Dr. Rosana Rodriguez
Dr. Beth Pearce
Address: 6 St. Johns Medical Park Dr. St. Augustine, FL 32086
Phone: 904-823-3301 | Fax: 904-823-3328

NEW PATIENT DEMOGRAPHICS

DATE: ______________________

PATIENT NAME: ____ DOB: ______________________

SS.#: ______________________ GENDER: ☐ M ☐ F HEIGHT: _________ WEIGHT: ________________

MARITIAL STATUS: _____________________________ OCCUPATION: ______________________________

PREFERRED LANGUAGE: ________________________ RACE: ____________________________________

HOME ADDRESS: ____

CITY: ________________________ STATE: ____________________ ZIP: ___________________________

MAILING ADDRESS: ____
(IF DIFFERENT FROM ABOVE)

PHONE NUMBER: _____________________ _____________________ ___________________________
(HOME) (CELL) (WORK)

EMAIL ADDRESS: ____ / NO EMAIL ADDRESS: _____

EMERGENCY CONTACT: ________________________ _________________ ______________________
(NAME) (RELATION) (CONTACT NUMBER)

NEXT OF KIN: _________________ ____
(NAME) (RELATION) (CONTACT NUMBER)

PRIMARY INS: _______________________ ID#: _____________________ GRP#: ____________________

SEC. INS. POLICY: ____________________ ID#: _____________________ GRP#: ____________________

PRIMARY CARE PHYSICIAN: ____

PHARMACY: ____

HOW WERE YOU REFERRED TO US?
Please check one:

☐ Physician Who: ______________________
☐ Insurance
☐ Google/Internet
☐ Other: _____________________________
☐ Other patient
☐ Friend/Family
☐ Magazine/Newspaper

Dr. Rosana Rodriguez
Dr. Beth Pearce
Address: 6 St. Johns Medical Park Dr. St. Augustine, FL 32086
Phone: 904-823-3301 | Fax: 904-823-3328

MEDICAL HISTORY

☐ **NO PREVIOUS DIAGNOSIS** ☐ **NO MEDICATION ALLERGIES**

MEDICATION ALLERGIES:

ARE YOU ALLERGIC TO ADHESIVE TAPE: ☐ YES ☐ NO

DO YOU SMOKE? ☐ YES ☐ NO

How much: ________________ Duration: ________________

DO YOU DRINK ALCOHOL: ☐ YES ☐ NO

How much: ________________ Duration: ________________

DO YOU TAKE BLOOD THINNERS? ☐ YES ☐ NO

MEDICATION: ________________

DO YOU TAKE ANTIBIOTICS BEFORE ANY PROCEDURES? ☐ YES ☐ NO

ANTIBIOTIC:________________

HAVE YOU EVER BEEN DIAGNOSED WITH:

☐ Diabetes	☐ Low Blood Pressure	☐ High Blood Pressure	☐ High Cholesterol
☐ Low Cholesterol	☐ Cancer	☐ HIV/AID	☐ Hepatitis
☐ Cardiac Disease	☐ COPD	☐ Depression	☐ Asthma
☐ Arthritis	☐ Seizures	☐ Anemia	☐ Poor Circulation
☐ Stroke	☐ Osteoporosis	☐ Tuberculosis	☐ Gout
☐ Kidney Disease	☐ Sickle Cell	☐ Hemophilia	☐ Emphysema
☐ Emphysema	☐ Varicose Veins	☐ Blood Clots	☐ Syncope
☐ Thyroid			

PHOTO CONSENT

☐ I agree and authorize the use of the photos, films, &/ videos for treatment, medical record keeping, and teaching purposes within the office only.

☐ **I DO NOT** AGREE NOR AUTHORIZE THE USE OF MY IMAGES.

PATIENT NAME: ________________SIGNATURE: ________________

Dr. Rosana Rodriguez
Dr. Beth Pearce
Address: 6 St. Johns Medical Park Dr. St. Augustine, FL 32086
Phone: 904-823-3301 | Fax: 904-823-3328

NEW PATIENT MEDICATION LOG

PATIENT NAME: ____ **DATE OF BIRTH:** ________________

☐ **NOT CURRENTLY TAKING ANY MEDICATIONS**

No.	MEDICATION NAME	DOSAGE	FREQUENCY
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

NEW PATIENT SURGICAL LOG

PATIENT NAME: ____ **DATE OF BIRTH:** ________________

☐ **DENIES ANY SURGERIES**

No.	SURGICAL PROCESURE	ESTIMATED DATE
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

Dr. Rosana Rodriguez
Dr. Beth Pearce
Address: 6 St. Johns Medical Park Dr. St. Augustine, FL 32086
Phone: 904-823-3301 | Fax: 904-823-3328

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I have a certain right to privacy regarding my Protected Health Information (PHI). I understand this information can and will be used to:

- Conduct, Plan, Direct my treatment, and Follow Up among the multiple healthcare providers who are involved in my treatment directly and/or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations, such as quality assessments and physician certifications.

I have received, read, and understand your Notice of Privacy Practices containing a complete description of the uses and disclosures of my health information. I understand that **ALL ABOUT FEET & LEGS, P.A.** has the right to change its Notice of Privacy Practices at any time and that I may contact **ALL ABOUT FEET & LEGS, P.A.** at any time at the addresses above to obtain a copy of the Notice of Privacy Practices.

