PATIENT NAME: _____ Date of birth:_____

What sort of problem are you having today?_____

Location of problem and which foot? _____

How long has it been bothering you? _____ Days _____ Weeks _____Years

If you are having foot pain, would you describe it as: ☐Sharp ☐Shooting ☐Throbbing ☐Aching

List previous foot and/or ankle problems: _____

List previous foot and/or ankle surgical procedures:_____

MEDICAL INFORMATION

You **MUST** answer **ALL** questions! This information is VERY important for our records and your health!!

Do you have DIABETES? ☐YES ☐NO If yes, for how many years? _____ Do you take insulin? ☐YES ☐NO

List serious illnesses here: _____

List previous surgeries: _____

_____

Primary care physician:_____ Date last seen by this Dr. _____

Are you under a physician's care for any type of condition? ☐ YES ☐ NO If yes, what type of condition?_____

May we contact your physician about your health? ☐YES ☐NO

Are you allergic to any medications or substances? ☐YES ☐NO If yes, please list: _____

List the medications you take regularly, with dosages. (use the back of this paper If needed) _____

_____

Name & location of pharmacy: _____

Are you, or could you be pregnant? ☐YES ☐NO

Please indicate below any symptoms you have experienced in the **PAST 12 MONTHS.** Please check **ALL** that apply!!

CARDIOVASCULAR:	GASTROINTESTINAL:	GENERAL:	NEUROLOGIC:	RESPIRATORY	VASCULAR:
☐Shortness of breath ☐Chest Pains ☐Irregular Heartbeat	☐Difficulty swallowing ☐Indigestion/heartburn ☐Nausea/vomiting ☐Diarrhea ☐Blood in Stools ☐Stomach Pains	☐Common cold ☐Weight Loss ☐Weight Gain ☐Fever/chills ☐Night Sweats ☐Multiple joint pains ☐Tooth abscess/infection	☐Blurred vision ☐Migraines ☐Headaches ☐Numbness/tingling ☐Dizziness ☐Depression	☐Wheezing ☐Shortness of Breath ☐Chronic Cough	☐Bleeding Disorder ☐Blood Clots ☐Swollen Legs ☐Difficulty stopping bleeding after surgery

PAST MEDICAL HISTORY: **Have you ever been treated for, or been informed by a physician that you have any problems with the following**:

☐Anemia	☐Epilepsy	☐HIV / AIDS	☐Rheumatic Fever
☐Arthritis	☐Frequent infections	☐Intestinal problems	☐Stomach ulcers
☐Asthma	☐Gout	☐Kidney Disease	☐Stroke
☐Blood pressure problems	☐Healing problems	☐Liver Disease	☐Tuberculosis
☐Cancer	☐Heart problems	☐Lung Disease	☐Unexplained weight loss
☐Circulatory Disorders	☐Hepatitis	☐Neurological Disorder	☐Other, explain:
☐Depression	☐High cholesterol	☐Polio	
☐Drug Abuse	☐Hormone problems	☐Prolonged bleeding	

Do you have any surgically placed prosthesis -- heart valve, hip joint, etc.? ☐YES ☐NO
Do you smoke? ☐YES ☐NO Number of packs per day:_____ How long?_____ Have you smoked previously? ☐YES ☐NO
Do you drink alcohol? ☐YES ☐NO If yes, how often? ☐Light usage (1-2 weekly) ☐Moderate usage (1-2 daily) ☐Heavy usage (2+ daily)
EMPLOYMENT: ☐Sit at job ☐Stand at job ☐Stand and walk at job ☐Retired

FAMILY HISTORY

Mother ☐Living ☐Deceased Cause of death:_____
Father ☐Living ☐Deceased Cause of death:_____
Sibling 1 ☐Living ☐Deceased Cause of death:_____
Sibling 2 ☐Living ☐Deceased Cause of death:_____

Is there family (blood relative) history of: ☐Arthritis ☐Bunions ☐Hammertoes ☐Flat feet ☐ Circulation problems in legs or feet
☐Bleeding disorder ☐Neurological Disorder ☐Diabetes ☐Heart Disease ☐Stroke

