Apex Foot & Ankle Center

C. Robert Dushack, DPM, FACFAS
Jessica Andrews, DPM

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Suite 201
Naples, FL 34109

Nombre: _____ Fecha de Nacimiento:____/____/_____

Dirección: _____

Telef. Domicilio: _____ Telef. Celular: _____

Num. seguro social: _____

Correo electrónico: _____

En Caso De Emergencia: (nombre)_____ Teléfono:_____

Seguro médico primario: _____ ID #: _____

Seguro médico secundario: _____ ID #: _____

¿A quién podemos agradecer por referirlo(a) al Dr. Dushack?

_____

HIPAA- INFORMACION DE PRIVACIDAD (la ley requiere una respuesta)

¿Recibir correo electrónico? SI NO

¿Recibir llamadas de teléfono y/o correo de voz? SI NO

¿Permitir el acceso electrónico al portal del paciente? SI NO

Entiendo que tengo derecho a recibir una copia del Aviso de Prácticas de Privacidad. Me han ofrecido el Aviso de Prácticas de Privacidad de esta oficina, que explica cómo se puede usar y divulgar mi información médica.

FIRMA DEL PACIENTE: _____ FECHA: _____ PAGINA 1 de 4 ->

Historia quirúrgico (indique TODAS sus cirugías o debe escribir "N/A")

_____

_____

_____

_____

Condiciones médicos (indique TODAS sus afecciones medicas o debe escribir “N/A”)

_____

_____

_____

_____

Historia Social (circula)

Estado Civil: Soltero(a) Casado(a) Divorciado(a) Viudo(a)

Estado de Trabajo: Estudiante Trabajando Retirado(a)

Estado de Fumador: Antes Nunca Ahora

Consumo de alcohol: No Raramente Socialmente Diario

Etnicidad / raza: _____

Historia Familiar

Edad de Madre:_____ ella está **viva** o **muerta** (circula)

Enfermedades:_____

Edad de Padre:_____ él está **vivo** o **muerto** (circula)

Enfermedades:_____

Escribe todas sus **medicamentos** o escribe "N/A"

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Escribe todas sus **alergias** o escribe "N/A"

_____

FIRMA DEL PACIENTE: _____ FECHA: _____ PAGINA 2 de 4 ->

Por favor, complete sus Vitales a lo mejor de su conocimiento.

Presión: ____/____
Altura: ____ft____in
Peso: _____lbs
Tamaño y anchura del zapato: _____
Año de su última vacuna: _____ Vacuna contra la neumonía: _____

Si tiene más de 65 años:
¿Se ha caído en los últimos 12 meses? SI NO
¿Tiene un **testamento vital** o un **mandato?** (Circula)

RAZON POR LA VISITA: _____
Cuando empezó:_____
Que ha hecho hasta ahora: _____
_____

¿Tiene Diabetes?: SI Tipo 1 o Tipo 2 o **NO**
¿Quién es su médico de atención primaria? _____ Nombre de su farmacia: _____ Núm.: _____

Cualquier información adicional que le gustaría agregar:
_____
_____
_____
_____

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PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Apex Foot & Ankle Center as your healthcare provider. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- The patient, or patient's guardian, is ultimately responsible for the payment for their treatment and care.
- Your insurance plan is a contract between you and your insurer. It is your responsibility to know and understand your insurance benefits, including whether we are a contracted and/or In-Network provider with your insurance company and specific plan, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.
- If we are contracted and/or In-Network with your insurance company, we will bill your insurance company for you and then bill you for any amount determined by your insurance company to be your responsibility.

However, the patient is required to provide us with the most correct and up to date information about their insurance, making sure to promptly inform the office of any updates or changes. Should you fail to provide this information, you will be financially responsible.

- Patients are responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by their insurance plan. Payment is due at the time of service, and for your convenience, we accept cash, check, and most major credit cards at our office.
- If my plan requires a referral, I understand that I must obtain that from my Primary Care Physician prior to my visit.
- If I am uninsured, I agree to pay for the medical services rendered to me at the time of service.
- Patients may incur, and are responsible for, payment of additional charges at the discretion of Apex Foot & Ankle Center. These charges may include (but are not limited to):
    - ♣ Charge for returned checks.
    - ♣ Charge for missed appointments without 24 hours advance notice.
    - ♣ Charge for the copying and distribution of patient medical records.
    - ♣ Any costs associated with collection of patient balances.

Patient Authorizations

- By my signature below, I hereby authorize Apex Foot & Ankle Center and the physicians, staff, and hospitals associated with Apex Foot & Ankle Center to release medical and other information acquired during the entirety of my examination and treatment to the necessary insurance companies, third-party payors, and/or other physicians or healthcare entities required to participate in my care.
- By my signature below, I hereby authorize assignment of financial benefits directly to Apex Foot & Ankle Center and any associated healthcare entities for services rendered as allowable under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment.
- By my signature below, I authorize Apex Foot & Ankle Center personnel to communication by mail, answering machine message, and/or email according to the information I have provided in my patient registration information.

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

_____ _____

Signature of Patient or Guardian Date

Waiver of Patient Authorizations

I do not wish to have information released and prefer to pay at the time of service and/or to be fully responsible for payment of charges and to submit claims to insurance at my discretion.

_____ _____

Signature of Patient or Guardian Date