _____

Address _____

City/State _____ Zip _____

Phone 1 _____ ☐ home ☐ cell ☐ work

Phone 2 _____ ☐ home ☐ cell ☐ work

Email _____

Occupation _____

How did you hear about us? _____

Responsible Party/Billing Contact *(if different from above)*

Name _____

Date of Birth _____ Social Security # _____

Address _____

City/State _____ Zip _____

Phone _____ ☐ home ☐ cell ☐ work

Please describe the reason for today's visit:

How long has it been bothering you? _____

Have you been treated for this problem? ☐ Yes ☐ No
If yes, please describe treatment:

If yes, please list type and dates:

PLEASE COMPLETE ALL SECTIONS

In Case of Emergency, Please Contact:

Name _____

Relationship _____

Phone _____

Primary Care Physician:

Name _____

Phone _____

Date of Last Visit _____

Preferred Pharmacy & Location:

_____

_____

Medical Insurance

Primary Policy

Company _____

Policy/ID # _____

Group # _____

Secondary Policy

Company _____

Policy/ID # _____

Group # _____

(Optional) ☐ I prefer not to share this info

Primary Language: _____

CHECK ALL THAT APPLY:
☐ Hispanic ☐ Non-Hispanic
☐ White
☐ Black or African American
☐ Asian
☐ American Indian or Alaska Native
☐ Native Hawaiian or Other Pacific Islander

PLEASE COMPLETE ALL SECTIONS.
If you have any of the following information already printed, we will be happy to make a copy.

Patient Name:_____ **Date**_____

Current Height_____ **Current Weight**_____ **Current Shoe Size**_____

Allergies

Have you experienced any allergic reactions or adverse effects from the following?

☐ **NO KNOWN DRUG ALLERGIES**

☐ Aspirin ☐ Penicillin
☐ Codeine ☐ Cortisone
☐ Iodine/Betadine ☐ Novocain/Lidocaine
☐ Sulfa Drugs ☐ Latex ☐ Tape

Other:

Medical & Family History

Please check if either ***you or a family member*** has experienced any of the following conditions:

Mother	Father	Patient	
☐	☐	☐	Anemia
☐	☐	☐	Arthritis
☐	☐	☐	Asthma
☐	☐	☐	Bleeding Disorder
☐	☐	☐	Breathing Problems
☐	☐	☐	Cancer- type:
☐	☐	☐	Cancer- type:
☐	☐	☐	Congestive Heart Failure
☐	☐	☐	Diabetes - Insulin Dependent
☐	☐	☐	Diabetes - Non-Insulin Dependent
☐	☐	☐	Gout
☐	☐	☐	Heart Disease
		☐	Hepatitis
☐	☐	☐	High Cholesterol
☐	☐	☐	High Blood Pressure
		☐	HIV
		☐	Joint Replacement: Hip (☐ Right ☐ Left) Knee (☐ Right ☐ Left)
☐	☐	☐	Kidney Disease
☐	☐	☐	Liver Disease
☐	☐	☐	Mitral Valve Prolapse
☐	☐	☐	Neuropathy
☐	☐	☐	Phlebitis (blood clots)
☐	☐	☐	Stomach Problems
☐	☐	☐	Thyroid Disorder
☐	☐	☐	Other:
☐	☐	☐	Other:
☐	☐	☐	Other:

Social History

Do you smoke? ☐ No
☐ Yes, every day ☐ Yes, occasionally
If Yes, how many years?_____
☐ I **previously smoked** for _____years
When did you quit?_____

Do you drink alcohol? ☐ No
☐ Occasional/social ☐ Mild ☐ Moderate ☐ Heavy

Medications

List all prescription medications as well as over the counter medications, vitamins & dietary supplements:

_____ (INITIAL) If available, I authorize McKinney Foot Care to obtain my current medication list from my pharmacy.

Surgical History

Please list any major surgeries:

FINANCIAL POLICY

As insurance coverage decreases and the patient's financial responsibility increases, we understand the need for clear communication of our financial policies. To better service the needs of our patients, we have added valuable tools to help you meet your increased medical expenses.