PATIENT INFORMATION

Full Legal Name:_____Preferred name:_____

Mailing Address:_____City:_____Zip:_____

Patient's Date of Birth:_____ Sex: ☐Male ☐Female SSN: _____

Email address (for internal use only)_____

Home Phone:_____ Cell Phone: _____

Marital Status: ☐Married ☐Single ☐Widowed ☐Divorced ☐Separated ☐Domestic Partner

Spouse's name:_____Date of Birth:_____

EMERGENCY CONTACT: Name:_____

Phone:_____Relationship to patient:_____

Please tell us how you found Crystal Coast Podiatry:

☐Doctor (name)_____ ☐Family/Friend ☐Internet ☐Other (please specify)_____

PRIMARY CARE PROVIDER: (Required for ALL Medicare/Advantage plans)

Name:_____Location:_____

Who is responsible for payment? ☐ Self ☐Other -- If someone other than patient, provide information below

Full Legal Name:_____Relationship to patient:_____

Address:_____

Phone:_____ ☐Cell ☐Home Date of Birth:_____

DESIGNATION OF RELATIVES, CLOSE FRIENDS, CAREGIVERS AS REPRESENTATVE:

I agree that the practice may disclose certain of my health information to a Personal Representative of my choosing, since this person is involved with my health care or payment relating to my health care. In that case, the practice will disclose only information that is directly relevant to the person's involvement with my health care or payment.

Print Name: _____ Phone #_____ Relation:_____

Print Name: _____ Phone #_____ Relation:_____

Print Name: _____ Phone #_____ Relation:_____

Thomas J. Bobrowski, D.P.M.
InStride Crystal Coast Podiatry
3109 Trent Road New Bern, NC 28562
Phone: 252.638.4700 Fax: 252.638-5766
www.crystalcoastpodiatry.com • www.instridefoot.com

Welcome "New Patients"

Our practice is a division of **InStride Foot & Ankle Specialists, PLLC**. We have divisions across North and South Carolina. As such, if you have seen any of the following physicians in the past **three years**, we need to know so that we can file your insurance appropriately.

Visits prior to 2019 do not need to be disclosed.

If you have been seen at any of the divisions below, please put a **√** on the line to the left of the practice name. Thank you for disclosing this information to us – this will allow for us to be in compliance with nationally mandated correct coding initiatives.

InStride Foot and Ankle Specialist Inner Coastal and Tidewater Region Locations:

Brunswick Foot & Ankle Surgery, PA	Joseph Kibler, Amy Kibler OT
Coastal Carolina Foot & Ankle	Thomas Hagan, Tyler Hagan
Crystal Coast Podiatry	Thomas Bobrowski
Kinston Podiatry	Dale Delaney
Roberson Foot Care, PC	Ainsley Rusevlyan
Summit Podiatry	Derek Pantiel Kevin Bachman (on/after 01/01/2019) Susie Sant'Anna (on/after 3/10/2020)
Wilson Podiatry Associates, PA	Kendall Blackwell

****If you have seen a Podiatrist in NC or SC and their name is not listed above, please list that provider's name on the line below:

Please check **ONLY ONE** of the following statements:

☐ I attest that to my best recollection, I have **NOT** been seen by any of the above divisions of InStride in the past **3** years.

☐ I attest that I have been seen by the above indicated physician in the past **3** years.

Signature of Patient or Personal Representative Date

CONSENTS AUTHORIZATIONS AND ASSIGNMENT OF BENEFITS

1. CONSENT TO TREAT: The undersigned consents to INSTRIDE FOOT & ANKLE SPECIALISTS, PLLC and its providers performing any initial or subsequent evaluations, examinations, x-rays, laboratory procedures, other tests, medications, medical treatment, surgery, physical therapy, home instructions, orthotics, or other durable medical equipment. The undersigned acknowledges that it is their duty to schedule the patient's follow-up appointments, other services, prescriptions, and ordered items. An ownership stake in pathology services may provide financial benefits to some INSTRIDE FOOT & ANKLE SPECIALISTS, PLLC physicians.

You have the right to choose a different pathology provider because of this ownership interest, and we will make arrangements for you to do so upon your request. The undersigned also acknowledges that while providers exercise reasonable skill and diligence in providing care, they do not guarantee outcomes or treatment.

