

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: _____

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