Patient Information

Name: _____

Date of Birth: ___/___/_____ Age:

Social Security #: _____

Mailing Address: _____

City, State, Zip Code: _____

Employer/Occupation: _____

Home Phone: (_____)_____

Cell Phone: (_____)_____

Work Phone: (_____)_____

Pharmacy: _____

Email : _____

Race: **(Circle one)**

American Indian **Asian** **Black** **White** **Native Hawaiian / Islander**

Ethnicity - Do you consider yourself Hispanic/Latino **YES** **NO**

Referring Doctor/
Primary Care Doctor: _____

How did you hear about our office?

Friend/Family

Other Doctor

Radio

Online

Other: _____

Emergency Contact / Guarantor Information

Full Name: _____

Mailing Address: _____

_____

Phone Number: (_____)_____

Relationship to patient: _____

Date of Birth: _____ Social Security#: _____

Is this the Guarantor for the patient: **YES** **NO**

If you would like for Ankle and Foot Surgical and Podiatry Clinic to file your insurance claim please provide your insurance card(s) along with a photo ID. Without your card your claim can not be filed. Payment is due in full at the time you are seen, unless other arrangements have been made with our business office.

By signing below I am authorizing Ankle and Foot Surgical and Podiatry Clinic to release all medical information necessary to process my insurance claim. I authorize payment of insurance benefits to be made to Ankle and Foot Surgical and Podiatry Clinic, unless my account is paid in full. I also understand it is my responsibility to know my insurance benefits and to ensure the following: Provider participation with my insurance policy, and obtaining all proper authorizations from Primary Care Providers when necessary.

_____

Signature Patient/Guarantor **Date**

Notice of Privacy Policies

Privacy Practices are posted in lobby area, website, and in the patient portal
Extra copies of Privacy Practices are available upon request

I acknowledge I was provided the opportunity to review a copy of the Notice of Privacy Practices and have read (or have had the opportunity to read) and understand the notice.

_____

Signature **Date**

The practice may need to contact you to discuss treatment, insurance, and billing questions. We may leave a message on your answering machine asking for you to call us back.

If you are unavilable, whom would like to designate for our clinic to discuss your medical condition, allow to pick up paper work / prescriptions for you, or be able to discuss your insurance claim/account information?

_____

Alternate Contact Name (if desired)

_____

Relationship

_____

Mailing Address

_____

Alternate Contact Phone Number(s)

_____

Patient/Guarantor Signature **Date**

No-Show Appointment Policy

Patient Name: _____

Dear Patient:

Thank you for choosing Ankle and Foot Surgical and Podiatry Clinic for your health care needs. We are committed to providing you with quality care.

If you are unable to keep your scheduled appointment(s), you need to contact our office (910)295-7400 at least 24 hours in advance. Cancellations without at least 24 hours notice may be charged a no-show fee of $50.00.

Cancellation in advanced allows your appointment time to be offered to other patients who may have an urgent healthcare need. We appreciate your understanding.

Your signature below indicates you have read and understand the Ankle and Foot Surgical and Podiatry Clinic no-show appointment policy.

_____

Patient Signature **Date**

_____

Witness Signature **Date**

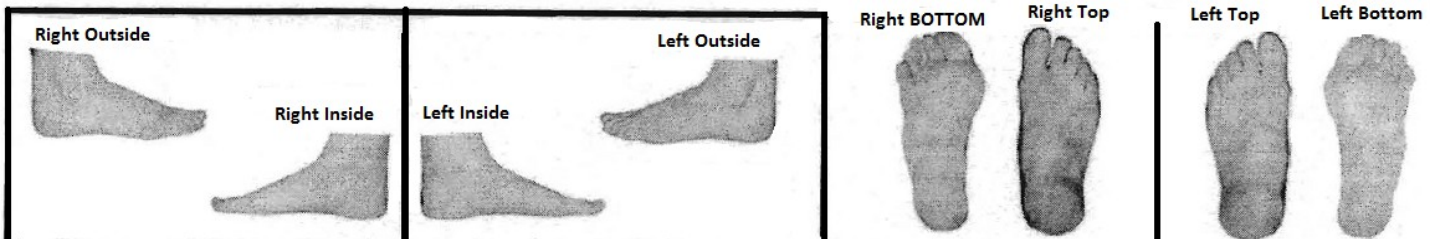
Ankle & Foot SURGICAL PODIATRY CLINIC

Patient History and Physical Sheet

Name: _____

Sex: Male / Female **Date of Birth:** _____ Age: _____

Shoe Size: _____ **Height:** _____ **Weight:** _____**lbs**



1. **Please mark the location of your problems on the above diagrams with an 'X'**
2. When did your problem start? _____
3. Describe the problem and the cause, if you know:

   _____
4. Circle all below that describe to your pain:

Burning **Shooting** **Sharp** **Aching** **Throbbing** **Numbness** **Tingling** **Dull**

5. What makes the problem worse? _____
6. List previous medical treatments or home remedies: _____
7. Anything else we should know?: _____

Are you DIABETIC? **Yes** **No** **If yes, for how long?** _____

Past Medical History: (Check the applicable boxes)

