



Today's Date: _____

Whom may we thank for your referral? _____

Patient Information

Patient's Name: _____ Date of Birth: _____ Age: _____

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

Primary Phone: _____ Alternate Phone: _____

Email Address: _____

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

Parent/Guardian's Name (If Patient is a Minor): _____ Relationship: _____

Email _____ Phone: _____

We may send appointment reminders and billing notifications by email or text.

Emergency Contact

Name: _____ Phone: _____ Relationship: _____

Insurance Information

Primary Insurance: _____ ID#: _____ Group #: _____

Subscriber Name _____ Subscriber DOB: _____ Relationship _____

Secondary Insurance: _____ ID#: _____ Group #: _____

Subscriber Name _____ Subscriber DOB: _____ Relationship _____

Referral Source

How did you hear about our office?

☐ Physician Referral

☐ Friend / Family

☐ Google / Internet Search

☐ Yelp

☐ Insurance Website

☐ Other _____

Optional Demographic Information

Race

☐ American Indian / Alaskan

Native

☐ Asian

☐ Black / African American

☐ Caucasian

☐ Decline to State

Ethnicity

☐ Hispanic

☐ non-Hispanic

☐ Decline to State

Preferred Language

☐ English

☐ Spanish

☐ Vietnamese

☐ Tagalog

☐ Mandarin

MEDICAL HISTORY

Reason For Visit

What foot or ankle problem brings you to our office today? Please be specific.

How long have you had this problem? _____

Pain Level (0-10): _____

Location of Problem

- ☐ Heel
☐ Arch
☐ Ball of Foot
☐ Toenail
☐ Ankle
☐ Skin
☐ Other _____

Which Foot

☐ Right ☐ Left ☐ Both Shoe Size: _____

Health Information

Weight: _____ Height: _____

Are you in general good health? Yes ☐ No ☐ If not, reason? _____

Previous treatment of feet by a doctor: No ☐ Yes ☐ When: _____ Doctor: _____

Have you been under a Physician's care during the past year? No ☐ Yes ☐

When: _____ Doctor: _____

Primary Care Physician: _____ Phone: _____

Address: _____ City: _____ Last Visit: _____

Pharmacy Name: _____ City: _____ Phone: _____

Surgeries/Hospitalizations

Current Medications:

Daily Vitamins _____ Daily Aspirin _____

MEDICAL HISTORY (Continued)

Medical Conditions (Circle if applicable)

Diabetes Type I / Type II	Thyroid	Blood Disease	Phlebitis
Low Back Pain	Anemia	Ulcer	Gonorrhea
Asthma	Liver Trouble	Eye Trouble	Cancer: _____
Arthritis	Heart Murmur	Blood Pressure	Drug Reaction
Blood Clot	Tuberculosis	Syphilis	Gout
Depression	Bleeding Disorder	Rheumatic Fever	Sickle Cell
Heart Disease	Anxiety	Stroke	Other _____

Are you allergic or sensitive to any of the following medications? (Circle if applicable)

Novocain / Local Anesthetics	Penicillin	Jewelry	Foods
Shellfish	Aspirin	Sulfa	Iodine
Adhesive Tape	Latex	Codeine	Metals
Other Drugs _____			None

Lifestyle

Do you smoke tobacco, marijuana or vape?

☐ Never ☐ Former ☐ Current

Alcohol Use

☐ Never ☐ Occasionally ☐ Frequently

FINANCIAL POLICY & OFFICE POLICIES

We appreciate your decision to trust our office with your medical care. Our team is dedicated to offering expert and high-quality services. Please note that by choosing to receive medical services here, you may have some financial responsibilities.

Insurance: We participate with many insurance plans and will submit claims on your behalf.

- Copayments, coinsurance, and deductibles are due at the time of service
- Verification of benefits is not a guarantee of payment
- Patients are responsible for any balance not paid by insurance

Medicare: We accept Medicare assignments. Patients are responsible for:

- Annual deductible
- Standard 20% coinsurance unless covered by secondary insurance

Secondary Insurance: Your medical claims will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company.

Self-Pay / Out-of-Network

Payment in full is due at or before the visit.

Non-Covered Services: Please be aware that some of the services may not be covered or not considered reasonable or necessary by Medicare and/or other insurance companies. You are responsible for full payment of these services at the time of service.

