ABC FEET
Podiatry Services
Dr. Diandra Gordon, DPM

OUR CANCELLATION / NO-SHOW POLICY

DUE TO THE INCREASING NUMBER OF NO-SHOW AND SAME DAY CANCELLATIONS OF APPOINTMENTS, WE ARE INSTITTUING A NEW POLICY, EFFECTIVE IMMEDIATELY.

THE POLICY IS AS FOLLOWS:

1. Cancelled appointments within 24 hours of appointment time - **$25.00 fee**
2. No show for appointment time - **$50.00 fee**
3. Surgery cancellation within five days of schedule surgery time – **$750.00 fee**
4. Any forms or letters will charge accordingly.

OUR STAFF APPRECIATES YOUR UNDERSTANDING

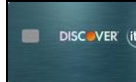
THANK YOU,

I have read and agree to the above policy.

Patient's Signature Patient Print Date

Your payment information

We Accept



Card Details

Card Number | Expiration Date / | CCV

PATIENT INFORMATION

First: ______________________ M.I.______ Last: ______________________

Preferred Name: ____________________ Sex: ☐ M ☐ F DOB: _______________

Mobile Phone: ______________________ E-mail: ________________________

Home Phone: _______________________ Work Phone: _____________________

Preferred method of communication: _____________________________________

Address: _______________________________________ Apt # _____________

City: _______________________ State: ____________ Zip Code: __________

Emergency Contact: ______________________ Relationship: _________________

Phone # _________________________ Alternative# _______________________

Patient relationship to Guarantor: ☐ Self ☐ Spouse ☐ Child ☐ Other

Guarantor Name: ____

Guarantor Address: ____

Guarantor City: _____________________ State: ________ Zip Code: __________

Guarantor DOB: ___________ ☐ M ☐ F Social Security #: _________________

Guarantor Phone: ____________________ Secondary Phone: __________________

Patient's Ethnicity: ______________ Language: __________ Patient's Race: ________

Primary Doctor: ______________________ Last Visit: Month __________ Year_____

How did you hear about us? ☐ Google ☐ Yelp ☐ Website ☐ Insurance

☐ Referred by: ________________________________

Pharmacy: ________________________ Phone Number: ____________________

Prescription History

In order to have the most current prescription information, we need to request the information electronically. Do we have permission to do so? ☐ Yes ☐ No

Signature: ________________________________ Date: _________________

Primary Doctor: ____________________________ Phone No: __________________ Date of last exam: __________

Describe the condition that brought you to this office: ____

If auto accident, date of accident _____________ Previous care for this condition? ☐ Yes ☐ No

Dr. ____ Date: _____________________

HEIGHT: ____________ WEIGHT: ____________ HAVE YOU RECEIVED THE FLU SHOT THIS YEAR? ☐ YES ☐ NO

<u>MEDICAL</u>: (Please check any of the following if it pertains to you)

___ Diabetes
___ Angina/Chest Pain
___ Kidney Disorder
___ Human Immunodeficiency Virus (HIV)
___ Heart Attack
___ Phlebitis
___ Bleeding Disorders
___ Seizures
___ Circulation Disorder
___ Stroke/TIA's
___ Bipolar
___ Scar Former
___ Angioplasty
___ Ulcers
___ ADHD
___ Hypertension
___ Hepatitis
___ Asthma
___ Depression
___ Hypercholesterol
___ Hyperthyrodism
___ Hypothyrodism

<u>ALLERGIES</u>:

___ None ___ Penicillin ___ Aspirin ___ Codeine ___ Novocain ___ Iodine ___ Latex

Other: ____

<u>MEDICATIONS</u>: (Please include Aspirin, Tylenol, Vitamins and Birth Control Pills) ___ See attached list

1 ___________________ 2 ___________________ 3 ___________________ 4 ___________________

5 ___________________ 6 ___________________ 7___________________ 8 ___________________

PREVIOUS SURGERIES AND HOSPITALIZATIONS:

1 ___________________ 2 ___________________ 3 ___________________ 4 ___________________

Please check all the apply

FAMILY HISTORY

☐**MATERNAL** ☐Diabetes ☐High Blood Pressure ☐Bleeding Tendencies ☐Other ___________

☐**PATERNAL** ☐Diabetes ☐High Blood Pressure ☐Bleeding Tendencies ☐Other ___________

<u>SOCIAL HISTORY</u>:

Alcohol Intake	☐None	☐Occasional	☐Moderate	☐Heavy
Caffeine Intake	☐None	☐Occasional	☐Moderate	☐Heavy
Illicit Drugs	☐None	☐Occasional	☐Moderate	☐Heavy
Exercise Level	☐None	☐Occasional	☐Moderate	☐Heavy
Smoking Status	☐Never	☐Former	☐Current	
General Stress Level	☐Low	☐Medium	☐High	

<u>PODIATRIC HISTORY</u>:

___ Flat Feet
___ Heel or arch pain (Child or Adult)
___ Pain in feet getting out of bed
___ Crooked toes (hammertoes)
___ Ankle instability (easy twisting injuries)
___ Growing pains
___ Poor coordination with sports
___ Abnormal foot posture (clubfoot, metadductus)
___ Pain or fatigue in feet & legs with activity
___ Numbness and tingling in feet and toes
___ Bunions (prominent foot bones)
___ Ankle swelling & stiffness
___ Leg pain (shin splints)
___ Difficulty walking/running
___ In-toe or out-toe gait
___ Achilles' tendon pain

Other problems with your feet/legs: ____

ABC Feet
Dr. Diandra Gordon
1126 University Blvd North, Jacksonville, FL 32211
Office (904) 765-5554 / Fax (904) 765-9302

ASSIGNMENT OF BENEFITS

ASSIGNMENT OF BENEFITS: I ____,
Do hereby IRREVOCABLY ASSIGN to the above-named medical provider, any right or benefits under my policy of insurance with _______________________________________, for any service and/or charges provided by the above medical provider. Pursuant to this ASSIGNMENT OF BENEFITS, you are hereby directed to mail any and all checks directly and solely payable to the above named medical provider at the address listed on the HCFA-1500A form in box 33. As part of this ASSIGMENT OF BENEFITS, I hereby instruct the insurance carrier that in the event the medical benefits are disputed for any reason, including medical reasonableness and/or necessity, that the amount of benefits claimed by **ABC Feet** is to be set aside and not disbursed until the dispute is resolved.

IN WITNESS WHEREOFF the undersigned has hereunto set his/her hand, this ___ day of ___________, 20___.

______________________________	______________________________
Patient's Signature	Patient's Name (please print)

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ACKNOWLEDGEMENT OF RECEIPTS OF PRIVACY NOTICE AND CONSENT TO USE HEALTH INFORMATION

(Read before singing the Acknowledgment and Consent)

This Acknowledgement of notice and consent authorizes **ABC Feet** to use health information about you for treatment, payment, and health care operations purposes.

NOTICE OF PRIVACY PRACTICES: ABC Feet has a Notice of Privacy Practices which describes how we may use your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgement and consent.

AMENDMENTS: We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

How to contact our Privacy Officer

Mail: 1126 University Blvd North, Jacksonville, FL 32211
Tel: (904) 765-5554 / Fax (904) 765-9302

Acknowledgment and Consent

I have received the Notice of Privacy Practices for **ABC Feet** is authorized to use health information about (please print patient's name)
___________________________________ for treatment, payment, and healthcare operations purposes consistent with its Notice of Privacy Practices.

______________________________	______________________	______________________
Signature of Patient	Date	Account #

Personal representative information (if applicable):

____	______________________________
Name of Personal Representative	Relationship to Patient

IDENTITY OF RECEPIENTS: Provide the name or other specific identification of the person(s) or class of persons to whom the covered entity may disclose the covered information:

Permission to Leave Message: ☐YES ☐NO

___ Daytime phone / Ph# ___________________________
___ On my home answering machine / Ph# _________________________
___ On my voicemail / Ph# __________________________
___ With my designated and authorized person(s) named below:

____

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PODIATRY SERVICES
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MEDIA RELEASE FORM

I, ___________________________________, grant permission to South Florida Lower Extremity Center to use my image (photographs and/or video) for use in media publications including:

☐ Facebook ☐Instagram ☐ Brochures ☐ Email Blasts (Mailchimp)

☐ Other: ____________________________

I hereby waive any rights to inspect or approve the finished photographs or electronic matter that may be used in conjunction with them now or in the future, weather that use is known to me or unknown.

Please **initial** the paragraph below which is applicable to your present situation:

______ I am 21 years of age or older and I am competent to contract in my own name. I have read this release before signing below, and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

______ I am the parent or legal guardian of the below named child. I have read this release before signing below, and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

Patient Name: ______________________________ Date: ________________________

Name: (Please print): ____

Address: ____

Signature of parent or legal guardian: ____
(if under 21 years old of age)