KF &A KNIGHT FOOT & ANKLE

Patient Demographic Form

Patient Information:		
Last Name:	First Name:	M.I:
Date of Birth:		SSN#:
Mailing Address:		
City/State/Zip:		
Home Phone:	Cell Phone:	Work Phone:
Primary Care Provider:		Date Last seen:

Email:		Preferred Method of Contact: ☐ Phone ☐ Email
Marital Status: ☐ Divorced ☐ Married ☐ Single ☐ Other	Sex: ☐ Male ☐ Female	Employer Name:
Emergency Contact Name & Number:		

Primary Medical Insurance	**Secondary Medical Insurance**
Ins. Co. Name:	Ins. Co. Name:
Policy Holder:	Policy Holder:
Policy Number:	Policy Number:
Policy Holder's SSN:	Policy Holder's SSN:

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Race (please select): Ethnicity (please select one): ☐ White ☐ American Indian ☐ Alaska Native ☐ Asian ☐ Hispanic or Latino ☐ African American ☐ Native Hawaiian or Pacific Islander ☐ Not Hispanic or Latino ☐ Other ☐ Decline	Preferred Language (please select one): ☐ English ☐ Indian (including Hindi & Tamil) ☐ Sign Language (ASL / Other Type) ☐ Spanish ☐ Russian ☐ Other • If non-english speaking and need a translator, please notify us of this ASAP. We may need to reschedule your appointment to allow us time to make arrangements.

Preferred Pharmacy Name:
Pharmacy Address:
Pharmacy Phone:

Patient Information

I certify that I have read and agree to the KFA payment policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to KFA all money to which I am entitled for medical expenses related to the services performed from time to time by Knight Foot and Ankle, but not to exceed my indebtedness to KFA. I authorize KFA to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90days of notification of the amount due will result in submission to an outside collection agency. A $20.00 returned check fee will be charged for checks returned due to insufficient funds. I choose to receive communications from KFA by phone or email at the number or address listed above, including but not limited to communication about appointments, feedback, treatment and payment. I understand that such e-mails and calls may not be secure and there is a risk that they may be read by third party comments submitted on surveys and may be anonymously shared on Knight Foot and Ankle's public website.

☐ I have reviewed a copy of Knight Foot and Ankle's Policy Notice.

Printed Patient Name: _____ DOB: _____

Signature of Patient/Representative: _____Date: _____Relationship if Representative: _____

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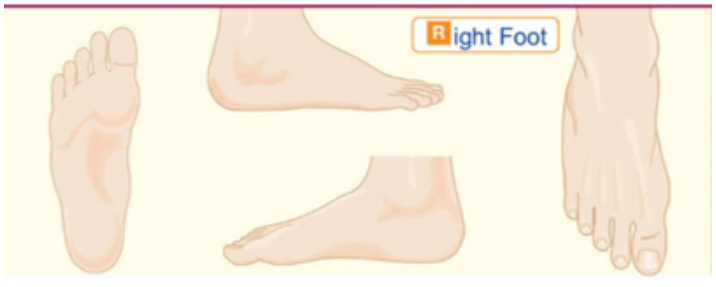
New Patient Complaint Form

Patient Name: _____ DOB: _____

Primary Complaint: **Rate the severity of your issue on a scale of 1 to 10: _____**

Location:	**Was there an injury? If so, please briefly list the incident.**
Brief description of problem/pain.	**Has any imaging been done for this problem? (XRAY, MRI, CT)**
	If so, where was this done?
Is this a work related injury?	**Duration of problem/pain.**

Please CIRCLE the corresponding area(s) of pain in the diagrams below:



Secondary Complaint:

Location:

Rate the severity of your issue on a scale of 1 to 10: _____

Additional Notes For The Provider:

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Patient Name: _____ DOB: _____

DRUG ALLERGIES AND MEDICATION HISTORY: List ALL DRUG ALLERGIES AND MEDICATIONS you may take, including over the counter (OTC) medications and vitamins. Include specific doses and when taken. If you have a medication list, please provide a copy to the medical staff.

