Apex Foot & Ankle Center

C. Robert Dushack, DPM, FACFAS

Jessica Andrews, DPM

9400 Gladiolus Dr
Suite 300
Fort Myers, FL 33908

1890 SW Health Pkwy
Suite 201
Naples, FL 34109

Phone: (239)433-0064 **Fax: (239)433-0224**

Name:_____ Date of Birth:____/____/_____

Florida Address:_____
Street City, State, Zip code

Northern Address:_____
Street City, State, Zip code

Home Phone:_____ Cell Phone:_____

SS Number:_____ Email:_____

Insurance: (you may skip this section if you have provided your cards for copies)

Primary Insurance:_____ ID #:_____

Secondary Insurance:_____ ID #:_____

Who may we thank for referring you to APEX Foot & Ankle Center?

_____

HIPAA- PRIVACY INFORMATION (an answer is required by law)

-Send mail to address on file? YES NO

-Call phone number on file and/or leave a voicemail? YES NO

-Allow electronic access to patient portal? YES NO

-Who may we leave a message with if we don't reach you?:

Name(s):_____

I understand that I am entitled to receive a copy of the Notice of Privacy Practices. I have been offered this office's Notice of Privacy Practices, which explains how medical information about me may be used and disclosed.

SIGNATURE:_____ DATE:_____

Surgical History (list **ALL** of your surgeries or must write "NONE". Don't leave blank.)

_____

_____

_____

Medical Conditions/History (list **ALL** medical conditions or write "NONE". Don't leave blank.)

_____

_____

_____

Do you have Diabetes? (circle) **NO** **YES - if yes** (circle) type 1 or type 2

Social History (circle)

Marital Status: Single Married Divorced Widowed

Working status: Student Working Retired Disabled

Smoking status: Former Never Current-Some day Current-Everyday

Alcohol consumption: None Rarely Socially Daily

Ethnicity/ Race: _____

Family History

Natural Mother age:_____ she is living or deceased (circle)

Medical Conditions:_____

Natural Father age:_____ he is living or deceased (circle)

Medical Conditions:_____

List all of your prescription **Medications** or must write "NONE"

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

List all of your **Allergies** or must write "NONE"

_____

SIGNATURE:_____ DATE:_____

Please fill in your Vitals to the best of your knowledge.

Blood Pressure: ____/____

Height: ____ft____in

Weight: _____lbs

Shoe size and width: _____

Year of your last Flu shot: _____ Pneumonia vaccine: _____

Have you fallen in the past 12 months? YES NO (circle)

Do you have a living will or power of attorney ? (circle)

REASON FOR TODAY'S VISIT:_____

When did this begin:_____

What have you done so far: _____

_____

What is the name of your Primary Doctor? _____

City:_____ State: _____ Phone number:_____

Date last seen?: _____

Pharmacy Name:_____ Phone number:_____

Intersection/ cross roads: _____

Emergency Contact:_____ Phone Number:_____

Any additional information you would like to add:

_____

_____

SIGNATURE:_____ DATE:_____

Apex Foot & Ankle Center
C. Robert Dushack, DPM, FACFAS
Jessica Andrews, DPM
Phone: (239) 433-0064 Fax: (239) 433-0224

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