DeLand Foot&Leg CENTER

Excellence in care as you walk through life

PRACTICE PHILOSOPHY:
The focus of our practice is the treatment of lower extremity problems. To this end we are in partnership with you and we require your full cooperation. Our commitment is to provide you with innovative medical care to the lower extremity. As part of our commitment to higher medical standards, our Center provides digital imaging, electronic medical records, and electronic billing. ***No paper originals or records are maintained.***

Should you encounter a lower extremity medical problem notify our office and/or leave a message. We are not an emergency medicine or crisis intervention center. You are therefore required to maintain the service of a primary care physician (i.e. internist, cardiologist, oncologist, gynecologist, etc.) If you don't have one, we will be delighted to give you a list of physicians to choose from.

TREATMENT AGREEMENT:
I hereby apply for treatment by DeLand Foot and Leg Center, LLC. I consent that photographs or videotaping may be taken for educational purposes.

CANCELLATION POLICY:
DeLand Foot and Leg Center, LLC requires a **24 hours cancellation notice**. We ask your full cooperation not to burden you. If your appointment is on Monday morning you can call Saturday to cancel. You may leave a message with our service when calling the office after hours. A $45.00 fee applies for appointment cancellations in less than 24 hours. A $250.00 fee applies for surgery canceled in less than 48 hours.

Initials: _____

FINANCIAL RESPONSIBILITIES:
All Payments and Co-payments Are Due at the Time Services Are Rendered. We accept checks, cash, MasterCard, Visa, and Discover. Any returned checks will incur an additional processing fee of $35.00 each. Fees not paid within 60 days of the date of services shall be subject to a finance charge of 1.75% per month or $3.00 per month, whichever is larger. In the event, your account goes into collections the entire collection fee will be added to your balance. Our office does submit delinquent accounts to reporting credit bureaus.

ABOUT OUR FEES:
Our consultations and evaluation fees are lower than the usually considered reasonable and customary current year Medicare Fee Schedule. Some insurers, however, may reimburse based on an arbitrary schedule of fees which bears no relationship to our standard of care, or they will not cover cosmetic procedures entirely. It is the patient responsibility to understand their coverage and the detail of their insurance policies.

INSURANCE INFORMATION:
We do participate with specific insurance companies. In case we are not a participant/provider with your insurance company, we will provide you with a receipt which includes the doctor's signature, diagnoses and description of services and fees. You may submit this to your insurance company**. You are responsible for all interactions with your out of network insurance company. Our staff is not trained to deal with every insurance company's particular issues.** Your insurance company has a contract with you and/or your employer, not with us. You have the right to demand an explanation for any decision they make. **WE WILL SUBMIT TO YOUR CO-INSURANCE ONE TIME, AS A COURTESY TO YOU. AFTER WHICH, ANY AND ALL DENIED OR UNPAID CHARGES BECOME YOUR RESPONSIBILITY.**

Medicaid does not pay your primary insurances' co-pay or balance. I understand and agree that **regardless of my insurance status**, I am ultimately responsible for the balance of my account for any and all professional services rendered. I furthermore agree to notify the DeLand Foot and Leg Center, LLC on any changes in my insurance or health status.

Initials: _____

I understand that my eligibility for coverage may not be defined at this time and it is my sole responsibility to understand my insurance policy. Furthermore, it is my responsibility to notify the office of any change to my medical coverage. I wish to receive medical service from DeLand Foot and Leg Center, LLC. If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided.

Prescription Refill requests take 48 hours to process, so please allow adequate time for us to fill your request. **Disability, Insurance, and/or Medical Forms** requests usually take 5-7 days to complete after the $35.00 processing fee has been paid for each packet. **Lab results**: it is the patient's responsibility to follow through on their care and request a copy of the results or all labs or testing performed in the office or out of the office, i.e. MRI, Bone Scan, and Pathology.
This is a notice to all patients, we are a practioner that participates in the Florida Prescription Drug Monitoring Program, known as E-FORCSE® .
My signature below attests that I have read and understood all of the information contained herein and agree to abide by the above Office Policies set forth by DeLand Foot and Leg Center, LLC.

