Dr. Darren Elenburg, DPM, FACFAS

Name: _________________________________ **Date of Birth**: ___________**SSN**: ________________
(Last) (First) (MI)

Address: _____________________________________ **City**: ___________________ **Zip**: ___________

Home #: (____)____-_____ **Cell** #: (___)____-_____ **Marital Status**: S M W D

Email Address: ____

Preferred method of Contact: Phone, Mail, Email, Text

Emergency Contact: _______________________ **Phone**#: (___)____-_____ Relationship: __________

Patient Employer: ____________________ **Occupation**: _______________ **Phone**# (___)_____-______

Employer Address: ____

Primary Language: _______________ **Ethnicity**: Hispanic Non-Hispanic
Please Circle Race
Declined Asian Black or African American American Indian or Alaska Native
Native Hawaiian or Other Pacific Islander White

Primary Care Doctor: ____
Are you Diabetic? **Y N**
If yes, please provide the name/phone of the doctor that is monitoring your diabetes:
____

How did you hear about our office? Family Friend Advertisement Dr. Referral: _________________

For Parents of Minor Children:
We **must** have an ID for the parent/guardian that brings the child to his/her appointment. We must also have complete address, phone number and date of birth for the primary insurance holder. If we do not have this information, your insurance company will deny your claim. Thank you in advance for your help.

Insurance/Billing Information
Please fill out this section for the primary insurance holder if other than the patient

Insured Name: _________________________ Insured DOB: ______________ Insured SS#: __________
Insured Employer: _____________________________ Employer Phone: (___)____-_____
Person Responsible for Bill: _________________________________ Phone: (___)____-_____
Address: ____

Patient Name:___________________________________ Date:____________________

Medical Information

Describe your foot or ankle
Problem(s):

____

____

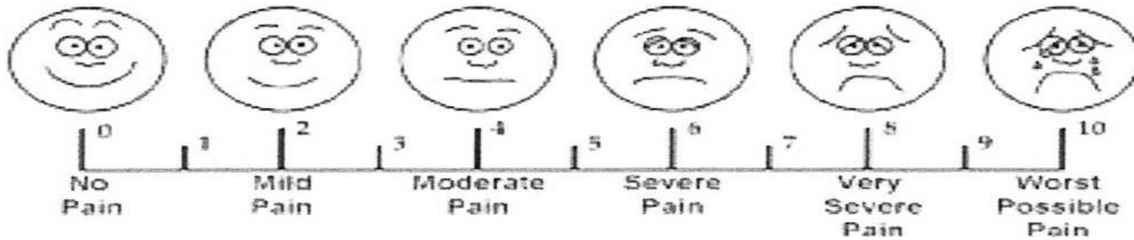
How long has it been bothering you? ____________________________________

Please list any treatment for this condition (by you or a doctor):

____

____

Using the pain scale below, please indicate your level of pain:



Please list any past problems or injuries with your feet or ankles:

____

____

Please list medications, dosages and medical conditions:

(If you have a list of your medications, please let us copy it)

- ___________________________________ ______________________________
- ___________________________________ ______________________________
- ___________________________________ ______________________________
- ___________________________________ ______________________________
- ___________________________________ ______________________________

Allergies: Do you have any allergies that you know of? (Please circle) **NO** **YES**

If **yes**, please circle what you are allergic or sensitive to:

Penicillin Sulfa Codeine Aspirin Latex Betadine/Iodine Tape

List any other medications or food you are allergic to and the reaction you have:

____

____

____

____

Patient Name: ______________________________________ Date:______________

Medical History: Please circle if you have been told you have or had any of the following:

Blood
Anemia
Bleeding Disorder
Blood Clots
Cancer –
What Type________

Musculoskeletal
Gout
Osteoarthritis
Rheumatoid Arthritis
Other Arthritis _______
Joint Stiffness
Joint Swelling
Leg Cramps
Joint Pain
Back Pain
Sciatica
Hip Pain
Knee Pain
Nighttime burning – Feet
Cramps of feet

Neurological
Neuropathy – Feet
Numbness
Stroke
Paralysis
Seizures/Epilepsy
Migraine Headaches
Cerebral Palsy
Nervous Disorder

Peripheral Vascular
Poor Circulation
Impotence
Calf pain when walking
Varicose Veins
Phlebitis
Swelling in the legs/feet

