Florida Foot & Ankle Associates LLC

Dr. Michael A. Rivera DPM,DABPS, FACFAS

Memorial Center
601 North Flamingo Road
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Telephone : (954) 888-1444
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POLICY ON MISSED APPOINTMENTS/CANCELLATIONS/NO SHOWS

$35.00 Charge for No-Shows/Cancellations/Reschedules

PLEASE NOTE: WE DO NOT WANT YOUR MONEY. WE WANT YOU TO KEEP YOUR SCHEDULED APPOINTMENTS.

Our follow-up protocols are based on years of experience and provide you with the highest standard care. Keeping your appointment is important to the health of the patient as well as to the outcomes of the treatments being prescribed. When you do not keep your appointment, we have gaps in our schedule that affects our schedule for the whole day. Those gaps may have been given to other patients who want earlier schedules.

You will be considered a No-Show if you miss an appointment and do not notify us 24 hours in advance. You will receive a bill for $35.00 if you no show/cancel or reschedule more than one appointment per year. Payment to be made via cash or credit card at the time of your next follow-up appointment.

Our office makes every effort to remind you of your appointment. Please update your home and cell phone numbers, address and e-mail address whenever there is a change. If you do not comply with our policy & regulations unfortunately we will have to discharge you from our practice.

I have read and understand the above policy.

Patient Signature _____ Date : _____

Witness: (Office Use only)_____

FLORIDA FOOT & ANKLE ASSOCIATES LLC

DR.MICHAEL A. RIVERA DPM

MEMORIAL OUTPATIENT CENTER

601 NORTH FLAMINGO ROAD SUITE #414 PEMBROKE PINES, FL 33028 TELEPHONE: (954) 888-1444 FAX: (954) 392-5990

PLEASE INCLUDE PHARMACY INFORMATION

***WE ARE A ELECTRONIC PAPERLESS OFFICE.**

THANK YOU.

PHARMACY NAME: _____

PHARMACY ADDRESS:

_____

PHARMACY PHONE NUMBER: _____

PATIENT SIGNATURE: _____

DATE: _____

FLORIDA FOOT & ANKLE ASSOCIATES

Patient Financial Responsibility Form

Patient Name:_____ **Date:**_____

Thank you for choosing a Florida Foot and Ankle physician for your podiatry needs. We are honored by your choice and are committed to providing you with the best quality of care. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- Patients are responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by their insurance plan.
- For your convenience, Florida Foot & Ankle Associates, LLC (FFAA) will bill the patient's insurance for services provided. However, the patient is required to provide FFAA with the most correct and updated information about their insurance coverage.
- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment of treatment and services rendered by FFAA.
- Patients will be responsible for the payment of additional charges incurred but not limited to the following:
    - Charge for returned checks
    - Any costs associated with collection of patient balances
    - Charge for missed appointments without advance notice of at least 24 hours prior to appointment.

I have read, understand and agree to the provisions of this Patient Financial Responsibility Form:

_____ _____

Signature of Patient or Guardian **Date**

_____

Print Name of Patient

Have you ever had injuries to your feet, ankles, legs, or back? ☐ Yes ☐ No If yes, please describe:_____

LIST YOUR PRESCRIBED DRUGS & OVER-THE-COUNTER DRUGS, SUCH AS VITAMINS AND INHALERS

Name the Drug	Strength/Dose (mg)	How often do you take it?

ALLERGIES TO MEDICATIONS

☐ I am NOT allergic to any medications that I am aware of

I am allergic to the following:

- ☐ Aspirin
- ☐ Codeine
- ☐ Novocaine
- ☐ Vicodin
- ☐ Penicillin
- ☐ Cipro
- ☐ Tranquilizers
- ☐ Cortisone
- ☐ Tape/Adhesives on the Skin
- ☐ Antihistamines
- ☐ Iodine (IV)
- ☐ Tetracycline
- ☐ Sulfa Drugs
- ☐ Other: _____

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

CONSENT FOR TREATMENT: I voluntarily consent to the tendering of care, including treatments, administration of anesthetics and performance of diagnostic and/or surgical procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

RELEASE OF INFORMATION: The physician(s) may disclose all or part of the patient's record to any person or corporation which is or may be liable under a contract to the physician(s) or to the patient or to a family member or employer of the patient for a all or part of the physician(s) charges, including but not limited to, Insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

MEDICARE AND MEDICAID PATIENT CERTIFICATION-PATIENTS CERTIFICATION AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title VII and/or Title XIX, of the Social Security Act, is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services. I understand that I am responsible for my health insurance deductible and co-insurance.