Patient PRINTED Name :	Date:
Patient/ Guardian's Signature:	

Jenneffer Pulapaka, DPM, AACFAS
DELAND FOOT AND LEG CENTER 844 N. Stone St., Ste 208, DeLand, FL 32720
Office: 386-738-3733 | Fax: 386-738-3733 | www.DFALC.com

Patient Name :	Social Security #:
Address:	City:
	Zip:
Home Phone:	Cellular Phone:
Work Phone:	E-mail Address:
Date of Birth:	Occupation:
Ethnicity & Preferred Language:	Marital Status:
Gender Identified with:	

Insurance Information (we do not accept **ANY** Medicaid or HMO policies)

Name Primary Insurance Information:
Name Secondary Insurance Information:

Emergency Contact Information

Name:	Relationship:
Address:	City, Zip:
Home Phone:	Cellular Phone:
Work Phone:	E-mail Address:

Alternate Address

Address:	City:
	Zip:
Home Phone:	Cellular Phone:
Work Phone:	E-mail Address:

Acknowledge of Receipt of Notice of Privacy Practices

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

Please be advised that the following forms are available upon your request:

- Patient Authorization of Release Health Information
- Patient Complaint Form
- Accounting of Disclosures Form
- Request for Correction/Amendment of Health Information
- Restriction Request Form
- Request for Confidential Communication

LIFETIME SIGNATURE AUTHORIZATION AND INSURANCE PAYMENT ORDER (REQUIRED)

I authorize the release of my medical information necessary to process my claims. I also authorize any request of payment of medical benefits to DeLand Foot and Leg Center, LLC or treating physician.

Everything I have answered is true, complete, and correct to the best of my knowledge.
THIS FORM WILL BECOME A PART OF YOUR PERMANENT MEDICAL RECORD.

Patient Name (print):	Date:
Patient or Guardian's Signature:	

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Permission to Discuss Protected Health Information

Note: To be valid, this form must be filled out COMPLETELY, including what information you are giving us permission to share.

Patient Name: _____ Date of Birth: _____

Approved voicemail/text message number to leave information: (_____)_____

Approved email address to leave information: _____

I give permission to DeLand Foot and Leg Center (DFALC) to **VERBALLY** and **IN WRITING** discuss the following medical and billing information about me **(check all that apply)**:

- ▫ Scheduling/appointment information
- ▫ Medical information, including my symptoms, diagnosis, medications, and treatment plan.
- ▫ Behavioral health information, including my symptoms, diagnosis, medications, and treatment plan
- ▫ Chemical dependency information, including my symptoms, diagnosis, medications, and treatment plan
- ▫ Lab/test results
- ▫ Billing and payment information
- ▫ Other:_____
- ▫ DFALC has my permission to discuss the above information with the below non-medical persons:

Name	Phone	Relationship to Patient

OR ▫ I decline permission to verbally discuss medical information with someone else

I understand that I may cancel this permission at any time (by writing to DFALC Health Information), but that cancelling it will not affect any information that has already been released.

This authorization expires:

- ▫ When I cancel it in writing; OR _____ *(specify date)*

*If no expiration date is specified, this authorization will remain in effect until DFALC Medical Records receives written notice to cancel it.

Signature of patient/guardian*	Date	Relationship to patient
Witness if patient is unable to sign*	Date	Reason patient is unable to sign

*If authorized representative, please sign and attach copies of supporting legal documentation.

Note: A minor patient's signature is REQUIRED (for ages 13 and above) for us to share information about care for (1) conditions relating to the minors sexuality including, but not limited to: family planning and sexually transmitted diseases (2) alcoholism and/or drug abuse; and (3) mental health conditions.)

