



Ankle and Foot Associates of Northern Michigan PC - (989) 275-3668  
**Roscommon Office**      **Houghton Lake Office**  
408 Lake Street / P.O.Box 949      5213 W. Houghton Lake Dr.  
Roscommon, MI 48653      Houghton Lake, MI 48629

**NH MEDICAL HEALTH HISTORY/INFORMATION FORM**

**Please bring ALL paperwork filled out completely prior to check-in.  
Failure to do so, may result in the rescheduling of your appointment.**

First Name:		Middle In:	Last Name:	Nickname:
Birth Date:		Age:	Male <input type="checkbox"/> Female <input type="checkbox"/>	Social Security #
Assisted Living Facility:			City/State:	Zip Code:
Mailing Address:			City/State:	Zip Code:
Home Phone:	Work Phone:		Cell Phone:	
Email Address:			<b>I give permission to leave messages over the phone: answering machine and/or person answering. (circle one):      YES      NO</b>	

Guardian Name(Medical Decisions):		Guard. Ph #:	Other Ph #:
Guardian Address:		City/State:	Zip Code:
Conservator Name(Financial Decisions):		Conser. Ph #:	Other Ph #:
Conservator Address:		City/State:	Zip Code:
Primary Care Physician:		Ph#:	Date of Last Visit:
Address:		City/State:	Zip Code:
Emergency Contact:		Relationship:	Phone #:
Pharmacy of Choice:	City/State:	Phone #:	

Please describe your foot problem: \_\_\_\_\_

How long has it been present: \_\_\_\_\_ What have you done to treat: \_\_\_\_\_

Does anything make it worse?: \_\_\_\_\_ Does anything make it better?: \_\_\_\_\_

*DAILY MEDICATIONS/VITAMINS: Please list any medications/vitamins you take regularly.*

	Name of Medicine:	Dose: (mg)	Frequency:		Name of Medicine:	Dose: (mg)	Frequency:
1				6			
2				7			
3				8			
4				9			
5				10			
Are you allergic to Penicillin: Yes/No		Are you allergic to Codeine: Yes/No		Reaction(s):			
Are you allergic to latex: Yes/No		Are you allergic to metal: Yes/No		Reaction(s):			
Any other allergies?:							

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**MEDICAL HEALTH HISTORY/INFORMATION FORM 2020 CONT.**

Please X the YES column if any of these conditions apply past or present, or mark here for  NONE.

<i>Condition</i>	<i>Yes</i>	<i>Condition</i>	<i>Yes</i>	<i>Condition</i>	<i>Yes</i>	<i>Condition</i>	<i>Yes</i>
Alzheimer's Disease		Depression		Kidney Disease		Parkinson's Disease	
Anxiety		Diabetes (1 or 2)		Knee Pain		Polio	
Arthritis		DVT		Leg Cramps		Pronation of feet	
Asthma		Epilepsy		Limb Length Discrepancy		Radiation Treatment	
Back Pain		Fibromyalgia		Lower Back Pain		Schizophrenia	
Bleeding Tendencies		GOUT		Low Blood Pressure		Seizures	
Blood Clots		Heart Disease		Multiple Sclerosis		Shortness of Breath	
Bunion		Hepatitis (A-B-C)		Neck Pain		Stroke	
Cancer		High Blood Pressure		Neuropathy		Swelling ankles/feet	
Circulation Problem		High Cholesterol		Onychomycosis		Torn Meniscus	
COPD		Hip Pain		Osteoarthritis		Tremors	
Deaf/HOH		HIV/AIDS		Osteoporosis		Varicose Veins	
Dementia		Hyperlipidemia		PAD		Vascular Disease	

List any other conditions you have \_\_\_\_\_

List any surgeries you have had \_\_\_\_\_

**Marital Status:** Married Single Divorced Widowed **Number of Children:** \_\_\_\_\_

**Who do you live with:** Alone Spouse Child Parent Significant Other

**Employer:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Do You:**(Circle One)

**Smoke?** Never Former (How long ago \_\_\_\_\_) Currently (How many per day \_\_\_\_\_)

**Chew Tobacco?** Never Former (How long ago \_\_\_\_\_) Currently (How much per day \_\_\_\_\_)

**Drink Alcohol?** Never Former (How long ago? \_\_\_\_\_) Currently (How much day \_\_\_\_\_)

**Use Recreational Drugs?** Never Former (How long ago? \_\_\_\_\_) Currently (Explain \_\_\_\_\_)

**Drink Caffeine?** YES or NO If yes, how many cups per day? \_\_\_\_\_

**Are you Pregnant?** YES or NO

**Shoe Size:** \_\_\_\_\_

**Family Status:**(Circle all that apply)

Mother: Alive Deceased *(circle all that apply)* Cancer Diabetes Heart Disease

Father: Alive Deceased *(circle all that apply)* Cancer Diabetes Heart Disease

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_

**I hereby give my permission to the physicians and staff of Ankle & Foot Associates of Northern Michigan to examine and treat myself/dependent as within the scope of practice for a podiatrist as defined by the state of Michigan, and release information to my physicians and/or my insurance companies.**

Patient Name Printed	Signature of patient/guardian	Today's Date

**Ankle & Foot Associates of Northern Michigan**  
Dr. Brian Brausa, DPM   Dr. Tracy Bacik, DPM  
OFFICE POLICIES & CONSENT FOR TREATMENT FOR OUR PATIENTS

Thank you for choosing Ankle & Foot Associates of Northern Michigan (AFANM) for your podiatry needs. Our goal is to provide you with quality medical care in a timely fashion. We strive to make your experience with us as pleasant and stress-free as possible. In order to do this we have implemented this policy to help us utilize available appointments for our patients. Please contact our office at your convenience if you have any questions or concerns about our policies.

