HENDERSON FOOT AND ANKLE CENTER
1485 W. Warm Springs Rd, Suite 102, Henderson NV 89014 Office: (702) 435-7987 Fax: (702) 435-7616

PATIENT REGISTRATION

PATIENT INFORMATION

Patient's Last Name First	Middle	❑ Mr. ❑ Mrs. ❑ Dr. ❑ Miss ❑ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid
Nickname (Name I preferred to be called)	Birth Date (mm/dd/yyyy)	Sex ❑ M ❑ F	Race (Circle One): Hispanic / Asian / Caucasian Pacific Islander/Native American/African American
Street Address	Social Security #		Home Phone # ( )
City State Zip Code	E-Mail		Employer/Work Phone # ( )
Employer	Employer Address		Mobile Phone # ( )
Pharmacy Name & Phone #	Primary Care Physician (PCP)		Date PCP Last Seen

PERSON RESPONSIBLE FOR BILL (IF DIFFERENT THAN ABOVE)

Name of Person Responsible for Bill	Birth Date (mm/dd/yyyy)	Sex ❑ M ❑ F	Relationship to Patient ❑ Self ❑ Spouse ❑ Child ❑ Other
Street Address	Social Security #		Home Phone # ( )
City State Zip Code	E-Mail		Employer/Work Phone # ( )
Employer	Employer Address		Mobile Phone # ( )

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD AND PHOTO ID TO RECEPTIONIST)

Primary Insurance	Subscriber Name	Birth Date (mm/dd/yyyy)	Social Security #

Insurance ID #	Group #	Policy #	Effective Date	Expiration Date	Co-Payment $

Secondary Insurance	Subscriber Name	Birth Date (mm/dd/yyyy)	Social Security #

Insurance ID #	Group #	Policy #	Effective Date	Expiration Date	Co-Payment $

IN CASE OF EMERGENCY

Name of Nearest Friend or Relative	Relationship to Patient	Home Phone # ( )	Work or Mobile Phone # ( )

REFERRAL

How did you learn about us? (Please check all that apply) ❑ Dr. _____ ❑ Friend/Family: _____ ❑ Other: _____

❑ Phonebook ❑ Website ❑ Insurance Plan ❑ Google ❑ YELP ❑ Healthgrades ❑ Other Internet: _____ ❑ Lecture

The above information is true to the best of my knowledge. I certify that I have insurance with the insurance company(ies) disclosed and assign directly to Henderson Foot and Ankle Center, LLC all insurance benefits, if any, otherwise payable to me for service(s) rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature below on all insurance submissions. Henderson Foot and Ankle Center, LLC may use my health care information and may disclose such information to the disclosed insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

X _____

PATIENT/GUARDIAN SIGNATURE DATE

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COMPREHENSIVE HEALTH REVIEW

Patient Name: _____ Date of Birth: _____ Today's Date: _____

HISTORY OF PRESENT ILLNESS / WHAT BRINGS YOU IN?

What is your specific foot/ankle problem? _____

_____

_____

When did the problem begin? _____

Which foot/ankle is involved? ❑ Right ❑ Left ❑ Both

First visit to a doctor for this problem? ❑ Yes ❑ No

Have you had a similar problem in the past? ❑ Yes ❑ No

How was the problem onset? ❑ Sudden ❑ Gradual

The problem is: ❑ Improving ❑ Worsening ❑ Unchanged

The problem is worst: ❑ AM ❑ PM ❑ At Rest ❑ With Activity

What aggravates the problem? _____

What improves the problem? _____

Is the problem painful? ❑ Yes ❑ No If so, rate your current pain: (none) 0 1 2 3 4 5 6 7 8 9 10 (worst)

Describe the pain: ❑ Sharp ❑ Dull ❑ Aching ❑ Throbbing ❑ Cramping ❑ Itching ❑ Popping

❑ Burning ❑ Tingling ❑ Clicking ❑ Shooting ❑ Stabbing ❑ Other: _____

Describe previous treatments: _____

Is this from an injury? ❑ Yes ❑ No If so, is it work-related? ❑ Yes ❑ No My Foot/Ankle Problem Limits my Activites ❑ Yes ❑ No

