Name ____ Date of Birth ___________________________

Patient Intake Form

Please fill out this form to the best of your knowledge. Your answers help us plan and provide your care.

Personal Information

Address: ____

City: ____________________ **State:** ____________________ **Zip Code:** _____________________

Age: ______________ **Sex:** M F **Race:** ______________ **Occupation:** ________________

Email: _______________________________ **Primary Language:** ____________________________

Home Number: _______________________ **Mobile Number:** _______________________________

Marital Status: ____________________ **Referring Physician:** _______________________________

PCP: _______________________________ **Last Seen Date:** ________________________________

Pharmacy Information

Pharmacy Name: ________________ **Address:** ____

Zip Code: __________________ **City:** ________________________ **Phone:** ___________________

Medical Insurance

Primary Ins Info: ________________________________ ID: _________________________

Secondary Ins Info: ______________________________ ID: _________________________

If Workers Comp Insurance please provide us with your Adjustors Information, Claims #, and Date of Accident: ____

____

____

Advanced Directives and Resuscitation Preferences

Do you have an Advanced Directive? Yes No

Please select all that apply:

- ☐ Do Not Intubate (DNI)
- ☐ Do Not Resuscitate (DNR)
- ☐ Full Code (All resuscitation efforts will be made)
- ☐ Living Will (A document stating your healthcare preferences)
- ☐ No Advanced Directive (No current advanced directive in place)
- ☐ Organ Donor (Registered to donate organs)
- ☐ Only Resuscitate (Only resuscitation efforts, no intubation)
- ☐ Power of Attorney (Someone designated to make healthcare decisions for you)
- ☐ Surrogate Decision Maker Assigned (A person chosen to make decisions if you are unable to do so)

Reason for Visit

Reason we are seeing you today: ____

Name ____ Date of Birth ___________________________

Current Prescriptions *(list all medications you are taking at present)*

Medication Name | Dosage/Route	**How Often**
Example: Lasix 20 mg, PO	*Daily*

Any medication allergies? ____

Mental Health

Over the last 2 weeks, how many bad days have you had?	
Had little interest or pleasure in doing things?	
Felt down, depressed or hopeless?	

Past Medical History (*check all that apply)*

☐ Anemia ☐ Arthritis ☐ Asthma ☐ Blood clot
☐ Coronary artery disease (heart attack) ☐ COPD/emphysema
☐ Cancer/History of cancer ☐ Chronic kidney disease
☐ Chronic liver disease/cirrhosis ☐ Congestive heart failure
☐ Depression ☐ Diabetes Type I/II ☐ GERD ☐ Hepatitis (type__)
☐ Hypertension (high blood pressure) ☐ Hyperlipidemia (high cholesterol)
☐ Migraine ☐ Seizure ☐ Stroke ☐ Thyroid (hypo/hyper)

Please list any other conditions not mentioned above: ____

Past Surgical History *(check all procedures that apply)*

☐ Appendectomy ☐ Coronary artery bypass (*open heart)*
☐ Cholecystectomy (*removal of gallbladder)* ☐ Gastric bypass
☐ Hysterectomy (*removal of uterus)* ☐ Joint repair/replacement (*i.e hip, knee,shoulder)*
☐ Nephrectomy (*removal of kidney)* ☐ Spinal surgery
☐ Splenectomy (*removal of spleen)*

Please list any other procedures not mentioned above: _______________________________________

Name ____ Date of Birth ___________________________

Social History

	Yes or No	How much or often
Do you smoke tobacco?		
Do you drink alcohol?		
Have you ever struggled with addiction? If yes, have you been sober?		

Family History (*please indicate first degree relatives only)*

☐ Anemia ☐ Arthritis ☐ Asthma ☐ Blood clot

☐ Coronary artery disease (heart attack) ☐ COPD/emphysema

☐ Cancer/History of cancer ☐ Chronic kidney disease

☐ Chronic liver disease/cirrhosis ☐ Congestive heart failure

☐ Depression ☐ Diabetes Type I/II ☐ GERD ☐ Hepatitis (type__)

☐ Hypertension (high blood pressure) ☐ Hyperlipidemia (high cholesterol)

☐ Migraine ☐ Seizure ☐ Stroke ☐ Thyroid (hypo/hyper)

Please list any other conditions not mentioned above: ____

Would you be interested in learning more about *(check all that apply)***:**

☐ Botox on the feet ☐ CBD products

☐ Medical Laser Treatment ☐ Minimally Invasive Surgical Treatment Options

How did you hear about us? ____

Extended Auth

I hereby authorize Cutting Edge Foot & Ankle, PLLC to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to Cutting Edge Foot and Ankle Clinic, PLLC all payments for medical services rendered to myself or my dependents. I am aware that it is my obligation to know my insurance company's policies and that I am responsible for any payment if I have not fulfilled their requirements. I also acknowledge the receipt of HIPAA privacy policy.

