

815 Wesley Pines Road
Lumberton, NC 28358
(910) 737-6600

The Foot & Ankle Institute
Dr. Patrick J. Ricotta

103 McAlpine Lane
Laurinburg, NC 28352
(910) 266-9900

Patient Information Sheet

Name: _____ Date: _____

Address: _____ City/State/Zip Code: _____

Home Phone Number: _____ Cell # _____ Male/Female: _____

Birthdate: _____ Marital Status: _____ Social Security Number: _____

Responsible Guarantor's Name: _____
(Required if patient is a minor)

Responsible Guarantor's Social Security Number: _____

Emergency Contact Name & Phone Number: _____

Employer's Name: _____ Phone Number: _____

Address: _____ City/State/Zip Code: _____

Primary Insurance Name: _____

Secondary Insurance Name: _____

Who may we thank for referring you to our office? _____

Address: _____ City/State/Zip Code: _____

What condition brings you to our office today: _____



(More pages to complete)

Patient Name: _____

Page 3 of 6

Are you allergic to any medications? Please list _____

Are you allergic to latex? Yes or No Are you allergic to any foods? _____

Please list any surgeries you have had and the year?

Surgery	Year
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list other reasons you were hospitalized and the year:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you use tobacco? Yes or No How often? _____ how many year? _____

Do you use Alcohol? Yes or No How often? _____ how many years? _____

What is your height ? _____ ft. _____ inches

What is your weight? _____ lbs. What is your shoe size? _____

**THE FOOT & ANKLE INSTITUTE
RELEASE OF INFORMATION
AND PAYMENT FOR SERVICES AGREEMENT**

Consent for treatment by The Foot & Ankle Institute

I consent to examination and/or treatment by The Foot & Ankle Institute. Minor patients must be accompanied by parents or have notarized letter from parent authorizing "The Foot & Ankle Institute" to the examination and/or treatment. Custodial guardians of minor patients must have legal documentation before examination or treatment can be initiated.

Authorization to Release Patient Information to The Foot & Ankle Institute

I authorize any holder of medical and/or non-medical information about me to Release to The Foot & Ankle Institute any information needed.

Authorize for Payment from Insurance

I request that authorized benefits be made payable to the Foot & Ankle Institute for services furnished to me.

Request for Medical Records/X-Rays, Medical, Disability Insurance Forms

I understand there will be a charge for all medical records and X-rays. The fee is \$10.00 for medical records and \$10 per film for X-rays which must be paid by myself and will not be billed to insurance carrier or attorney. Our fee schedule also includes a charge of \$10.00 per page for Medical/Disability and some insurance forms. **Please allow 5-7 business days for completion.**

Return Check Charge

There will be a \$25.00 fee for all returned checks. If you have any returned checks with our practice cash, debit or credit cards will be accepted thereafter from you before treatment can be rendered.

Cancellations/No-shows

A 24 hr cancellation notice is appreciated if you are unable to keep any of your appointments. After you miss or no show for three (3) appointments you may be discharged from our practice.

Effective September 1, 2009 you may be charged a \$20.00 no show fee if you do not cancel any scheduled appointments within 24 hrs. prior to the scheduled appointment date/time.

Payment for Services by Patient

I understand that although I have insurance, I will be responsible for any deductible, co-payments, denied services or cost share that my insurance will not cover. I understand that this amount must be paid at time of service. We do not accept personal checks for amounts over \$100.00.

We accept cash, Mastercard, Visa and debit cards. Please be advised, any unpaid balance over a period of time will be sent to a collection agency and may be reported to credit bureaus which can affect your credit report. Payment for all services provided are due when services are rendered. No Exceptions.

If there should be any remaining balance(s) on your account due to any of the above reasons this will need to be resolved/paid before your next scheduled visit.

X _____
Patient Signature

Date

Witness of Signature

Date

Compound Authorization for Release of Information

Name of Patient: _____ Date of Birth: _____

The Foot & Ankle Institute is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information. Check each person/entity that you approve to receive information.	Description of information to be released. Check each that can be given to person/entity on the left in the same section.
<input type="checkbox"/> Voice mail (Answering machine)	<input type="checkbox"/> Results of lab tests/xrays <input type="checkbox"/> Appointment reminders
<input type="checkbox"/> Give information to employer <input type="checkbox"/> Give information to school	<input type="checkbox"/> Appointment absentee information
<input type="checkbox"/> Spouse	<input type="checkbox"/> Family billing information <input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows: _____
<input type="checkbox"/> Parent (provide name)	<input type="checkbox"/> Family Billing information <input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows: _____
<input type="checkbox"/> Other (provide name)	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows: _____
<input type="checkbox"/> Support Group (provide name)	<input type="checkbox"/> Demographic Information

Rights of the Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to the Office Manager. I understand that revocation is not effective in cases where the information has already been disclosed but will be effective going forward

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

X

Signature of Patient or Personal Representative

Date:

The Foot & Ankle Institute

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name & Address: _____

I have received a copy of the Notice of Privacy Practices for the above named practice.

X _____

For office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- An emergency existed and a signature was not possible at the time
- The individual refused to sign.
- A copy was mailed with a request for a signature by return mail.
- Unable to communicate with the patient for the following reason:
- Other: _____

Prepared by: _____

Signature: _____

Date: _____