1. We will continue to look to insurance companies for their payment, and assist you in receiving proper reimbursement for our services. Unfortunately, most insurance no longer covers services fully and most current insurance plans chosen by our patients require significant out-of-pocket expenses to be paid by the patient.
2. Our staff has been trained to be able to communicate with you and answer your questions regarding payment and insurance reimbursement.
3. It is your responsibility to verify that all requirements of your insurance plan are met. We will assist you with pre-certification for procedures ordered by our office, but it is ultimately your responsibility to verify whether any care you receive is covered by your insurance plan. This office is not responsible for the expense of treatment, which is not paid by your insurance. With continuous changes in coverage, it is important for you to verify your benefits and be aware of all restrictions and expenses of your plan.
4. In accordance with the requirements of most insurance contracts, we will require payment of office co-payments at the time of service. Any person being seen for treatment or service will be required to pay the necessary co-payment at the time of service. Your insurance company will be notified when this contractual payment is not paid at the time of the appointment.
5. For patients owed balances, we will offer credit card, debit cards, and payment plans to assist you in meeting your financial obligations to our office. You must advise us of any payment you receive from insurance or any third party for our services and forward this amount to our office immediately.
6. If we are a contracted provider on your insurance plan, we will file a claim with your carrier and you will be billed when they have responded to our claim. Upon receipt of their response, payment or denial, you will receive a statement for the amount your insurance company notifies us is your responsibility.
7. If the office is not a contracted provider for your insurance plan, we will file a claim with the information you provide and you will be billed when they have responded to our claim. You will receive monthly statements and we will look to you for payment. You will be responsible for working with your insurance company to insure prompt payment.
8. If you do not have a current insurance card with you, you will be billed for the entire amount and asked for payment at the time of service. It is your responsibility to give us your card at each visit (if requested). We will not be able to file your insurance without a copy of your insurance card.

If you have an insurance plan that requires a referral, we will require that the referral be received in our office before we can see you. We will do our best to assist you in obtaining the referral, but to expedite matters it is best for you to contact your primary care physician and have them fax the referral to us or bring the referral in with you.

CONSENT FOR TREATMENT

I grant permission for Dr. John(Jack) MacKenney and his assistants to render care in the diagnosis and or treatment of my foot condition(s) and release related information to my physician and or emergency medical personnel and as required by law.

I acknowledge that I have read and understand the Financial Policy. I understand that Dr. John(Jack) MacKenney is not ultimately responsible for collecting from my insurance or negotiating settlement of claims.

I understand the financial policies and accept responsibility for payment of any balance owed on my account. I understand that I am financially responsible for all charges whether or not paid by insurance.

Responsible Party: _____ **Date** _____

Print Name: _____

Patient Name (*if different from Responsible Party*): _____

If you would like a copy of the policies to take with you, please let a staff member know.

NOTICE OF PRIVACY PRACTICES

I hereby give my consent for John D. MacKenney D.P.M. PA to use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment and healthcare Operations (TPO).

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. John (Jack) MacKenney reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to John D MacKenney D.P.M. PA, 6550 North Wickham Road Ste. 4, Melbourne, FL 32940

With this consent, John D. MacKenney D.P.M PA may call my home or other alternative location and **leave a message on voice mail or in person** in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others. However, our policy is not to leave detailed messages regarding Protected Health Information or anything related to treatment, payment or healthcare operations.

With this consent, John D. MacKenney D.P.M PA may **mail to my home or other alternative location** any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, John D MacKenney D.P.M. PA may **e-mail to my home or other alternative location** any items that assist the practice in carrying out TOP, such as appointment reminder cards and patient statements.

I have the right to request that John D. MacKenney D.P.M PA restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, John D. MacKenney D.P.M PA may decline to provide treatment.

I acknowledge that I was provided a copy of the Notice of Privacy Practices. I have read and understand the notice. By signing this form, I am consenting to John D. MacKenney D.P.M. PA **disclosure of my Personal Health Information (PHI) to carry out Treatment, Payment and healthcare Operations (TPO).**

Responsible Party: _____ **Date** _____

Print Name: _____

Patient Name (*if different from Responsible Party*): _____

ASSIGNMENT OF BENEFITS

I certify that I or my dependents have insurance coverage with the above named carrier and hereby authorize the release of all medical information necessary to process insurance claim(s). I hereby assign and authorize direct payment of all medical and/or surgical benefits, including major medical, private insurance and other health plans to John D. MacKenney D.P.M. PA

The above named practice, its agents, and assigns may use my health care information and may disclose such information to above named insurance company (companies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

This Assignment will remain in effect until revoked by me in writing.
A signed photocopy of this Assignment will be considered as valid as an original.

Responsible Party: _____ **Date** _____

Print Name: _____

Patient Name (*if different from Responsible Party*): _____

If you would like a copy of the policies to take with you, please let a staff member know.