Alabama Foot Institute

2000 Stonegate Trail
Suite 112
Vestavia Hills, AL 35242

Surgery, Medicine & Biomechanics of the Foot
WWW.ALABAMAFOOTINSTITUTE.COM

(205) 559-5811 Voice
(205) 559-5556 Fax

Dr. Todd Falls
Angelo Thompson, C.PED.

Name_____ Date____/____/_____
First Middle Last

Address_____

City_____ State_____ Zip_____

Cell Phone_____ Home_____

Work Phone_____

Email:_____

Date of Birth_____ Age_____ S.S.#_____

Place of Employment (Name/Address) (If Minor-Parents)

_____

Marital Status (circle): Married, Divorced, Single, Widowed

If you are a Minor, Parent's Name_____

Primary Care Physician_____ Phone #_____

Physician's Address_____

Emergency Contact_____ Relationship_____ Phone#_____

Authorization Statement

"I authorize Dr. Todd Falls to render all medically necessary treatments, including surgical treatments, to myself. I authorize the release of any medical information to my insurance for billing purposes as well as to any physicians that Dr. Falls deems necessary."

Signature of patient_____ Date_____/_____/_____

Medicare Statement

"I authorize Dr. Todd Falls to render all medically necessary treatment, including surgical treatments, to myself. I request that payment of authorized Medicare benefits be made to Dr. Falls on my behalf for any services provided to me by the physician or any supplier. I authorize any holder of medical information about myself be released to the health care financing administration & its agents to determine benefits payable for related services."

Signature of patient_____ Date_____/_____/_____

ALABAMA FOOT INSTITUTE

NAME _____ **DATE**___/___/_____

DOB___/___/_____

Have you or your parent's had: (please circle)

	YOU	MOTHER	FATHER
Diabetes (If yes do you take insulin or pills) _____	yes	yes	yes
High Blood Pressure	yes	yes	yes
Mitral Valve Prolapse	yes	yes	yes
Heart attack	yes	yes	yes
Hepatitis	yes	yes	yes
TB	yes	yes	yes
Stroke	yes	yes	yes
Phlebitis	yes	yes	yes
HIV	yes	yes	yes
Blood clots	yes	yes	yes
Gout	yes	yes	yes
Cancer	yes	yes	yes
Anemia	yes	yes	yes
Sickle Cell Trait	yes	yes	yes
Lupus	yes	yes	yes
Painful Scars	yes	yes	yes
Dialysis	yes	yes	yes
Pacemaker	yes	yes	yes

OCCUPATION:_____

Do you smoke?_____ How much & how often?_____

Do you drink?_____ How much & how often?_____

PHARMACY NAME: _____ **Location:**_____

Pharmacy Phone # _____

ARE YOU ALLERGIC TO: (circle if YES)

Penicillin
Sulfur
Local Anesthetics
Tape
Iodine
Other_____

CURRENT MEDICATIONS
(List name and dosage)

_____

_____

_____

History & Physical

Name _____ DOB____/____/_____

Height:_____ Weight:_____

Previous Surgeries (other than the foot):

_____

_____

_____

Previous foot Surgeries (please list type/date):

_____

_____

_____

REASON FOR TODAY'S VISIT :

_____

_____

_____

_____

Alabama Foot Institute

2000 Stonegate Trail
Suite 112
Vestavia Hills, AL 35242

Surgery, Medicine & Biomechanics of the Foot
WWW.ALABAMAFOOTINSTITUTE.COM

(205) 599-5811 Voice
(205) 599-5556 Fax

Dr. Todd Falls
Angelo Thompson, C.PED

Financial Policy

Payment is expected at the time services are rendered. We will file your claim with all active insurance carriers. If a referral is required for your insurance it is your responsibility to acquire the referral before your appointment. If you are seen without a referral you accept full responsibility for any charges.

The trimming of toenails, corns, calluses may or may not be covered under your insurance policy. This serves to acknowledge that you have been informed that these and other services may not be covered under your plan and you may be billed for them.

There is a charge of $30 per form for the completion of disability, family leave, medical review or any other form that you or your insurance company may require.

A re-billing fee of $25 may be assessed to your account after 25 days of a balance being unpaid unless suitable payment arrangements have been made. Additional collection charges will be assessed if your account requires placement with a collection agency.

YOU ARE RESPONSIBLE FOR ANY COPAYS, DEDUCTIBLES, AND COINSURANCES AT THE TIME SERVICES ARE RENDERED.

Signed:_____ Date:_____

Print name:_____

Date of birth:_____

ALABAMA FOOT INSTITUTE

ACKNOWLEDGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

❑ I acknowledge that I have received a copy of the Notice of Privacy Practices.

❑ I do **NOT** wish to be provided a copy of the Notice of Privacy Practices.

I _____ authorize Alabama Foot Institute to discuss my protected health information with the following individuals:

*Name*_____ *Relationship*_____

*Name*_____ *Relationship*_____

*Name*_____ *Relationship*_____

_____

Patient Name **(Please Print)** Date

_____

Signature

_____

Parent or Authorized Representative (if Applicable)