Signature: ____**Date**: __________________

Consent for Treatment

I hereby request and voluntarily consent to such office care, including routine diagnostic procedures and medical treatment as may be deemed necessary by Cutting Edge Foot & Ankle, PLLC and/or his designees.

Signature: ____ **Date:** _____________

FINANCIAL POLICY

Thank you for choosing Cutting Edge Foot and Ankle for your podiatry needs. Our physicians and staff are committed to delivering quality care and service to you. Understanding our financial policy is an important part of our professional relationship. Below is an explanation of our payment, cancellation, and no-show policies. Please make yourself aware of these policies as you sign off on them.

IN-NETWORK INSURANCE

Cutting Edge Foot and Ankle (CE) participates in most major insurance plans. To ensure that CE is in network with your insurance, please contact your insurance carrier. It is your responsibility to provide CE with accurate, up-to-date insurance information.

- CE is currently in network with United Healthcare, Medicare, Cigna (with the exception Connect/EPO Network), Cigna Healthspring, Aetna, Amerigroup, TennCare, Humana (except for HMO Network), Medicaid, Blue Cross and Blue Shield, UHC Community Plan, Humana Medicare plans, and Bright Health.
- At this time, CE cannot see Oscar, or PHCS/Multiplan patients including but not limited to: Blue Care (Medicaid), Blue Care Plus dual eligibility Medicare/Medicaid Plan, Cigna Connect/EPO, WellCare, Humana HMO, Ascension Complete, and BCBS Medicare Advantage PPO.
- CE requires a referral for patients with Tricare Prime, United Healthcare HMO, and Amerigroup HMO.

COPAYMENTS, DEDUCTIBLES, AND COINSURANCE

Your insurance co-payment is due at the time of your visit. Nail biopsies and in-house pathology services will be charged along with the office visit. If further testing is required to obtain an accurate diagnosis, your specimen will be sent to an outside laboratory, where additional charges may apply. If you are unable to pay your co-payment at the time of your visit, we will reschedule your office visit. If we determine that you have a deductible or a co - insurance amount due, you will be asked to pay **$75** at your visit. We do our best to have accurate collections, but please note that your co-pay/deductible are subject to determination by your insurance company. As a courtesy, our office will file your claim with your insurance company and initiate correspondence with the purpose of getting you the maximum coverage your insurance allows.

SELF-PAY FEE SCHEDULE

CE is out of network with certain insurance providers. It remains the responsibility of the patient/policyholder to know your insurance coverage, including out-of-network benefits. CE does not file out-of-network benefits. CE has a flat fee schedule for out-of-network patients. These fees are subject to change without notice. CE will provide information regarding the fees upon request. If you have not provided medical insurance, you hereby confirm that you do not have insurance to be billed and understand that payment is due at the time of service.

REFERRALS

If your insurance carrier requires you to obtain a referral from your primary care physician to see a specialist such as a podiatrist, it is your responsibility to bring this with you to your visit. Referrals and/or authorizations are not a guarantee of payment. You are responsible for any balances classified as “Patient Responsibility'' by your insurance company. Any dispute with claim processing is between you and your insurance company. If you do not have a referral

and your insurance requires one, we will reschedule your appointment until you obtain one, or you will be responsible for the self-pay rate.

HEALOW PAY (Online Payment)

CE encourages patients to pay through Healow Pay (an online payment system) when insurance claims are filed. Healow Pay helps reduce the amount of paper statements sent. After a claim for services rendered has been submitted and fully processed by your insurance company, any balances listed as “Patient Responsibility'' can be paid through Healow Pay. Patients will receive an email and text message with a link to pay. The transaction will try and process for 4 consecutive business days. If the payment fails or declines, the claim will remain declined, and the patient will receive a statement in the mail.

