Foot and Ankle Specialist of The Villages

PLEASE PRINT

Dr. Shannon Floyd DPM

Patient Name: _____ D.O.B._____/_____/_____

SSN: _____ Identify as Male: _____ Female:_____ Prefer not to answer:_____

Physical Address: _____City _____State _____ Zip _____

Mailing Address: _____ City _____ State _____ Zip _____

Email Address _____

Employer/School: _____ Phone: (_____) - _____ - _____

Home Phone: (_____) - _____ - _____ Cell Phone: (_____) - _____ - _____

Emergency Contact Information

Name: _____

Phone: (_____) - _____ - _____

Relationship to patient: _____

Patient Responsibility/Insurance Company

Insurance Company _____ Subscriber D.O.B _____/_____/_____

Secondary Insurance Company _____

Local pharmacy Information

Pharmacy Name: _____ Location: _____

Phone: (_____) - _____ - _____

Personal Contacts (ok to release personal health information to the following person(s):

Name: _____ Relationship _____

Name: _____ Relationship _____

Name: _____ Relationship _____

X _____

Patient Signature

X _____

Date

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Dr. Shannon Floyd , DPM

Date: _____/_____/_____ Name: _____

D.O.B. _____/_____/_____ Identify as Male: _____ Female: _____ Prefer not to answer: _____

Height: _____ Weight: _____ Shoe Size: _____

Race: ____American Indian _____Asian _____ Black/African American _____Native American ____White

Ethnicity: _____ Hispanic/Latino _____ Non-Hispanic/Latino

Language: ___English ___Spanish ___French ___Russian ___Italian ___Dutch ___ Chinese ___ Japanese

Reason for visit: _____

Date of onset: _____/_____/_____

Primary Physician: _____ Date Last Seen: _____/_____/_____

How did you hear about our office? _____

Medical History: (Check only those items that apply)

___ Type 1 Diabetes ____Type 2 Diabetes___ Insulin___ Oral Medication___ Diet Controlled When Diagnosed _____

___ Kidney Disease

___ Anemia

___ Peripheral Vascular Disease

___ Arthritis

___ Liver Disease

___ High Blood Pressure

___ Stomach Ulcers

___ Cancer

___ Heart Disease

___ Varicose Veins

___ Epilepsy

___ Hypothyroidism

___ Autoimmune Disease

___ Rheumatic Fever

___ Asthma

___ Eye Pathology

___ Charoot Joint

___ Leg Cramps/numbness

___ High Cholesterol

___ CVA (Stroke)

___ Gastric Reflux

___ HIV

___ AIDS

___ Hepatitis C

___ Not Listed _____

_____

_____

Surgical History (Check only those that apply): Patient Name: _____

___ Angioplasty
___ Appendectomy
___ C-Section
___ Cataract
___ Carotid Artery
___ Gallbladder
___ D & C
___ Arterial Bypass
___ Heart Bypass
___ Open Heart
___ Hysterectomy
___ Hernia Repair
___ Hip Replacement
___ Mastectomy
___ Foot Surgery Please list procedure: _____
___ Other: _____

___ Back Surgery
___ Breast Biopsy/ Lumpectomy
___ Venous Ligation
___ Prostate
___ Tonsillectomy
___ Pacemaker
___ Kidney Stones
___ Kidney Removal

Family History: Please circle if positive

	Diabetes	Cancer	High Blood Pressure	Heart Disease
Mother	yes	yes	yes	Yes
Father	yes	yes	yes	Yes
Siblings	yes	yes	yes	Yes

Social History: (Please Check)

_____ Alcohol? What type and how often? _____

Tobacco: Never ____ Former ____ Current/ Everyday ____ Current/ Somedays ____

Exercise or Activities? What type and how often _____

_____

Allergies (Please Circle): Novocain Aspirin Codeine Penicillin Cortisone

Adhesive Tape Latex Sulfa Other: _____

_____

Please complete the following list with your current medications as prescribed to you by your other physician(s). Be sure to include dosage and frequency. You may attach a list as an alternative. FOR YOUR SAFETY PLEASE BE SURE TO NOTE ANY DRUG ALLERGIES!

Patient Name:			Date of Birth:	
Pharmacy:			Pharmacy Phone:	
Date Prescribed	Medication	Dose	Quantity	Frequency

!!!!List Any Allergies!!!!

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Foot and Ankle Specialist of The Villages

Financial and Lifetime Authorization

Missed Appointments: Our policy is to charge $25.00 to any patient that does not show for their appointment and or does not give 24 hours' notice of cancellation. Appointments cannot be rescheduled until payment is received in the office. Patients may be discharged from the practice after three (3) no show appointments.

