InStride Foot & Ankle Specialists
Dr. James Shipley DPM | Dr. David Collard DPM, MHA | Dr. Walter Falardeau DPM

LET'S GET ACQUAINTED
(Please Print)

Date: _____/_____/_____

Patient Name: _____ _____ _____ Date of Birth: ____/____/_____ Age: ____ Sex: M F
Last First MI

Home Address: _____ City/State: _____ Zip: _____

Marital Status: ☐Single ☐Married ☐Partnered ☐Legally Separated ☐Divorced ☐Widowed

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HOW CAN WE REACH YOU?

Primary Phone: _____ Type: _____ Secondary Phone: _____ Type: _____

E-Mail: _____ Primary Language: _____

Employer: _____ Occupation: _____

OTHER CONTACTS:

Emergency Contact: _____ Relationship: _____ Phone #: (_____) _____-_____

Due to HIPAA regulations, we will not share your private information with anyone without your consent. Is there a family member or other person you would like to grant permission to speak with us concerning your diagnoses, treatments, or bills? ☐Yes ☐No

If yes, who? (Please list name and relationship): _____

If anyone other than you will be paying your bills, please complete the following:

Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone #: (_____) _____-_____

Do you have a Legal Guardian or Healthcare Power of Attorney? ☐Yes ☐No

If yes, Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone #: (_____) _____-_____

How did you hear about us? ☐Doctor ☐Health Fair ☐Insurance ☐Website ☐Friend/Family ☐Sign ☐Other

**I acknowledge that I was provided a copy of the Notice of Privacy practices and that I have read (or had the opportunity to read if I so chose) and understand the notice.

_____ _____
Print Name of Patient, Parent or Guardian If other than patient, relationship to patient

_____ _____
Signature Date

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Patient Name: _____ Date of Birth: _____/_____/_____

Primary Care Doctor: _____ Approximate Date of Last Visit: _____/ _____
month year

Height _____ Weight _____ Shoe Size _____

Home Health: Have you had any home health nurse treating you in your home in the last 90 days?
☐Yes ☐No If yes, please circle: (physical therapy, administer oxygen, B12 injections, wound care)

MEDICATIONS AND ALLERGIES

Please attach or write a list of all medications you are currently taking (including prescriptions and over-the-counter medications).

_____

_____

_____

Please attach or write a list of any drug/medication allergies you may have: ☐**No known drug allergies**

_____

_____

Other Allergies: ☐ Tape ☐Latex ☐Iodine ☐Shellfish ☐Foods ☐Other _____

MEDICAL HISTORY

Please check any of your current or past conditions:

☐ Arthritis
☐Cancer (type: _____)
☐Diabetes*
☐Fibromyalgia
☐Gout
☐High Blood Pressure
☐Neuropathy
☐Stroke

**If you are diabetic*, do you take Insulin? ☐Yes ☐ No
Last glucose reading: _____
Last A1C Level: _____
Other conditions: _____
_____
_____

Have you ever tested positive (+) for: ☐None of the following ☐TB ☐Hepatitis ☐HIV/AIDS ☐MRSA

SURGICAL HISTORY

Please check all that apply. ☐None of the following apply
☐Heart surgery ☐Stent placement ☐Hip replacement ☐Knee replacement
☐Foot or ankle surgery: ☐Bunion ☐Hammertoe ☐Joint Fusion
☐Other: _____

FAMILY HISTORY

☐Cancer ☐Diabetes ☐Gout ☐Heart Disease ☐High Blood Pressure ☐Stroke ☐Rheumatoid Arthritis

SOCIAL HISTORY

Tobacco: ☐Current Smoker ☐Former Smoker ☐Never Smoker
If current, duration of use: _____ If former, when did you quit? _____