- ☐ DIABETES
- ☐ High Blood Pressure
- ☐ Circulation
- ☐ Phlebitis
- ☐ Gout
- ☐ Cancer
- ☐ Asthma
- ☐ Stomach Problems
- ☐ Liver
- ☐ Osteoarthritis
- ☐ Kidney Disease
- ☐ Alcoholism

Past Surgical History: _____

_____

Artificial Joints: _____ Anesthesia Complications: _____

Family History: (Is there a Family History of any of these disorders? Check the applicable boxes)

- ☐ Tuberculosis
- ☐ Kidney Disease
- ☐ Mental Illness
- ☐ Migraines
- ☐ Heart Attack
- ☐ Spinal Disorder
- ☐ Hypertension
- ☐ Other: _____
- ☐ Cancer
- ☐ Gout
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Diabetes
- ☐ Alcoholism

Social History: (Check the applicable boxes)

- ☐ Married
- ☐ Use of Tobacco
- ☐ Single
- ☐ Use of Alcohol
- ☐ Divorced
- ☐ Use of illicit drugs

Employer/Occupation: _____ Years of School: _____ Degrees: _____

Current Medications: (List ALL medications below, including dosages)

_____

Allergies: (Check the applicable boxes)

- ☐ Penicillin
- ☐ Sulfa Drugs
- ☐ Aspirin
- ☐ Chemicals _____
- ☐ Morphine/Demerol _____
- ☐ Antibiotics _____
- ☐ Codeine
- ☐ Adhesive Tapes _____
- ☐ Foods _____
- ☐ Other Drugs _____
- ☐ Other _____

Allergic Reactions to these: _____

Consent to Use AI Technology during Medical Encounters

Dear Patient,

We are committed to providing the best possible care for you, and as part of this commitment, we are continually looking for ways to enhance our services.

Your physician may choose to use an artificial intelligence (AI) tool that assists us during visits by generating clinical notes based on our conversations. This tool allows us to focus more on you, the patient, and less on computer documentation.

What is it?

A tool that listens to the conversation during a medical consultation and generates a written summary or "note" based on that conversation. This note is then reviewed and approved by your doctor.

How will this affect you?

The tool does not interact with you directly. It merely listens to the conversation and creates a summary. Any text generated by the tool gets reviewed by your healthcare professional before becoming part of your record.

Data Privacy and Confidentiality

We want to assure you that your privacy is our utmost priority. The AI tool adheres strictly to Health Insurance Portability and Accountability Act (HIPAA) compliance guidelines to ensure your data is secured and protected. Only the healthcare professionals involved in your care will have access to these notes.

Your Consent

Your participation is completely voluntary. If you agree to the use of our AI tool during your consultations, please sign and date the form below. If you have any questions or concerns, please feel free to discuss them with us.

I, _____, consent to the use of AI technology during my appointments at **Ankle and Foot Surgical and Podiatry Clinic.**

Signature: _____ Date: _____

ANTHONY HARO III, DPM
Diplomate, American Board of Foot and Ankle Surgery
Certified in Reconstructive Rearfoot/Ankle Surgery & Foot Surgery
Fellowship in Reconstructive Foot and Ankle Surgery

AMIE L. HARACZ, DPM
Diplomate, American Board of Foot and Ankle Surgery
Certified in Foot Surgery
Qualified in Reconstructive Rearfoot/ Ankle Surgery

KEVIN W. SCHMIDTKE, DPM
Diplomate American Board of Foot and Ankle Surgery
Board Qualified in Foot Surgery, Associate American College of Foot & Surgery

RECORDS REQUEST

DATE: _____

TO: _____

I, _____ AUTHORIZE THE ABOVE MENTIONED TO RELEASE MEDICAL RECORDSTO THE FOLLOWNG:

___ Dr. A. Anthony Haro III ___ Dr. Amie Haracz ___ Dr. Kevin Schmidtke

Other: _____

THE MEDICAL RECORDS RELEASED SHOULD INCLUDE THE FOLLOWING:

_____OFFICE NOTES
_____LABORATORY PROCEDURES
_____XRAY REPORTS
_____XRAY DISC ($15)
_____OPERATIVE REPORTS
_____INSURANCE INFORMATION
_____PRESCRIPTIONS
___OTHER: _____

PATIENT NAME: _____ DOB: _____
PATIENT SIGNATURE: _____
WITNESS: _____
(OFFICE STAFF SIGNATURE REQUIRED)

200 WESTGATE DRIVE SUITE A, WEST END, NC 27376
PHONE (910) 295-7400 FAX (877) 295- 0079

For personal requests: By signing this request I authorize Ankle and Foot Surgical and Podiatry Clinic, PA to release a copy of my medical records to me. By doing so, I understand the clinic and its staff will no longer be responsible for the confidentiality of the medical records provided and any redisclosure of these records may no longer be protected by federal or state law. Contact number for records pick up: _____

By submitting this medical record request, you acknowledge and agree that the information will be used solely for the specified purpose, subject to applicable laws. While we strive to protect the confidentiality of your records, we cannot guarantee absolute security. You authorize the release of records to designated recipients, understanding the potential sensitivity of the information. Ankle & Foot Surgical & Podiatry Clinic is not liable for any damages arising from the release or use of records. This authorization will expire one year from the date above.