Dr. Zachery P. Barnett, DPM

Date: _____ / _____ / _____

PATIENT INFORMATION

First Name: ___________________________________ MI: _______ Last Name: ________________________________

Sex: M / F Cell Phone: (_______) _______ - ___________ Home Phone: (_______) _______ - ___________

Email Address: _________________________________ Date of Birth: ____ / ____ / ____ SSN: _____ - ____ - _______

Address: _____________________________________ City: ___________________ State: ____ Zip Code: _________

Referred By: Google / Urgent Care / Primary Care Physician / Friend / Family / Other: ________________________

Primary Care Physician: ____ Date Last Seen: _____ / _____ / _____

Pharmacy Name: ____ Pharmacy Phone: (______) ______ - _________

Pharmacy Address: _______________________________ City: __________________ State: ____ Zip Code: __________

Employer Name: ____ Employer Phone: (_____) ______ - _________

EMERGENCY CONTACT INFORMATION

First Name: _____________________________________ Last Name: ____

Cell Phone: (_______) _______ - ___________ Relationship to Patient: _____________________________________

PRIMARY INSURANCE POLICY HOLDER INFORMATION

Insurance Name: ________________________________ Member Number: ___________________________________

Policy Holder's First Name: _________________________ Policy Holder's Last Name: _________________________

Relationship To Patient: Self / Spouse / Child / Other: __________ If Spouse, Spouse's Date of Birth: ____ / ____ / ____

SECONDARY INSURANCE POLICY HOLDER INFORMATION

Insurance Name: ________________________________ Member Number: ___________________________________

Policy Holder's First Name: _________________________ Policy Holder's Last Name: _________________________

Relationship To Patient: Self / Spouse / Child / Other: __________ If Spouse, Spouse's Date of Birth: ____ / ____ / ____

ALLERGIES

Do you have any allergies? Yes ⬜ No ⬜ *If yes, circle all that apply:* Penicillin / Sulfa Drugs / Iodine / Latex / Ibuprofen / Aspirin / Codeine / Cortisone / Lidocaine / Local Anesthesia / General Anesthesia / Other: _________

CURRENT MEDICATIONS

Do you take medication? Yes ⬜ No ⬜ *If yes, list medications below or you may provide a medication list.*

1. ______________________________ 4.________________________________ 7. ______________________________
2. ______________________________ 5.________________________________ 8. ______________________________
3. ______________________________ 6.________________________________ 9. ______________________________

FAMILY MEDICAL HISTORY

Father Living? Yes ⬜ No ⬜ Past Medical History: ____

Mother Living? Yes ⬜ No ⬜ Past Medical History: ____

# of Brothers: _____ Past Medical History: ____

# of Sisters: _____ Past Medical History: ____

PATIENT MEDICAL HISTORY

Please indicate any of the following conditions that you have or had:

☐ Anemia	☐ Charcot Foot	☐ High Blood Pressure	☐ Osteoporosis
☐ Arthritis	☐ Circulatory Disorders	☐ Kidney Disease	☐ Pacemaker
☐ Atrial Fibrillation	☐ Congestive Heart Failure	☐ Liver Disease	☐ PAD
☐ Autoimmune Disease	☐ COPD	☐ Lupus	☐ Rheumatoid Arthritis
☐ Bleeding Disorders	☐ CRPS / RSD	☐ Lymphedema	☐ Stroke
☐ Blood Clots	☐ Gout	☐ Neuropathy	☐ Other: ______________
☐ Cancer _____________	☐ Heart Disease	☐ Osteoarthritis	________________________

ARE YOU DIABETIC? Please check one: Yes ☐ No ☐ If yes, last glucose reading: ________________

If yes, what doctor handles your diabetes? ___________________ Phone: (______) ______ - _______

SOCIAL HISTORY

Circle all that apply: Single / Married / Partnered / Widowed / Separated / Divorced

Do you have children? Yes ☐ No ☐ *If yes,* # of Healthy Children: ______ # of Deceased Children: ______

Living Arrangements: Alone / Spouse / Family / Nursing Home / Assisted Living / Other: ____________________

Substance Use:

Alcohol? Yes ☐ No ☐ If yes, how often? _____________________

Smoker? Yes ☐ No ☐ If yes, how many packs per day? ________________ or Smokeless Tobacco ______________

Quit Smoking? Yes ☐ No ☐ If yes, how many years did you smoke? __________ When did you quit? ___________

Other drug use: ____

Exercise:

Do you exercise regularly? Yes ☐ No ☐

If yes, circle all that apply: Walk / Run / Swim / Bike / Weight Lifting / Aerobic Activity / Other: ___________

SURGICAL HISTORY:

Have you had surgery before? Yes ☐ No ☐ *If yes, please describe below:*

Procedure: ____ Date: _____ / _____ / _____

Procedure: ____ Date: _____ / _____ / _____

Procedure: ____ Date: _____ / _____ / _____

VITAL SIGNS

Height: ______ ft ______ in Weight: __________ lbs Shoe Size: _________________

CHIEF COMPLAINT

Frequency:	**Location:**	**Type of Pain:**
Intermittent / Constant	Left / Right Foot / Ankle / Toe	Sharp / Dull / Achy

Describe your current foot and/or ankle problem(s): ____

____

____

____

AUTHORIZATION OF TREATMENT

I acknowledge that Align Foot and Ankle will provide a copy of Notice of Privacy Practices upon request. I also hereby give Align Foot & Ankle permission to diagnose and administer treatment for my foot and/or ankle condition and authorize any release of information obtained during the course of my treatment.