Use of Alcohol: ☐Current ☐Formerly ☐Never

Use of Recreational Drugs: ☐Current (type: _____) ☐Formerly ☐Never

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REVIEW OF SYSTEMS

Please mark any current symptoms you are experiencing: ☐**None of the following apply**
Const: ☐Fatigue ☐Fever/chills ☐Night Sweats ☐Recent weight gain or loss
Skin: ☐Dry skin ☐Itchy skin ☐Peeling of skin ☐Localized skin discoloration ☐Rash
Cardio: ☐Chest pain ☐Palpitations ☐Leg pain with exercise ☐Varicose veins
Pulm: ☐Difficulty breathing ☐shortness of breath ☐cough ☐wheezing
MS: ☐Back pain ☐Joint pain ☐Muscle aches ☐Joint swelling ☐Joint stiffness ☐Muscle weakness
Neuro: ☐Dizziness ☐Limb weakness ☐Difficulty with balance ☐Tingling ☐Numbness

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CURRENT PROBLEM

What specific problem brings you to our office today? (What part of your foot/ankle/lower leg is causing trouble?) _____

_____

Was this problem caused by an injury? ☐Yes ☐No If yes, please explain: _____

_____

How long ago did this problem first start? _____

How would you describe your pain/problem? ☐No pain or discomfort ☐Numbness and/or Tingling
☐Sharp ☐Dull ☐Aching ☐Burning ☐Itching ☐Stabbing ☐Other: _____

Since your pain or problem began, has it: ☐Stayed the same ☐Become Worse ☐Improved

How would you rate your pain on average, from 0 to 10?

0 1 2 3 4 5 6 7 8 9 10
(no pain) (worst pain possible)

What makes your pain or problem feel worse? ☐Walking ☐Standing ☐Daily Activities ☐Resting

☐Dress Shoes ☐Flat Shoes ☐Any Closed Toe Shoe ☐Running ☐Other _____

What makes your pain or problem feel better? _____

What treatments/remedies have you tried for this problem? Has any of it worked? _____

_____

Welcome to our New Patients

Our practice is a division of the **InStride Foot & Ankle Specialists, PLLC**. We have divisions across North and South Carolina, and we operate under one tax ID number. As such, if you have seen any of the following physicians in the past **three years**, we need to know so that we will not file a new patient code for your visit today. Since the insurance carriers look at us as one large practice, if you have been seen at any of the following divisions, you will not be considered a new patient in our practice. **Visits prior to 2015 do not need to be disclosed**.

Please review the names of the divisions and podiatrists below and indicate if you have been seen at any of these divisions by putting a **√** on the line to the left of the practice name. Thank you for disclosing this information to us – it will allow us to be in compliance with nationally mandated correct coding initiatives.