Psychology
Depression/Anxiety
Sleep Disturbances
Psychiatric Care

Head
Hearing loss
Macular Degeneration
Cataracts/glaucoma

Cardiac
Congestive Heart Failure
Heart Disease
High Blood pressure
Heart attack (previous)
Irregular beats
Murmur
Clogged Arteries (stent)
Pacemaker

Endocrine
Diabetes
How long? _____Yrs
Insulin? ___
Hypoglycemia
Hypothyroid
Osteoporosis

GI
Intestinal Disease
Stomach Ulcers
Reflux Disease / GERD

Kidney
Kidney Disease / Failure
Kidney Stones
Dialysis

Liver Disease
Hepatitis
Type? _________
Cirrhosis

Skin
Slow Healing
Keloid/Thick Scar
Psoriasis
Type? _______
Changing Skin Lesion
Skin Cancer
Type? ________

Respiratory
Lung Problems
Asthma
Bronchitis
Emphysema
Pneumonia
Pulmonary Embolism

Infectious
Aids / HIV
Polio
Tuberculosis
Lyme's Disease

Other problems not listed?_____________
____
____
____

Medical Information

Surgical History

Please list any surgeries you have undergone:

____

____

Any problems with **Anesthesia** during surgery? (Please circle) **YES** **NO**

If **yes**, please list problem:

____

____

Family History

Have there been medical problems in your family? (Please circle) **YES** **NO**

If **yes**, please list what they are:

Mother: ____

Father: ____

Social History

Do you smoke? **YES** **NO** **NEVER** packs per day? ________ How long? _______ Quit?________

Do you drink alcohol? **YES** **NO** if yes, would you describe your use as social or heavy? _______

Take illegal drugs? **YES** **NO** any problem with addiction / alcoholism? **YES** **NO**

If **yes**, please list what your addiction is to:

____

Shoe Size ____________ Current Weight ___________ Height _____________

Any additional information you would like us to know? **YES** **NO**

If **yes**, please list

____

____

____

This information is correct to the best of my knowledge: ____

Signature Date

PATIENT HIPAA ACKNOWLEDGEMENT – DESIGNATION AND DISCLOSURE FORM

I. **Acknowledgement** of Practice's ***Notice of Privacy Practices***

____ ____________________________________

Name of Patient Date of Birth Signature of Patient/Parent/Guardian Date

II. **Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative**:
I agree that the practice may disclose certain of my health information to a Personal Representative of my choosing since such person is involved with my health care or payment relating to my health care. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Print Name: ______________________________________ Last 4 digits of Social / DOB (required): _____________
Print Name: ______________________________________ Last 4 digits of Social / DOB (required): _____________
Print Name: ______________________________________ Last 4 digits of Social / DOS (required): _____________

III. **Request to Receive Confidential Communications by Alternative Means**:
As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below

Home Telephone number:
____
__Ok to leave a message with detailed information
__ Leave a message with call back numbers only

Work Telephone Number:
____
__Ok to leave message with detailed information
__Leave message with call back numbers only

Written Communication address:
____
__ Ok to mail to address listed above
__ E-mail me at ________________________________

Fax Communication
____
___Ok to Fax at the number listed above
___ E-mail me at ______________________________

Other: ____

IV. The following person(s) **<u>are not authorized</u>** to receive my Patient Health Information (PHI)
Print Name ________________________ **Print Name___________________________**
Print Name ________________________ **Print Name ___________________________**

V. **The HIPAA Privacy rule requires healthcare providers to take reasonable steps to limit the use** or disclosure of, and requests for PHI. I understand that this accounting wills not reflect disclosures that are made in the course of the Practice's ordinary health care activities related to providing patient treatment, obtaining payment for its services or its internal operations. Also, the Practice does not have to account for disclosures for which I have executed and Authorization permitting disclosures of my PHI.

1. The above authorizations are voluntary and I may refuse to agree to their terms without affecting any of my rights to receive health care at this practice.
2. These Authorizations may be revoked at any time by notifying the Practice in writing at the Practices amiling address marked to the attention of "Privacy Officer"
3. The revocation of the authorization will not have any effect on disclosures occurring prior to the execution of any revocation.
4. I may see and copy the information described in this form, if I ask for it, and that I will get a copy of this form after I sign it.
5. This form was completely filled in before I signed it and I acknowledge that all of my questions were answered to my satisfaction, that I fully understand this authorization form and have received an executed copy.
6. This authorization is valid as of the date I have signed below and shall remain valid for a period of a year.