ASSIGNMENT OF BENEFITS

I hereby authorize my insurance company to pay directly to Dr. Zachery Barnett, of Align Foot & Ankle, the benefits and amount due and otherwise payable to me for their services, as described on the customary charges for those services. I acknowledge and understand that I am responsible for all the charges for all services rendered to me or any member of my immediate family. Although I have requested the doctor to bill my insurance company, I clearly understand that it is still my responsibility to make sure the bill is paid in a reasonable time. If for any reason any portion of my bill is not paid by my insurance, I further agree to make arrangements for prompt payment of the bill.

MEDICARE

I hereby authorize my insurance company to pay directly to Dr. Zachery Barnett, of Align Foot & Ankle, the benefits and amounts due and otherwise payable to me for their services as described, but not to exceed the reasonable customary arches for those services. I understand that I am financially responsible for all remaining charged incurred, whether or not covered by said insurance.

AUTHORIZATION TO RELEASE INFORMATION

I, ________________________, hereby authorize Dr. Zachery Barnett, of Align Foot & Ankle, to release any information regarding medical treatment for the purpose of validating and determining benefits payable in connection with any claims.

Signature of Patient / Responsible Party: ____ Date: _____ / _____ / _____

Printed Name of Patient / Responsible Party: ____

FINANCIAL RESPONSIBILITY

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor. We want a clear and transparent cost of care for our patients.

- As our patient, you are responsible for all authorizations / referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We accept VISA, MasterCard, Discover, cash or check.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctors. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay within 60 days, you will receive a bill.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be “not covered,” or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to getting services rendered.
- You must inform the office of all insurance changes and authorization/ referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery or at the time of your pre-op appointment.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due to the office.
- Patients who are 90 days past due on their balance will be sent to collections unless a payment plan has been initiated.
- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.
- In fairness to all our patients, we understand that emergencies occur, but repeated no shows or cancellations with less than 24 hours’ notice will result in a fee of $25.00. You might be asked to pay before you are seen by the doctor.
- Patients who arrive fifteen minutes later than scheduled appointment might be asked to reschedule.

Signature of Patient / Responsible Party: ____ Date: _____ / _____ / _____

Printed Name of Patient / Responsible Party: ____

HIPAA COMPLIANCE PATIENT CONSENT FORM

The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. The terms of this notice may change. If so, you will be notified at your next visit to update your signature and date.

By signing this form, you consent to our use and disclosure of your protected healthcare information according to the indications below.

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- This privacy policy may be changed by the practice, when necessary, as required or allowed by law.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- This privacy policy will stay in effect until the time that it is revoked by the patient or changed as required by law.

HEALTH NOTIFICATIONS

Please indicate how you would like to be notified of the following:

Auto Appointment Reminders: ☐ E-mail ☐ Phone ☐ Text message

Practice Announcements: ☐ E-mail ☐ Phone ☐ Text message

Billing information: ☐ E-mail ☐ Phone ☐ Text message

May we discuss your medical condition with a family member? Yes ☐ No ☐

If YES, please list those family members' names and their relationship to the patient: ______________________________

____

I consent to have my medical records shared with other Align Foot & Ankle Providers.

Yes ☐ No ☐ Only upon my request ☐

I consent to have my medical records shared with my healthcare providers outside the Align Foot & Ankle network.

Yes ☐ No ☐ Only upon my request ☐

Signature of Patient / Responsible Party: ____ Date: _____ / _____ / _____

Printed Name of Patient / Responsible Party: ____

MEDICAL RECORDS REQUEST

I hereby grant my permission for Align Foot and Ankle to release medical information relating to my care from and to the following parties:

Patient Name_________________________________ Date of Birth: ____ / ____ / ____ Cell Phone: (____) ____ - _____

Address: _______________________________________ City: ____________________ State: ____ Zip Code: _________

Name of office / doctor to receive medical records:

____

Address: _______________________________________ City: ____________________ State: ____ Zip Code: _________

Office Phone Number: (_______) _______ - ___________ Office Fax Number: (_______) _______ - ___________

I specify that this release should include:

☐ 1. Entire Chart: This information might include HIV testing and/or AIDS treatment, substance abuse treatment, and/or rehabilitation and psychiatric testing and/or treatment. *OR*

☐ 2. Specific Information: Please specify exactly what you would like to be released (for example: labs, x-rays, etc.):

____

____

I understand that this authorization may be withdrawn at any time in writing. This authorization will remain in effect for 90 days after I sign and date the form. Recipients of my information are forbidden from re-disclosure without my specific authorization. A facsimile may be utilized with the same effectiveness as the original.

Signature of Patient / Responsible Party: ____ Date: _____ / _____ / _____