**Office Hours:** Our office is open Monday-Thursday 8:00 am- 4:00 pm. Our office can be reached at 989-275-3668. Please follow the prompts to get you to the person you need to speak to.

**Appointments:** We see patients by appointment only. Same day appointments are held for **emergent** patients only. When you arrive for your appointment, [please check in at the front desk and have your ID and insurance cards ready](#).

**Being on time:** Due to the high volume of patients that we see daily, [your appointment will be rescheduled if you are more than 15 minutes late](#).

**Cancellations:** Please call within 24 hours if you need to cancel or reschedule your appointment. This will allow us to have time to offer this time slot to another patient.

**Cell Phones:** So we can better assist you with your needs, we ask that all cell phones be turned off while in the office. Thank you.

**Treatment of Minors:** Patients under the age of 18 must be accompanied by a parent/guardian **or** have a written permission for treatment from parent/guardian **and** be accompanied by a responsible adult.

**Medical History:** To keep your medical records current, let us know of any changes in your medical history and/or medications as soon as possible.

**Surgery:** If a surgery is needed in the office or at the hospital, patients are required to sign a surgical consent form before the surgery. A copy will be given to you upon request.

**Dismissal:** We have the right to “dismiss” you from the practice. If you are dismissed from the practice then you can no longer make appointments nor get prescriptions. We will send you a letter of dismissal, and you will need to find another podiatrist for your foot care. Common reasons for dismissal are, but not limited to: noncompliance of physician instructions, failure to keep appointments, abusive to staff or other patients, failure to pay bill.

**Insurance:** [It is your responsibility to know your insurance plan](#) and to make sure that our physicians are covered under your plan. If your insurance changes, it is your responsibility to inform us of this as soon as possible.

**Insurance Billing:** We will bill your primary insurance for our services, and then your secondary. If there is a balance from your insurance companies, that will become your responsibility. If your insurance becomes inactive, you will be responsible for all fees for the date of service. If you do not have insurance, then you will be responsible for the fee of the visit at time of service.

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**Fees & Payments:** Any fees that are not covered by your insurance will be collected at time of service. This includes any co-pay, deductible, co-insurance, and/or product received. For your convenience we do accept cash, checks, Visa, Master Card, American Express, HSA or FSA cards. There is a \$30 charge for any check that is returned by your bank for any reason.

**Billing:** Should you get a bill from our office, it is because we have billed your insurance company and this is the amount that they say is your responsibility. If you think that this is an error, please contact your insurance company first to find out why they are making you responsible. We will not become involved in disputes between you and your insurance company.

**Collections:** Statements that are 30-59 days old will be considered overdue. Statements that are 60-89 days old and are less than \$200 will be turned over to our collection agency. Statements that are 90+ days old and greater than \$200 will be turned over to our legal team for further process. To avoid this process please pay your bill in a timely matter. IF you cannot pay your bill in full, please call to make payment arrangements.

**CONSENTS**

**Consent to Treat:** I consent to Dr Brausa, Dr Bacik and their assistants to administer and perform such procedures deemed necessary in the diagnosis and/or treatment of my podiatry needs.

**Consent to treat minor patient:** I consent to Dr Brausa, Dr Bacik and their assistants to administer and perform such procedures deemed necessary in the diagnosis and/or treatment of my child's podiatry needs.

**Photography/Film/Video:** I consent to Dr Brausa, Dr Bacik and their assistants to photograph/film/video the treatment site for medical record. I understand that these materials may be used for teaching purposes. I am aware that my identity will NOT be disclosed.

**Insurance & Medical:** I consent to AFANM to release any information to my insurance company for billing purposes. I authorize payment from my insurance company to be sent directly to AFANM.

**Authorization to verbally release medical information to a FAMILY MEMBER OR FRIEND:** I authorize my medical treatment, billing information and appointment times to be discussed without limitation with the person/people listed below.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

**Acknowledgment of Review--Notice of Privacy Practices**

I have the right to review this office's policy, which explains how my medical information will be used and disclosed. By signing below I acknowledge that I have reviewed AFANM office policies, consents, authorizations and I understand them. I understand that whatever my insurance does not cover is my responsibility and I will pay the balance. I understand that I am entitled to receive a copy of this document upon request.

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Patient Name Printed

Signature of patient/guardian

Today's Date

## **Ankle & Foot Associates of Northern Michigan**

Roscommon Office

408 Lake Street / P.O.Box 949

Roscommon, MI 48653

Roscommon (989) 275-3668 / Houghton Lake (989) 302-4800 / FAX (989) 275-3338

Dr Brian Brausa, DPM    Dr Tracy Bacik, DPM

Houghton Lake Office

5213 W. Houghton Lake Dr.

Houghton Lake, MI 48629

### **MIPS Additional Patient Information**

**Patient printed name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

1. Have you received a Flu vaccination for the current season? Yes    No
  - a) If no, what was the reason?
    - Patient Allergy
    - Patient Declined
    - Vaccine Unavailable
2. Have you received a Pneumonia vaccination? Yes    No
  - a) If no, what was the reason?
    - Patient Allergy
    - Patient Declined
    - Vaccine Unavailable
3. Do you have a living will **OR** someone who can make decisions on your behalf?  
Yes    No

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Office Use:**

**Medical Assistant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_