

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: \_\_\_\_\_

### Reason for Visit

The reason we are seeing you today: \_\_\_\_\_

### 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:

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

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

Medication Name   Dosage/Route	How Often
<i>Example: Lasix 20 mg, PO</i>	<i>Daily</i>

Any medication allergies? \_\_\_\_\_

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

Please list any other procedures not mentioned above: \_\_\_\_\_

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**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 (Patient Confidentiality and Consent Form) and Patient Complaints and Grievances 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, Bright Health, and Oscar.
- At this time, CE cannot see 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, BCBS Medicare Advantage PPO and Devoted Health.
- 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: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_



**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 & DOB)

Relationship to patient: \_\_\_\_\_ Phone Number: \_\_\_\_\_

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: \_\_\_\_\_



## Patient Confidentiality Consent Form

### Confidentiality of Medical Information

At Cutting Edge Foot and Ankle Clinic, we are committed to maintaining the confidentiality of your personal and medical information in compliance with federal and state laws, including the Health Insurance Portability and Accountability Act (HIPAA).

- Your medical records and any personal information will be kept private and secure.
- Only authorized personnel involved in your care or the administration of your medical services will have access to your information.
- We will only share your information with third parties (e.g., other healthcare providers, insurance companies) with your explicit written consent, except when required by law (e.g., court orders, public health requirements).

### Patient Rights

As a patient, you have the right to:

- Access your medical records upon request.
- Request corrections to any inaccurate information.
- Know how your information is being used and shared.
- Withdraw your consent for the sharing of information, except where disclosure is required by law.

### Use and Disclosure of Information

By signing this form, you consent to the use and disclosure of your medical information for the following purposes:

- To provide treatment and coordinate healthcare services.
- For billing and payment purposes with your insurance provider.
- To facilitate healthcare operations, including quality assessments, staff evaluations, and accreditation.

You may choose to limit the sharing of your information for purposes unrelated to your treatment or payment by contacting our office.

### Electronic Communications

We may communicate with you via email or text message regarding appointments, billing, and treatment plans. These forms of communication may not be fully secure, and by signing below, you acknowledge that you understand and accept the risks associated with electronic communication.

- I give consent to receive appointment reminders and healthcare information via Email & Text message

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Patient Complaints and Grievances Policy

### Purpose:

To provide a clear, transparent, and accessible process for patients to express complaints or grievances regarding their care and to ensure that these concerns are addressed promptly and professionally.

### Patient Rights

- Patients will not be discriminated against or penalized for filing a complaint or grievance.
- All complaints will be treated confidentially to the extent possible, consistent with the need to investigate the concern and take corrective action.

### Procedure for Filing a Complaint or Grievance

- **Contact Person:** Patients can report complaints or grievances directly to the Office Manager, the designated contact person for patient concerns.
- **Phone Number:** Patients can reach the Office Manager at **615-866-9639** to file a complaint or express any grievances.
- **Written Complaints:** Patients may also submit written complaints via mail to the following address:  
*Cutting Edge Foot and Ankle Clinic*  
*3443 Dickerson Pike, Unit 310*  
*Nashville, TN 37207*  
Or via email at [info@cefootandankle.com](mailto:info@cefootandankle.com)
- **In-Person Complaints:** Patients are welcome to report their concerns in person at the clinic reception desk.
  - All complaints and grievances will be acknowledged within 3 business days of receipt.
  - A full investigation will be conducted within 10 business days.
  - The Office Manager will communicate the findings and resolution to the patient, family member, or caregiver who filed the complaint.
  - Complaints will be reviewed by the clinic's leadership and relevant staff members.
  - If the grievance involves clinical care, it will be reviewed by the appropriate medical personnel.
  - Corrective actions will be taken to resolve the issue and prevent recurrence.