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Office: 386-738-3733 | Fax: 386-738-3733 | www.DelandPodiatry.com

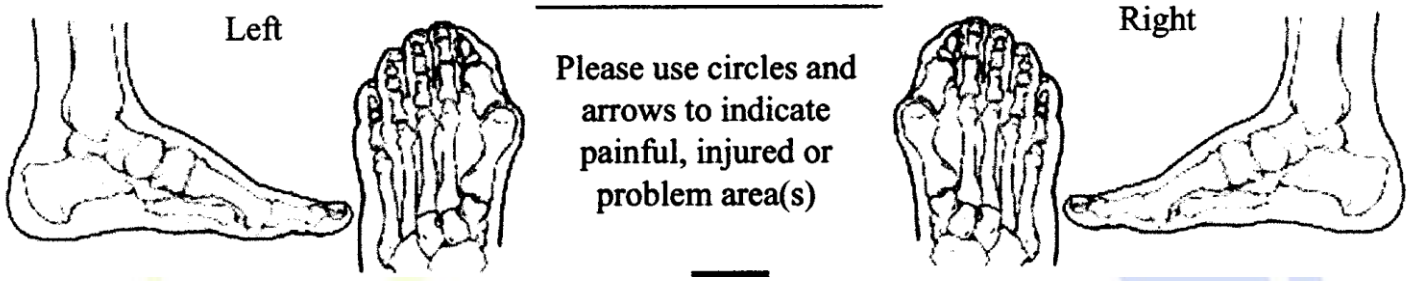
PATIENT INITIAL HISTORY QUESTIONNAIRE

Everything I answer is true, complete, and correct to the best of my knowledge. Failure to provide a truthful and complete medical history may result in serious complications, harm, **or discharge from this office**. You may be required to provide more medical information so that we can give you the best care and assessment.

Patient Name: _____ Date: _____

Date of Birth: _____ (Office use only) MR#_____

Family/Primary Doctor: _____ Who referred you to us?_____



REASON FOR VISIT: _____

HOW LONG HAS THIS PROBLEM BEEN PRESENT?_____

THE PROBLEM IS: ☐Improving ☐Getting Worse ☐Not Changing

THE PAIN SCALE IS: 0 1 2 3 4 5 6 7 8 9 10 (worst**)**

Other Physician's you have seen for this problem: _____

ARE YOU TAKING ANY MEDICATION FOR THIS PROBLEM?_____

DOES THE MEDICATION HELP? ☐Yes ☐No

WHAT AGGREVATES THE PROBLEM? _____

WHEN IS THE PROBLEM WORSE? ☐Morning ☐End of day ☐While sleeping

ALLERGIES: ☐ **No Known Drug Allergies** Name of Drugs: _____

Ongoing Medical Problems:

☐ **No Known Medical Problems**

☐ Hypertension	☐ Atherosclerosis	☐ Vascular disease	☐ Elevated Cholesterol
☐ Insulin Diabetes	☐ Asthma	☐ Past heart attack	☐ Bi-polar, depression
☐ Non-insulin Diabetes	☐ Ulcers	☐ Hepatitis A/ B / C	☐ Renal problem
☐ Cancer	☐ Tuberculosis	☐ Liver disease	☐ GI problems
☐ Seizure disorders	☐ Thyroid Disorder	☐ Emphysema	☐ Fibromyalgia
☐ COPD/Lung dz	☐ Immune Disorder	☐ Overweight	☐ Arthritis: knee, hip, wrist, etc
☐ Osteomyelitis	☐ DVT	☐ Varicose veins	☐ Back pain/problems
☐ Leg cramps	☐ Anxiety	☐ Neuropathy	☐ Others: _____