INSURANCE BALANCES

CE will submit claims to in-network insurance on behalf of the patient as a courtesy. The balance becomes your responsibility if we do not receive payment or resolution from your insurance company within 60 days of filing the claim. The patient is responsible for non-covered medical services.

APPOINTMENT CANCELLATIONS AND NO-SHOWS

We understand that situations arise in which you must cancel your appointment. It is required that if you must cancel your appointment, you provide **24 hours notice**. Providing advanced notice is a courtesy to your provider and allows another patient to be seen. Without notification, you are subject to a late cancellation fee or a no-show fee. We understand that special unavoidable circumstances may cause you to cancel within 24 hours prior to your appointment. Fees in this instance may be waived, but only with management approval.

________ (initial) I understand that office appointments which are canceled with less than 24 hours notice are subject to a **$50.00** cancellation fee.

________ (initial) I understand that if I no-show an appointment, I will be charged **$50.00** to reschedule an office appointment and to reschedule a procedure appointment.

CHARGEBACKS AND RETURNED CHECK FEES

There will be a **$25.00** fee in addition to the original amount owed if your check is returned from the bank or your credit card charge is charged back to CE.

________ (initial) I understand that a **$25.00** fee will be incurred for returned checks and credit card chargebacks.

PAST DUE BALANCES

Past account balances must be settled prior to being seen for a subsequent appointment.

________ (initial) I understand that past due balances must be paid prior to being seen for a subsequent appointment.

I certify that I have read the financial policies of Cutting Edge Foot and Ankle, and I agree to abide by these policies:

Signature ____________________________________ Today’s Date: __________/__________/__________

GUARANTOR INFORMATION AND PAYMENT FOR PATIENTS UNDER THE AGE OF 18

Guarantor information is responsible party information. A guarantor (or responsible party) is the person held accountable for the patient's bill and services rendered. A patient presenting for care that is 18 years of age or older is always the guarantor for bills relating to their care, except in an incapacitated adult. College students 18 years or older are always the guarantor for services they receive. CE does not bill absent parents for payments due at the time of service. The adult presents the minor for care to the responsible party and guarantor.

NOTE: If the parent presenting the minor brings a divorce decree stating that the other parent is financially responsible for the child's medical bills, the guarantor is changed to the parent designated in the divorce decree. The financially responsible parent's information is required before the patient can be treated, including full name, billing address, phone number, email address, and phone number.

Guarantor name: ____

Relationship to patient: _______________________________ **DOB:** _________/_________/_________

Mailing Address, if different than a patient:

Street Name: _______________________________ **City:** ____

State: _____________________________________ **Zip:** ____

Email Address:______________________________ **Phone Number:** _________/_________/__________

MEANINGFUL USE QUESTIONNAIRE

We collect this information from all of our patients and use it to track the quality of care. This information goes into your medical record and is confidential.

Today's Date:_________________

Patient Name:_____________________________ DOB:______________

Gender: □ Male □ Female □ I decline to answer

Race: □ White/Caucasian □ American Indian □ Asian
Black/African American □ Native Hawaiian/Pacific Islander
□ I decline to answer the question above
□ Other_________________________

Ethnicity: □ Hispanic or Latino □ Non-Hispanic or Latino
□ I decline to answer the question above
□ Other_________________________

Language: □ English □ Spanish □ French □ Russian
□ Italian □ Dutch □ Portuguese
□ I decline to answer the question above
□ Other_________________________

What is meaningful use?

The Federal government requires us to capture this information to improve health outcomes in the following areas: Improve the quality of care, efficiencies, and safety in treating patients; Reduce health disparities; Engage patients and families; Improve care coordination; Improve population and public health Guarantee adequate privacy and security protection of PHI

Consent Form
Giving permission for a relative/friend/carer to discuss a patient's confidential information

Cutting Edge Foot and Ankle Clinic
3443 Dickerson Pike
Nashville, TN 37207

I, ____,
(Enter full name and date of birth of the patient)

hereby give my permission for: ______________________________________
(Full name of the authorized person)

Relationship to patient: ____

Address: ____

to discuss my confidential medical information (as specified below) with the staff at Cutting Edge Foot and Ankle Clinic on my behalf. (Please tick the applicable boxes below)

☐ Nail/Callus/Corn Care
☐ Wound Care
☐ Medical Conditions
☐ Other issues (please specify): _________________________________

Patient Information

Name: ____

Address: ____

Signature: _________________________ Date: ___________________________