Ankle and Foot Associates of Northern Michigan PC

Roscommon Office - (989) 275-3668
408 Lake Street / P.O.Box 949
Roscommon, MI 48653

Houghton Lake Office
5213 W. Houghton Lake Dr.
Houghton Lake, MI 48629

MEDICAL HEALTH HISTORY/INFORMATION FORM

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

First Name:	Middle In:	Last Name:	Nickname:
Birth Date:	Age:	Male ☐ Female ☐	Social Security #
Mailing Address:		City/State:	Zip Code:
Home Phone:	Work Phone:		Cell Phone:
Email Address:		**I give permission to leave messages over the phone: answering machine and/or person answering. (circle one): YES NO**	

Primary Care Physician:	Phone #:	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				11			
2				12			
3				13			
4				14			
5				15			
6				16			
7				17			
8				18			
9				19			
10				20			

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 CONT.

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

Condition	*Yes*	*Condition*	*Yes*	*Condition*	*Yes*	*Condition*	*Yes*
Alzheimer's Disease		Dementia		Kidney Disease		Parkinson's Disease	
Anxiety		Diabetes (1 or 2)		Knee Pain		Pronation of feet	
Arthritis		DVT		Leg Cramps		Radiation Treatment	
Asthma		Epilepsy		Limb Length Discrepancy		Schizophrenia	
Back Pain		Fibromyalgia		Lower Back Pain		Seizures	
Bleeding Tendencies		GOUT		Low Blood Pressure		Shortness of Breath	
Blood Clots		Heart Disease		Multiple Sclerosis		Stroke	
Bunion		Hepatitis (A-B-C)		Neuropathy		Swelling ankles/feet	
Cancer		High Blood Pressure		Onychomycosis		Torn Meniscus	
Circulation Problem		Hip Pain		Osteoarthritis		Tremors	
COPD		HIV/AIDS		Osteoporosis		Varicose Veins	
Deaf/HOH		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: If it is necessary to cancel or reschedule your appointment, patients are required to call and leave a message at least 24 hours before the appointment time. Failure to do so two times in a twelve month period will result in a written warning sent via certified letter. A third missed appointment will result in discharge from the practice.

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. There is a $4 fee to process any Credit/ Debit cards.

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 polices, 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.

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

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MEDICAL RECORD RELEASE

Patient Name:_____ Date of Birth:_____
Patient Phone Number: _____

□ I authorize Ankle & Foot Associates of Northern Michigan to **RELEASE** information to my doctor. including primary and/or specialist. Information to be disclosed but not limited including all Appointments, Lab Results, X-ray Reports, All Chart Notes, Operative Reports, and Pathology Reports.

□ I authorize Ankle & Foot Associates of Northern Michigan to **OBTAIN** information from my doctor including primary and/or specialist. Information to be disclosed but not limited including all Appointments, Lab Results, X-ray Reports, All Chart Notes, Operative Reports, and Pathology Reports.

This authorization is voluntary and will remain in effect until notifying the providing organization in writing, except where a disclosure has already been made in reliance on my prior authorization.

_____ _____
Patient/Patient Representative Signature Today's Date

_____
Relationship to Patient

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MIPS Additional Patient Information

Patient printed name: _____ **DOB:**_____

1. Have you received a Flu vaccination for the current season? ☐Yes ☐No
   Date of vaccination: Month/Year _____
   a) If no, what was the reason?
      - ☐ Patient Allergy
      - ☐ Patient Declined
      - ☐ Vaccine Unavailable

2. Have you received a Pneumonia vaccination? ☐Yes ☐No
   Date of vaccination: Month/Year _____
   a) If no, what was the reason?
      - ☐ Patient Allergy
      - ☐ Patient Declined
      - ☐ Vaccine Unavailable

3. Do you have a history of falling? ☐Yes ☐No

4. Date of Last A1C _____ Result____

Patient Signature: _____ **Date:**_____