2. DIGITAL E-PRESCRIBING: I authorize INSTRIDE FOOT & ANKLE SPECIALISTS, PLLC and its associates to view my external prescription history via electronic e-prescribing services. I understand that prescription history from multiple, other unaffiliated, providers, insurance companies, pharmacies and pharmacy benefit managers may be viewable by the providers and staff of INSTRIDE FOOT & ANKLE SPECIALISTS, PLLC and it may include prescriptions back in time for several years and may include prescriptions to treat HIV, substance abuse and psychiatric conditions. If applicable, I understand that my prescription history will become part of my record at this practice. I understand all of the above, I hereby provide informed consent to INSTRIDE FOOT & ANKLE SPECIALISTS, PLLC to enroll me in the e-prescribe program. This consent will remain enforced until revoked or changed.

3. ASSIGNMENT OF BENEFITS: I hereby irrevocably assign, transfer and convey to INSTRIDE FOOT & ANKLE SPECIALISTS, PLLC and any practitioner providing care and treatment to me/my dependent, any and all benefits and all interest and rights (including causes of action, the right to enforce payment and the right to appeal an adverse benefit determination) to which I am entitled under an employee benefit plan sponsored by my employer, all insurance policies, benefits, any third-party reimbursement, or prepaid health care plan for services rendered or products I received from INSTRIDE FOOT & ANKLE SPECIALISTS, PLLC.

4. MEDICARE ASSIGNMENT: I agree to complete the Medicare screening form annually and certify that the information I provided when applying for payment under Section XVIII of the Social Security Act is accurate. I grant permission for the Social Security Administration or its intermediaries to obtain information about me, as well as any information required to submit a Medicare claim on my behalf. I request that payment and authorized benefits be made on my behalf. I assign benefits payable for services to INSTRIDE FOOT & ANKLE SPECIALISTS, PLLC.

5. AUTHORIZATION TO RELEASE INFORMATION: I give INSTRIDE FOOT & ANKLE SPECIALISTS, PLLC and its agents permission to share my health information with any of the following entities for payment, treatment, or healthcare operations: any practitioner, support staff, or facility involved in my care plan or care transfer, as well as my insurance company and its affiliates. I am aware that the Privacy Notice outlines the potential uses and disclosures of my Health Information. On our website, you can find the HIPAA Notice of Privacy Practices. Individual copies are available in the lobby and in the office. I have read my HIPAA rights, which include paying for records, and I have had the opportunity to read them.

6. DESIGNATION OF AUTHORIZED REPRESENTATIVE: I authorize INSTRIDE FOOT & ANKLE SPECIALISTS, PLLC (and its agents) to act on my behalf to recover benefits from my employee benefit plan, insurance policy, and any third-party reimbursement or prepaid health care plan by: 1) requesting and receiving a copy of the summary plan description; 2) pursuing a benefit claim; 3) appealing any adverse benefit determination; and/or 4) filing a legal/equitable action. I acknowledge and agree that my designated representative shall have full authority to act and receive notices on my behalf with regard to an initial determination of the claim for health benefits relating to treatment and health care services received by me or my dependent at INSTRIDE FOOT & ANKLE SPECIALISTS, PLLC, any requests for documents relating to this claim, and an appeal of an adverse claim determination.

7. FINANCIAL AGREEMENT: To the extent I am legally obligated to do so, I hereby promise to pay for any and all goods or services received or provided to me or my dependent. I am aware that I am responsible for any and all copayments, deductibles, coinsurances, OTC (over-the-counter) convenience items, non-covered services, and other charges incurred during the service or during the pre-operative appointment. I, as the designated responsible party, am liable for all funds owed to INSTRIDE FOOT & ANKLE SPECIALISTS, PLLC in the event that the insurance company misrepresents their coverage or delays payment of a claim for more than 60 days. This applies regardless of the assignment of benefits. Additionally, I am aware that the insurance contract is between me and the company; As a result, if a policyholder has questions about benefits, they should first get in touch with the insurance company.