_____ Patient's Name (Please Print)	_____ Witness Name	_____ Patient's Agent or Representative
_____ Patient's Signature / Date	_____ Witness Signature / Date	_____ Relationship / Date

FLORIDA FOOT & ANKLE ASSOCIATES

PATIENT MEDICAL/SURGICAL HISTORY & PHYSICAL QUESTIONNAIRE

Name *(Last, First, M.I.):*	**Date:**
Primary Care Doctor:	**Date of last physical exam:**

Are you currently being treated by another physician ? If so, for what reason?:

PERSONAL HEALTH HISTORY

What is your chief foot complaint?:

What is your shoe size?:

Height: **Weight:**

Past Medical History: (check all that apply)

- ☐ Diabetes
- ☐ Family member with Diabetes _____
- ☐ Asthma
- ☐ Poor circulation
- ☐ Varicose Veins/Venous Stasis
- ☐ Foot or leg ulcers
- ☐ Heart trouble
- ☐ High blood pressure
- ☐ Stroke/CVA/TIA
- ☐ Sciatica
- ☐ Nervousness/ Anxiety
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ HIV/AIDS
- ☐ Hepatitis B
- ☐ Scleroderma
- ☐ Bleeding Disorders
- ☐ Tuberculosis
- ☐ Kidney Disease
- ☐ Dialysis
- ☐ Stomach Ulcers
- ☐ Anemia
- ☐ Leg Cramps: Daytime Nighttime
- ☐ Headaches/Migraines
- ☐ Cancer Type
- ☐ Gout
- ☐ Depression
- ☐ Polio
- ☐ Scar Poorly
- ☐ Lupus
- ☐ Blindness/Retinopathy
- ☐ Hepatitis C
- ☐ Other: _____

Are you currently Pregnant?

Are you subject to prolonged bleeding?

Do you use tobacco? ☐ Yes ☐ No	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Cigars - #/day	☐ Pipe - #/day
☐ # of years	☐ Or year quit			

SURGERIES

Surgery	Year	Hospital

OTHER HOSPITILIZATIONS

Reason	Year	Hospital

FLORIDA FOOT & ANKLE ASSOCIATES

REGISTRATION FORM

PRIMARY CARE/REFERRING PHYSICIAN:			DATE LAST SEEN:
PATIENT INFORMATION			
DATE:	SOC SECURITY#		
LAST NAME:	FIRST NAME:	MI:	SUFFIX:
OTHER:	EMAIL:		
DOB: __/__/____	MARITAL STATUS: (CIRCLE ONE) Single / Married / Divorced / Separated / Widowed	RACE:	SEX: ☐ M ☐ F
ADDRESS:	CITY:	STATE:	ZIP CODE:
HOME PHONE:	WORK PHONE:	CELL PHONE:	

INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION

INSURANCE NAME:	
INSURANCE PLAN TYPE:	
PATIENT'S RELATIONSHIP TO SUSCRIBER: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER _____	
POLICY#:	SUBSCRIBER EMPLOYER NAME:
SUBSCRIBER NAME:	SUBSCRIBER EMPLOYER #:

SECONDARY INSURANCE INFORMATION

INSURANCE NAME:	
INSURANCE PLAN TYPE:	
PATIENT'S RELATIONSHIP TO SUSCRIBER: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER _____	
SUBSCRIBER ID:	SUBSCRIBER EMPLOYER NAME:
SUBSCRIBER NAME:	SUBSCRIBER EMPLOYER #:

WHOM MAY WE THANK FOR REFERRING YOU?

HAVE YOU EVER SEEN A PODIATRIST? ☐ NO ☐ YES IF YES, WHEN?_____

IN CASE OF EMERGENCY

EMERGENCY CONTACT NAME:	RELATIONSHIP TO PATIENT:	HOME PHONE #:	WORK/CELL PHONE #:
		( )	( )

The above information is true to the best of my knowledge.

Patient/Guardian signature	***Date***