Current Medications: _____

_____

Drug Allergies:

_____

PERSONAL MEDICAL HISTORY: (Please mark all that apply)

☐ ADHD	☐ Renal Dialysis	☐ Neuropathy
☐ COPD	☐ High Cholesterol	☐ Heart Disease
☐ Rheumatoid Arthritis	☐ Alcoholism	☐ Bladder Problems / Incontinence
☐ Dementia	☐ HIV	☐ Parkinson's Disease
☐ Seizure Disorder	☐ Allergies	☐ Peripheral Vascular Disease
☐ Seasonal Depression	☐ Hepatitis	☐ High Blood Pressure
☐ Diabetes	☐ Anemia	☐ Headaches
☐ If diabetic, last A1C: ____	☐ Irritable Bowel Syndrome	☐ Psoriasis
☐ Stroke	☐ Anxiety	☐ Kidney Disease / Kidney Stone
☐ Cancer	☐ Lupus	☐ Bipolar
☐ Thyroid Disorder	☐ DVT (Blood Clot)	☐ Osteopenia/Osteoporosis
☐ Arrhythmia (irregular heart beat)	☐ Liver Disease	☐ Heart Attack (MI)
☐ Pulmonary Embolism (PE)	☐ Arthritis	☐ Bleeding Problems
☐ GERD (Acid Reflux)	☐ Macular Degeneration	☐ History of Foot Ulcer
☐ Asthma	☐ Glaucoma	☐ Other: _____

Other medical problems if not listed above: _____

List other medical providers you see on a regular basis (i.e. Cardiologist, Kidney Doctor, Dentist, etc.):

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SURGICAL HISTORY. Please list all prior surgeries and approximate dates performed.

SOCIAL HISTORY:

Are there any vision or hearing problems that affect your communication? ☐Yes ☐ No

Are there any limitations to understanding or following instructions (either written or verbal)? ☐Yes ☐ No

Smoking/ Tobacco Use: ☐ Current ☐ Past ☐ Never; Type: _____ Amount/day: _____ # of Yrs: _____

Alcohol: ☐ Current ☐ Past ☐ Never Drinks/week: Recreational Drug Use: ☐ Current ☐ Past ☐ Never; Type:

FAMILY HISTORY: Please list any family medical history below.

FATHER:_____

MOTHER: _____

Siblings: _____

Medical Release Permission

I _____, authorize **Knight Foot and Ankle** to speak to the following person(s) regarding medical information, including but not limited to records pertaining to examinations, treatments, consultants, billing records, imaging and reports, history, laboratory findings, admissions and discharge reports, treatment records, diagnosis and prognosis records, nurse's and doctor's notes and any other non-medical information in my file.

Name of Authorized Person:	Relationship to patient:	Phone Number:

I also understand that I may terminate this at any time. To terminate this, I must notify the staff at Knight Foot and Ankle in writing with the termination date and the date of effectiveness.

Printed Patient Name: _____ **DOB:** _____

Signature of Patient/Representative: _____**Date:** _____**Relationship if Representative:** _____

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PATIENT FINANCIAL & PAYMENT POLICY

This financial payment policy is an agreement between Knight Foot and Ankle and you, the patient, or the responsible party. By signing the patient registration form, you are acknowledging that you understand and agree to our financial payment policy. Your appointment today may be for an initial consultation; however, it may be medically necessary to perform additional testing. If you have questions about the cost, please ask any member of our staff, as you or your insurance company will be charged for services rendered. **We are happy to file any insurance on your behalf, but please be aware that we do not participate in all plans**.

Patient Responsibility:

- You must provide us with a current insurance card and billing information. Your insurance policy is a contract between you and the insurance company. It is your responsibility to know your insurance benefits and pay any remaining portion due after insurance processes your claim.
- ***Copays are due at the time of service.***
- ***ALL Cash Pay Services are due BEFORE the service is provided.***
- NSF Fees: A $20.00 returned check fee will be charged for checks returned due to insufficient funds.