INITIAL HERE: _____

CONSENTS AUTHORIZATIONS AND ASSIGNMENT OF BENEFITS

8. CONSENT FOR PHOTOGRAPHY: I authorize INSTRIDE FOOT & ANKLE SPECIALISTS, PLLC to take photographs during the course of my treatment. I understand that the media is the property of INSTRIDE FOOT & ANKLE SPECIALISTS, PLLC, and I may obtain a copy upon my written request. I agree and authorize the use of the media in my medical record and for teaching purposes, which includes being shown to other patients. I am aware that my name and identity will not be disclosed.

9. CONSENT FOR COMMUNICATION: I give INSTRIDE FOOT & ANKLE SPECIALISTS, PLLC and its associates permission to call me at any account-associated phone number, including wireless phone numbers, that could result in charges to me. INSTRIDE FOOT & ANKLE SPECIALISTS, PLLC, and its partners may likewise reach me by sending instant messages or messages, utilizing any email address you give us to utilize. Pre-recorded or artificial voice messages and/or an automatic dialing device may be used as methods of communication.

10. PRIVACY NOTICE: I understand that INSTRIDE FOOT & ANKLE SPECIALISTS, PLLC may use and disclose my protected health information for purposes of treatment, payment, and health care operations. We may use your protected health information for our own health care operations and for those of the Organized Health Care Arrangements in which we participate. I also acknowledge that I have received, have been offered to read the notice at www.instridefoot.com, or have received in the past a copy of the Practice's Notice of Privacy Practices, which provides information about how the practice, and individuals involved in my care in the practice, may use and disclose my protected health information. As provided in the notice, the terms of the notice may change. To obtain a copy of any current notice, contact the privacy office at INSTRIDE FOOT & ANKLE SPECIALISTS, PLLC.

I understand that I have the right to request that the practice restrict how my protected health information is used or disclosed for treatment, payment or health care operations, but I also understand that the practice is not required to agree to a requested restriction.

However, if the practice does agree, it is bound by that agreement. I understand that I have the right to revoke this consent in writing at any time, except to the extent that the practice, or individuals involved in my care in the practice, have already used or disclosed protected health information in reliance on my prior consent.

AFFIRMATION:

I certify, to the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

I give permission to the practitioners at InStride Foot and Ankle Specialists to administer and perform any diagnostic, therapeutic and/or operative procedures as may be deemed medically necessary in diagnosis and/or treatment of my condition.

Patients/minors under the age of 18, will not be treated without a parent or legal guardian present. If another family member, caretaker or friend, over the age of 18 will be present; written consent from the parent/legal guardian stating as such must be presented at the time of the appointment. Thank you.

_____ _____

Patient Name (PRINT) Legal Guardian (PRINT)

_____ _____

Patient signature Legal Guardian signature

_____

Date

OFFICE POLICIES & PROCEDURES

These policies have been established to help us contain costs and provide the best possible care to all patients.

1. Our office will work to determine your insurance benefits prior to your visit. Please note that payment in full is expected at the time of your visit based on the benefits provided by your insurance carrier.

2. The patient is responsible for all insurance coverage, co-insurance, deductible, and copays.

3. The patient is responsible for any required referral prior to his/her visit.

4. If your check is dishonored/returned for any reason, we will electronically debit your account for the amount of the check + $35 processing fee.

5. There is a $25.00 fee charged for all paperwork completed by doctors. (i.e. Disability forms, FMLA paperwork, etc.) Please allow at least 3 business days for these requests.

6. Requests for copies of medical records: Pursuant to North Carolina code § 90.411 the fee is $10.00 plus 50 cents per page for the first 50 pages; then 25 cents per page thereafter. Any applicable postage fees will also be assessed. There is a $10 fee to copy x-rays to disc. Please allow at least 3 business days for these requests.

7. All medical devices and durable medical equipment (custom orthotic, insoles, walking cast boots, night splints, surgical shoes, orthotics, etc.) are non-refundable.

8. There is a $7 per month billing fee for accounts unpaid after thirty days

9. Billing questions pertaining to lab fees should be directed to the lab from which the bill was received.

10. There is a $45 no show fee or failure to reschedule at least 24 hours in advance of the appointment.

I HAVE READ AND UNDERSTAND THE ABOVE POLICIES.

Please print patient name here date of birth

Signature today's date