_____

Major Medical Event or Hospitalization for: ☐ **No Significant History**

_____

_____

PAST SURGICAL HISTORY: ☐ **No Previous Surgeries**

☐ Hysterectomy	☐ Appendectomy	☐ Lumbar laminectomy
☐ Cataract extraction	☐ Mastectomy	☐ By-pass / open heart
☐ Tonsillectomy	☐ Gall bladder	☐ Prostate surgery
☐ Hernia repair	☐ Foot Surgery	☐ Other:_____

FAMILY HISTORY: (MUST BE UP TO DATE)

_____

_____

_____

PREVENTATIVE CARE & PHARMACY ADDRESS/PHONE:

(NO PRESCRIPTIONS WILL BE FILLED WITHOUT A LISTED PHARMACY**)**

_____

_____

_____

NUTRITION (VITAMINS,DIET RESTRICTIONS): ☐ **Normal**

_____

_____

DEVELOPMENTAL/PEDIATRIC HISTORY: ☐ **Normal**

_____

HOW MUCH ALCOHOL DO YOU CONSUME?

(A) I'm a non-drinker
(B) I'm a recovering alcoholic
(C) I drink only occasionally
(D) I drink weekends only
(E) An average of 1-2 drinks per day
(F) An average of 3 or more

TOBACCO USAGE:

(A) Yes, I am currently a smoker or use tobacco
I smoke (circle one) 1 2 3 packs/day
I have smoked for _____ years
(B) No, but I did for _____ years
(C) No, I have never used tobacco

I WORK: _____ ☐ **I DO NOT WORK**

I LIVE WITH:_____

MEDICATIONS: ☐**NONE** ☐**See List** **Dr. Pulapaka will not prescribe medication if the medical history or medication list is not complete.**

NAME	DOSE

THE FOLLOWING CHECK MARKS INDICATE ABNORMALITIES: ☐ **I HAVE NO PROBLEMS**

☐ blurred vision ☐headaches ☐ stiffness ☐ difficulty swallowing
☐ chest pain ☐ palpitations ☐ SOB ☐ coughing
☐ nausea ☐vomiting ☐ frequent urination
☐ leg cramping ☐ resting pain in toes ☐ swelling
☐ arthritis ☐ joint pain ☐ total joint implant

_____

Patient or Guardian's Signature / Date

THIS WILL BECOME A PART OF YOUR PERMANENT MEDICAL RECORD AT DELAND FOOT AND LEG CENTER, LLC
.Part 2: Patient Questionnaire to be signed after the information has been entered into the system by medical staff.
Dr. Pulapaka does not prescribe medication if the medical history or medication list is not complete.

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Insurance Patient Mandatory Quality Assurance

Patient Name:_____ Date:_____

Age:		Office use only Dx:V70.0
Height:	Weight :	**PF Automatic** ☐
Vaccination Pneumonia	☐Done ☐Not done	65yo+/ **PF Immunization Section "Historical Vaccine" "Pneumovax 23/Pneumococcal, 23-valent, adult (CVX 33)"** ☐
Vaccination Influenza	☐Done Jan-March☐ Oct-Dec☐ ☐Not done	**PF Immunization Section "Historical Vaccine Fluzone High Dose/Influenze, High Dose Seasonal (CVX 135)"** ☐
Updated Current medications with office:	☐Yes ☐No	☐ **PF Quality of Care Section "Document Current Meds"**
Tobacco use	☐No ☐Yes	☐ **PF Screening Section "tobacco cessation counseling"**
2 or more falls or any fall with injury in past year :	☐Yes ☐No	65yo+/ **PF Screening Section "Fall Risk"** ☐

Below For Diabetic Patients Only

Retinal Eye Exam	☐Done ☐Not done	18-75yo/ **PF Screening Section "Examination of Retina"** ☐
Current A1c	A1c Value: Date:	17-75yo/ **A1c 9.0** **PF "Enter Lab Results"** ☐

Office use only

Diabetic Foot Screen	☐Yes ☐No	18-75yo / **PF Screening Section "DM Foot Exam"** ☐

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