Referrals/Authorizations

If your insurance requires a referral or authorization, it must be obtained before your appointment.

Without proper authorization, the patient may be responsible for full payment.

Claim Submission: We will submit claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays your claim or not. Your insurance benefit is a contract between you and your insurance company.

Personal Injury Cases: This office does not bill for auto accidents, other liability, or lawsuit-related cases. You are responsible for payment at the time of service. We do not accept liens.

Patient Billing: All co-payments, co-insurance, or deductibles must be paid **at time of service**.

As a courtesy, our office **does** verify benefits with your insurance carrier; however, it is recommended that you verify your benefits with your insurance carrier as well.

Missed Appointment, Cancellations, & Late Arrival Policy: We kindly request at least **72 hours'** notice if you need to cancel or reschedule your appointment so that we may offer the time to another patient. Appointments cancelled with less than 72 hours' notice or missed without notice may be subject to a **\$50** missed appointment fee. Patients who arrive more than 15 minutes late may need to reschedule their appointment to avoid delays for other patients. Patients with three **(3) or more missed** or late-cancelled appointments may be required to provide a **\$100** deposit to reserve future appointment times, which will be applied toward the scheduled visit.

Billing & Collections:

- Payment is due at the time of service.
- You are responsible for any expenses related to collecting outstanding balances, including but not limited to legal and collection services.
- In the event your account is sent to a collection agency, a 35% fee will be added to your account. You are financially responsible for any fee(s) incurred.
- We accept the following methods of payment: cash, check and most major credit cards. (We do not accept starter checks)
- Returned checks with incur a \$25 fee.
- In the event your insurer sends payment to you (the patient) it should be forwarded to our office to be applied to your balance.

HIPAA Acknowledgement:

I acknowledge that I have received or had the opportunity to review this office's Notice of Privacy Practices.

Assignment of Benefits:

I authorize payment of medical benefits directly to For Feet Sake Podiatry Group, Inc. for services provided.

I understand that I am financially responsible for all charges whether or not they are paid by my insurance carrier.

AI-Assisted Documentation Consent:

Our office uses an AI documentation tool (such as FreedAI) to assist in creating clinical notes during visits.

- The system helps generate draft medical notes
- The podiatrist reviews and approves all documentation
- The system does not diagnose or make treatment decisions

Your information is protected under:

- HIPAA
- California Confidentiality of Medical Information Act (CMIA)
- California Consumer Privacy Act (CCPA/CPRA)

Participation is voluntary and may be declined at any time.

Patient Acknowledgement:

I certify that the information provided is accurate and complete to the best of my knowledge. I understand the financial policies and consent to treatment.

Responsible Party Name (Print): _____

Signature: _____

Date: _____

AI-Assisted Documentation Consent

To improve efficiency and allow your podiatrist to focus more directly on your care, our office uses an artificial intelligence (AI) documentation tool called **FreedAI (or any other AI scribe software)** to assist in creating clinical notes during your visit.

What This Means

- During your appointment, information discussed about your foot or ankle condition may be processed by the AI tool to create a draft progress note.
- This may include medical history, symptoms, exam findings, wound care details, procedures, imaging review, and treatment plans.
- The AI tool does **not** diagnose conditions or make treatment decisions.
- Your podiatrist reviews and approves all notes before they become part of your medical record.

Privacy & Security

Your medical information is handled in accordance with:

- The Health Insurance Portability and Accountability Act (HIPAA)
- California's Confidentiality of Medical Information Act (CMIA)
- The California Consumer Privacy Act (CCPA), as amended by the California Privacy Rights Act (CPRA)

We maintain appropriate safeguards and contractual protections to help protect your health information. Your information is **not sold** and is not used for marketing purposes through this system.

Please note that no electronic system can guarantee absolute security, although reasonable protections are in place.

Your Choice

- Your participation is voluntary.
- You may decline or withdraw consent at any time.
- Declining will not affect your care or your relationship with our office.
- If you decline, documentation will be completed through alternative methods.
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Patient Acknowledgment

I acknowledge that I have been informed that this practice uses AI-assisted documentation (FreedAI) to support medical record creation, and I consent to its use during my visits.

Patient Name (Print): _____

Signature: _____

Date: _____

Parent/Guardian's Name (If Patient is a Minor): _____ Relationship: _____