I understand that I am financially responsible for all charges regardless of third-party involvement. I agree to pay any deductible, co-insurance, copay, or any service(s) deemed a “non-covered benefit” by my insurance company. I understand that failure to pay outstanding balances within 90 days of receiving my first statement will result in the submission of my account to an outside collection agency. If the debt remains after transfer to our outside collection agency, the debt may be reported to credit bureaus and your credit rating may be affected. In addition, failure to pay delinquent account balances may result in termination of care from Knight Foot and Ankle.

Printed Patient Name: _____ DOB: _____

Signature of Patient/Representative: _____Date: _____Relationship if Representative: _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of your protected health information, to notify you of our legal duties and privacy practices with respect to your health information, and to notify affected individuals following a breach of unsecured health information. This Notice summarizes our duties and your rights concerning your information. Our duties and your rights are set forth more fully in 45 CFR Part 164. We are required to abide by the terms of our Notice that is currently in effect.

1. Uses And Disclosures We May Make Without Written Authorization . We may use or disclose your health information for certain purposes without your written authorization, including the following:

Treatment. We may use or disclose your information for purposes of treating you. For example, we may disclose your information to another health care provider so they may treat you; or to provide information about treatment alternatives or services we offer.

Payment. We may use or disclose your information to obtain payment for services provided to you.

Healthcare Operations. We may disclose your PHI for activities that are necessary to operate our practice and optimize patient care.

Other Disclosures. We may disclose your information for other purposes allowed by 45 CFR § 164.512 including:

- To avoid a serious threat to your health or safety or the health or safety of others.
- As required by state or federal law such as reporting abuse, neglect or certain other events.
- As allowed by workers compensation laws for use in workers compensation proceedings.
- For certain public health activities such as reporting certain diseases.
- For certain public health oversight activities such as audits, investigations, or licensure actions.
- In response to a court order, warrant or subpoena in judicial or administrative proceedings.
- For certain specialized government functions such as the military or correctional institutions.

2. Uses and Disclosures with Your Written Authorization . Other uses and disclosures not described in this Notice will be made only with your written authorization, including most uses or disclosures of psychotherapy notes; for most marketing purposes. You may revoke your authorization by submitting a written notice to the Privacy Contact identified below. The revocation will not be effective to the extent we have already taken action in reliance on the authorization.

3. Your Rights Concerning Your Protected Health Information . You have the following rights concerning your health information. To exercise any of these rights, you must submit a written request to the Privacy Officer identified below.

- You may request additional restrictions on the use or disclosure of information for treatment, payment or healthcare operations. We are not required to agree to the requested restriction except in the limited situation in which you pay for an item or service, and you request that information concerning such item or service not be disclosed to a health insurer.
- We normally contact you by telephone, mail at your home address and possibly by e-mail. You may request that we contact you by alternative means or at alternative locations. We will accommodate reasonable requests.
- You may inspect and obtain a copy of records that are used to make decisions about your care or payment for your care, including an electronic copy. We reserve the right to charge you a reasonable cost-based fee for providing the records.
- You may request that your protected health information be amended. We may deny your request for certain reasons, e.g., if we did not create the record or if we determine that the record is accurate and complete.
- You may receive an accounting of certain disclosures we have made of your protected health information. You may receive the first accounting within a 12-month period free of charge. We may charge a reasonable cost-based fee for all subsequent requests during that 12-month period. You may obtain a paper copy of this Notice upon request.

4. Complaints. You may complain to us or to the Secretary of Health and Human Services. If you believe your privacy rights have been violated. You may file a complaint with us by notifying our Privacy Officer. All complaints must be in writing.

5. Contact Information. If you have any questions about this Notice, or if you want to object or complain about any use or disclosure or exercise any right as explained above, please contact our privacy officer: Kayla Nichols, p:405-513-0385 Address: 941 W I-35 Frontage RD St. 116, PMB #595 Edmond, OK 73034 E-mail:kayla@knightfootandankle.com

Printed Patient Name: _____ **DOB:** _____

Signature of Patient/Representative: _____**Date:** _____**Relationship if Representative:** _____