	DIVISION	PODIATRIST
	Alta Ridge Foot Specialists	Robert van Brederode, William Broyles, Thomas Verla
	Ankle & Foot Center of Charlotte **(Resigned from group 7/1/2017)**	Scott Basinger
	Brunswick Foot & Ankle Surgery, PA	Joseph Kibler
	Carmel Foot Specialists	Barbara Kaiser, Richard Lind, Richard Miller, Kevin Molan, Tori Simmons-Lewis
	Carolina Foot & Ankle Health Center	Millicent Brown
	Carolina Foot Care Associates, PLLC	Ashma Davidson, Terry Donovan(ret), William O'Neill
	Carolina Podiatry Group	Brandon Percival, Julie Percival, William Harris
	Central Carolina Foot & Ankle Associates	Melissa Hill, Gary Liao, Alan Sotelo, Phil Ward (ret.), John Iredale (ret.)
	Chapel Hill Foot & Ankle Associates, P.A.	Jane Andersen, Alan Bocko, Katherine Williams
	Charlotte Foot & Ankle Specialists, PLLC **(resigned from group 8/1/2017)**	Kristine Strauss
	Coastal Carolina Foot & Ankle	Thomas Hagan, Tyler Hagan
	Comprehensive Foot & Ankle Center, P.A.	Zack Nellas
	Crystal Coast Podiatry	Thomas Bobrowski
	Eastover Foot & Ankle, P.A. **(Resigned from Group 1/1/17)**	Chris Fuesy, Ron Futerman, Kent Picklesimer
	Family Foot & Ankle Center, P.A.	Patrick Dougherty, Doug Smith
	Family Foot Care	Kevin McDonald
	Foot & Ankle Center of Durham	Eric Simmons
	Foot & Ankle of the Carolinas, PLLC	Eric Ward, Blaise Woeste
	Gaston Foot & Ankle Associates, P.A.	David Kirlin, Ryan Meredith, Wagner Santiago, Randell Contento
	Greensboro Podiatry Associates, P.A.	Martha Ajlouny, N'Tuma Jah (resigned 12/21/17), Jonathan Simpson (eff: 1/1/18) Term 5/10/18
	Hendersonville Podiatry	Russ Barone(ret), Pam Stover
	James Mazur, D.P.M., P.A.	James Mazur
	Kinston Podiatry	Dale Delaney
	Matthews Foot Care	Brian Killian, Kevin Killian, David Ellenbogen
	Mt. Airy Foot & Ankle Center, PLLC	Jim Shipley, David Collard, Thurmond Siceloff
	Myers Podiatric Clinic	William Myers
	Piedmont Foot & Ankle Clinic	Rick Hauser, Rob Lenfestey (ret.), Jason Nolan, Joel Kelly, Elizabeth Bass Daughtry, Jacob Panici, Brian Futrell (eff:3/1/18)
	Piedmont Podiatry Associates	Subodh Choudhary, Nicholas Canoutas, Cassandra Pike, Sarah Fitzgerald, Smitha Joseph (ret.)
	Queen City Foot & Ankle Specialists, P.C.	Roxanne Burgess, Alison Garten
	Raleigh Foot & Ankle **(Resigned from Group 1/1/2018)**	Alan Boehm, Robert Hatcher, Jordan Meyers, Kirk Woelffer
	Ryan Foot & Ankle Clinic	David Garchar, Jeff Glaser, Michael Ryan, Scott Whitman, Matthew Borns
	Salem Foot Care	Walter Falardeau, Scott Matthews
	Summit Podiatry	Derek Pantiel
	Upstate Foot Care	Hans Blaakman
	Wake Foot & Ankle Center	Mike Hodos, Jim Judge
	Wilson Podiatry Associates, PA	Kendall Blackwell

_____ I attest that I have been seen in the above indicated division of the InStride since **01/01/2015.**

_____ I attest that to my best recollection, I have not been seen by any of the above divisions/physicians since **01/01/2015.**

Signature of patient: _____ Date: _____

Printed Name: _____ DOB: _____

CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours notice. This will allow another person who is waiting for an appointment slot.

Office appointments which are canceled with less than 24 hours notification may be subject to a **$25.00** cancellation fee.

Patient who do not show up for their appointment without a call to cancel an office appointment will be considered as **NO SHOW**. Patients who No-Show two (2) or more times in a 12 month period, may be dismissed from the practice thus they will be denied any future appointments.

The cancellation and No Show fees are the sole responsibility of the patient and **MUST be paid in full before the patient's next appointment.**

We understand that special, unavoidable circumstances may cause you to cancel within 24 hours. In this instance, fees may be waived but only with management approval.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no show fees should be directed to the office manager at (336)443.9190.

Please sign that you have read, understand and agree to this Cancellation and No Show Policy.

_____
Patient Name (Please Print)

_____
Signature of Patient or Patient Representative

_____
Date

Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or office manager.

- As our patient, **you are responsible** for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, **we will have to look to you for payment.**
- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the copay/coinsurance/deductible at the time of service.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, **you will be responsible** for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, **you remain responsible** for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all insurance changes and authorization/referral requirements. In the event the office is not informed, **you will be responsible** for any charges denied.
- For most services provided in the hospital, we will bill your health plan. Any balance due is **your responsibility.**
- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.
- Past due accounts are subject to collection proceedings. All cost incurred including, but not limited to collection fees, attorney fees and court fees shall be **your responsibility** in addition to the balance due at this office.
- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

Printed Name of Patient/Responsible Party: _____ Date: _____

Signature of Patient/Responsible Party: _____ Date: _____

_____ Patient initials to indicate copy received