I understand that I may request in writing that **ALL ABOUT FEET & LEGS, P.A.** restricts my private information to be used or disclosed to carry out treatment, payment, or other healthcare operations. I also understand you are not required to agree to my requested restrictions, but if it does agree, then you are bound to abide by such restrictions. I request and authorize **Dr. Rosana Rodriguez** and the assistant of her choice to perform Medical Treatment.

I understand I am responsible for any co-payment, co-insurance, or deductible at the time of service unless prior arrangements have been made. I authorize the release of any medical information and records concerning my diagnosis and treatment to any third party: (Insurance Companies, Gov't Agencies, or Physicians). This is necessary for the use of determining payment or continuing medical treatment.

MEDICARE PATIENTS:

I certify that the information given by me in applying for payment under title XVII/XIX of the social security act is correct. I authorize any medical or other information needed for determining a claim for payment of treatment and/or diagnosis to be released to the Social Security Administration and its intermediaries and/or carriers.

PATIENT NAME: ________________________________ SIGNATURE: ________________________________

RELATIONSHIP TO PATIENT: ____ DATE: __________________

Dr. Rosana Rodriguez
Dr. Beth Pearce
Address: 6 St. Johns Medical Park Dr. St. Augustine, FL 32086
Phone: 904-823-3301 | Fax: 904-823-3328

PATIENT FINANCIAL POLICY

If you have any questions, please discuss them with our front office staff or supervisor.

- 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 is due at the time of service. We will accept cash, or check ONLY.
- 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 the assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay, co-insurance, 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 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 authorization. You will be responsible for the complete charge. We will attempt to verify services. In the event your health plan determines a service to be not covered, or you do not have any 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.
- Past due accounts are subject to collection proceedings. All costs incurred, including, but not limited to, collection fees, attorney fees, and court fees shall be your responsibility in addition to the balance due to this office.

PATIENT NAME: ______________________________ PATIENT SIGNATURE: __________________________________

WITNESS SIGNATURE: ____

RELATIONSHIP: ____

Dr. Rosana Rodriguez
Dr. Beth Pearce
Address: 6 St. Johns Medical Park Dr. St. Augustine, FL 32086
Phone: 904-823-3301 | Fax: 904-823-3328

ALL ABOUT FEET AND LEGS APPOINTMENT POLICIES

Due to a significant increase in the number of broken appointments, we find it necessary to implement the following policies:

1. A 'broken' or 'failed' appointment is any appointment not canceled with at **LEAST 24 HOURS** notice. Broken appointments prevents us from seeing another patient in the time reserved, especially for **YOU**.
2. After the first failed appointment, you will be reminded of our policy. We are aware that emergencies do occur, which prevents you from keeping your appointment. Please contact our office as soon as you realize you cannot fulfill your appointment. After hours, you may leave a message on our answering machine at this phone number **904-823-3301.** Please include your name, date, and time of scheduled appointment and a call back number where you may reached to reschedule.
3. After the second and subsequently failed appointments, we reserve the right to charge a broken appointment fee.
4. If an appointment is canceled or rescheduled three or more consecutive times, without appropriate reasoning, the practice reserve the right to send a letter to the patient giving them **30 days** to find another physician, and they will be discharged from the practice.

There will be a $50.00 Fee for Missed Appointments without a 24 hours advanced notice if not due to an emergency.

- **Surgery Appointments:** A deposit in the amount of **$75.00** per surgical procedure, or series of surgical procedures will be collected at the time of scheduling that the doctor has reserve for you. Without a **48 hour** notice you deposit will be applied towards your broken appointment.
- We will retain this deposit as compensation for the time reserved.
- Please note that insurance companies will not pay broken appointment fees.

I UNDERSTAND THE APPOINTMENT POLICES OF ALL ABOUT FEET AND LEGS AND AGREE TO ABIDE BY THEM. ANY QUESTIONS I HAVE ABOUT THESE POLICIES HAVE BEEN EXPLAINED BY THE OFFICE STAFF.

Signature: ______________________________

Date: ______________________________

Print Name: ______________________________

Dr. Rosana Rodriguez
Dr. Beth Pearce
Address: 6 St. Johns Medical Park Dr. St. Augustine, FL 32086
Phone: 904-823-3301 | Fax: 904-823-3328

MEDICAL RECORDS AUTHORIZATION

Patient Name: ____ DOB: __________________ MR#: __________________

Patient address: ____

Phone No:____

I ☐ Request from ☐ Release to Physician Name: ____

Phone #: ____ Fax #: ____

Records Requested:

☐ Labs (Pathology)
☐ Immunization records
☐ All Records on file
☐ Office Visit/Physical Exam
☐ Diagnostic Testing (XRAY, CT, MRI)
☐ Other: ___________________

I, ____ authorize the release/request of any medical records. I understand that the information disclosed in this authorization may contain sensitive information, including any or all records relating to sexually transmitted diseases, HIV or AIDS viruses, behavioral or mental health, drug and/or alcohol abuse. I understand I have the right to revoke this authorization at any time. If I choose to do so, I must provide a written authorization revocation and present it to this facility/office. I understand that the revocation will not apply to any documentation or information that has already been authorized and received prior to my revocation. I also understand that my revocation will not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy.

I understand that once the above information is disclosed, it may be re-disclosed by the recipient, and the information may not be protected by federal privacy laws and regulations I understand authorizing this disclosure and authorization that is completely voluntary. I need not sign this from to ensure healthcare treatment.

____

Patient Signature

* Please ensure you have completed the above forms to the best of your ability prior to your submittal. Please email to **aboutfeetstaff@gmail.com** once complete. This will send your forms to our staff for review and scheduling of your appointment.