____ ____

Name of Patient (Printed) Signature of Patient Date

Foot & Ankle Center of Oklahoma
3705 NW 63rd
Suite 200
Oklahoma City, Ok 73116
Tel: (405)463-6700 Fax: (405)463-0020

Revised 6/02/2015

Financial policy for Foot & Ankle Center of Oklahoma

Thank you for choosing us as your Foot & Ankle Specialist. It is our goal to provide you with the highest quality of care at the most reasonable prices. We invite you to discuss with us any questions you have regarding our services or payment policies. The best health services are based on mutual understanding between provider and patient.
Please be prepared to pay any co-pay, non-covered and/or over-the-counter charges at the time of your visit.

For the purpose of payment, I allow ***Foot & Ankle Center of Oklahoma*** to release my Private Health Information to any and all of my insurance carriers, their third party payors and claim reviewers, until the claim is resolved. For the purpose of treatment, I also allow the above listed practice to release my information or contact any and all of my treating physicians.
Minor Children: Parents or guardians of minor children are responsible for financial obligations incurred for medical services received. In the case of divorced parents, the parent bringing the child to his/her appointment is responsible for any balance incurred. As a courtesy we are happy to file your claim with insurance, however, final payment is the parent/guardian responsibility.
Insurance: Your insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company. It is your responsibility to know your benefits, as they vary depending on your particular contract. It is also your responsibility to provide any referrals or authorizations that may be required by your insurance company. **ALL CHARGES ARE YOUR RESPONSIBILITY, WHETHER YOUR INSURANCE PAYS OR NOT.**
Co-payments, deductibles and co-insurance: All co-pays and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-pays and deductibles from patients can be considered fraud. The Foot & Ankle Center of Oklahoma is not a bank or financial institution. We do not extend credit or carry balances on accounts. We accept cash, check, MasterCard, Visa, Discover, American Express and Care Credit. Care Credit financing requires advance pre-authorization and these arrangements must be made with office staff before your appointment.
Proof of Insurance: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your Driver's License/ID and current valid insurance card to provide proof of insurance.
Durable Medical Equipment / Non-Covered Services: Many insurance companies do not cover Durable Medical Equipment (DME). We often use these items for your appropriate care and you may be responsible for these purchases. Items commonly used include, but are not limited to: Custom Orthotics, pre-made orthotics, surgical shoes, removable casts, braces and bandages. You are responsible for any non-covered services you choose to receive. You will be informed of any non-covered charges and must pay for them in full before leaving our office. Non-covered items will not be billed to your insurance.
In the case of custom items, it is our policy to dispense them in the office in order to ensure that the items fit the patient. When the item is received in our office, we will contact you and schedule a fitting. If, after 30 days we are unable to contact you we will ship the item to your home address. We will bill your insurance for the appropriate charges and you will be responsible for shipping costs incurred.
Missed Appointments: It is our policy to charge $30, plus any additional costs incurred by our office on behalf of the patient, for a missed appointment if not cancelled within 48 hours. This charge is at our discretion. Please help us to serve you better by keeping your regularly scheduled appointment.
Cancellation of Surgery: If you cancel your surgery within 3 days or less of the scheduled time, our policy is to charge $30 plus any additional costs incurred by our office on behalf of the patient. This charge is at our discretion.
Non-Payment: After 90 days of non-payment, you will be sent a 10 day collection notice from our billing office. If there is no response within the allotted time, your account will be turned over for collections and be subject to a 30% collection fee. All collection fees, legal fees and court costs will be added to the patient balance in addition to the balance due to the office.
NSF Checks: Restitution for returned checks is required within (5) working days with case, money order or credit card and will be subject to a $25 returned check fee. If checks are not picked up within the allotted time, they will be turned over to the District Attorney for prosecution.
Forms and Documents: Completion of ALL forms, such as disability applications, FMLA paperwork etc., will be subject to a $25 fee. Please allow 72 hours for request of records from our office.
Medicare Patients: We would like you to understand that taking ASSIGNMENT means that YOU are responsible for the yearly deductible of $143 and the 20% co-insurance of what Medicare allows, If you secondary insurance carrier does not cover co-pays / co-insurance, you are responsible for the balance.

I understand that honest and complete answers to each question on the previous pages are important to my medical care. I have answered them to the best of my ability. I have been informed that if I am uncertain about any question(s) on these forms I should ask the doctor or a member of the office staff for assistance.
I have read, understood and have received a copy of the payment policy and I agree to abide by its guidelines.

Patient signature____ Date ______________________________

Revised 6/02/2015