Payment for service is due at time services are rendered: We accept cash, personal checks, and credit/debit cards. Returned checks less than $50.00 are subject to a service charge of $25.00. Checks between $50.00 and $300.00 are subject to a service charge of $30.00. For checks greater than $300.00 there is a fee of $40, you will also lose your privilege to write a check in our office.

X-Rays: There will be a fee of $15.00 out of pocket charge for copies of x-rays.

Surgery: There will be a $250.00 fee for any surgery that is rescheduled or cancelled. Certain exceptions will be made at the doctor's discretion.

Minor Patients: Patients under the age of 18 Must be accompanied by an adult or legal guardian or treatment will be denied.

Release of information: I, the below named patient, do hereby The Foot and Ankle Specialist of The Villages to release any third payer (such as insurance company or governmental agency, example: Blue Cross of Florida or Medicare) any medical, psychiatric condition, alcohol or drug related condition and records concerning diagnose and treatment when requested by such third party for it use in connection with determining a claim for payment for such treatment and/ or diagnosis.

Physician Insurance Assignment: I, the below named patient, do hereby authorize payment directly to Foot and Ankle Specialist of The Villages for their Services as described but not to exceed the reasonable customary charges for these services.

Medicare/Medicaid: Patients certification authorization to release information and payment request. I certify that the information given by me in applying for payment under Title XVII/XIX of the SSA is correct. I authorize any holder of medical or other information about me to released to the SSA Division of Family Services or its intermediaries or carriers any information needed for this or related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

I PERMIT A COPY OF THIS AUTHORIZATION AND ASSIGNGMENTS TO BE USED IN PLACE OF THE ORIGIANAL WHICH IS ON FILE AT THE PHYSICAN'S OFFICE. The assignment will remain in effect until revoked by me in writing.

Commercial Insurance: Co-Payments and deductibles must be paid at the time of service. We are under contract with most insurances and will file your insurance.

Medicare: We are Medicare providers and will file your claim. We will file with MOST secondary insurances. If you have any questions, please check with the front desk.

Financial Agreement: We will gladly discuss for proposed treatment and do our best to answer any questions relating to your insurance. You must realize that your insurance is a contract between you and your insurance company. We are not part of that contract. Not all services are a covered benefit.

Pictures: Any photos taken within the office are not released as part of your legal health record. All photos are stored in a secured password protected computer that does not travel to other locations. All photos are deleted from hard drive once uploaded to the patient's electronic health record. If you wish not to have your photo taken, please inform the front desk.

ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICES ARE RENDERED Please remember that insurance is considered a method of reimbursing that patient for fees paid to the doctor and is not suitable for payment. Some companies pay fixed allowances for certain procedures, and others pay percentage of the charge. I understand that it's my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance or third-party payer within a reasonable amount of time. Collection action will be taken on any balances over 90 days. If it becomes necessary to collect any sum due through an attorney, the patient agrees to pay all reasonable cost of collection including attorney fees.

X _____ X _____

Patient Signature Date

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FOOT & ANKLE SPECIALIST
of The Villages
Complete Care of the Foot & Ankle

Dr. Shannon Floyd, DPM, PA

Cancellation and No-Show Policy

We understand that situations may arise in which you have to cancel your appointment. Therefore, we request that if you must cancel your appointment, you provide 24 hours' notice. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hours' notice, we are unable to offer that time slot to another person.

Office appointments which are cancelled with less than 24 hours notification may be subject to a **$ 25 cancellation fee.**

Patients who do not show up for their first office appointment will be considered a NO SHOW. Patients who NO Show three times in a 12-month period, may be dismissed from the practice. The patient will be denied any future appointment. Patient may also be subject to a **$25.00 NO SHOW fee.**

The cancellation and NO-SHOW fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We do understand that unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with approval by the physician.

It is the sole responsibility of the patient to remember their appointment time and date. We provide patients with printed paperwork of their next appointment time and date. The office sends out reminder calls after 2 p.m. the day before your appointment. If you call to cancel/ re-schedule after your reminder, call you will not be subject to a cancellation fee. If for any reason you were not provided with a reminder call that will not be a valid reason for a fee waved or NO-SHOW forgiveness.

By signing the form below, you acknowledge your understanding of NO- SHOW fees and the cancellation process. If you have any questions or concerns, please feel free to speak to a receptionist or call the office at 352-633-8230.

X _____ X _____

Patient's Name (Please Print) Date of Birth

X _____ X _____

Signature of Patient or Patient representative Today's Date

(6)