PAST MEDICAL HISTORY

❑ Diabetes Type 1 2 Duration ____ years Last Blood Sugar _____ HbA1c ____

❑ Acid Reflux
❑ Anemia
❑ Anesthesia Complications
❑ Arthritis (❑ Osteo / ❑ Rheum)
❑ Asthma
❑ Back Problems/Sciatica
❑ Blood Clot/DVT
❑ Cancer: _____
❑ Cellulitis/Skin Infection (❑ MRSA?)
❑ Circulation Problem
❑ Dementia/Alzheimer's
❑ Excessive/Easy Bleeding
❑ Fibromyalgia
❑ Foot/Leg Ulcer
❑ Gout
❑ Healing Problems/Keloids
❑ Heart Disease/Heart Attack
❑ High Blood Pressure (❑ Low BP?)
❑ High Cholesterol
❑ Hormone Therapy
❑ Immune Disorder/HIV
❑ Kidney Disease (❑ Dialysis)
❑ Liver Disease (❑ Hepatitis)
❑ Leg Cramps/Leg Pain at Rest
❑ Lung Condition: _____
❑ Mitral Valve Prolapse/Murmur
❑ Multiple Sclerosis
❑ Nervous Disorder/Depression
❑ Neuropathy
❑ Osteomyelitis/Bone Infection
❑ Parkinson's Disease
❑ Previous Addiction to: _____
❑ Pulmonary Embolism
❑ Rashes/Skin Condition
❑ Raynauds Disease/Phenomena
❑ Seizure Disorder/Epilepsy
❑ Sickle Cell Disease/Trait
❑ Sleep Apnea
❑ Stomach Ulcers
❑ Stroke ❑ Rt ❑ Lt (year _____)
❑ Thyroid Condition (❑ Hi ❑ Lo)
❑ Varicose Veins
❑ Women – Are You Pregnant or Breast Feeding?
❑ Other problems not listed: _____

PAST SURGERIES

❑ Foot/Ankle Surgery: _____
❑ Joint Replacement: _____
❑ Open Heart/Bypass Surgery
❑ Hysterectomy ❑ Tubal ligation ❑ C-Section
❑ Stent Placement: Heart Leg
❑ Cosmetic Surgery: _____
❑ Appendix ❑ Gallbladder ❑ Tonsils/Add
❑ Leg Bypass ❑ Open Fracture Repair
❑ Carotid Surgery ❑ Vein Surgery
❑ Hernia repair ❑ Thyroid ❑ Back surgery
❑ Other: _____

FAMILY HISTORY (circle relative)

	Mother	**F**ather
❑ Cancer	M	F
❑ Diabetes	M	F
❑ Gout	M	F
❑ Heart Disease	M	F
❑ High Blood Pressure	M	F
❑ Severe Arthritis	M	F
❑ Anesthesia Complications	M	F
❑ Foot Problems	M	F
❑ Other: _____	M	F

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COMPREHENSIVE HEALTH REVIEW

Patient Name: _____

MEDICATIONS (include RX meds, OTC meds, and vitamins)

Medication	*Dosage*	*Medication*	*Dosage*

ALLERGIES

- ❑ **None**
- ❑ Adhesives/Tape
- ❑ Aspirin
- ❑ Codeine
- ❑ Cortisone
- ❑ Iodine
- ❑ Latex
- ❑ Local Anesthetics
- ❑ Penicillin
- ❑ Seafood/Shellfish
- ❑ Sulfa Drugs
- ❑ _____

SOCIAL HISTORY

Occupation: _____

I Drink Alcoholic Beverages ❑ Yes ❑ No How much/often? _____

I currently use Tobacco Products ❑ Yes ❑ No Type: _____

I Have used Tobacco Products ❑ Yes ❑ No When Stopped? _____

Packs/Day _____ Years _____

❑ I Use or Have Used Drugs that are Illegal

I Stand _____ % of My Day

I Exercise Each Week: ❑ 0 days ❑ 1-2 days ❑ 3+ days List

Sports/Activities: _____

I Live With: ❑ No One ❑ Children ❑ Parents ❑ Other

I am: ❑ Single ❑ Mar ❑ Div ❑ Separated ❑ Widowed

REVIEW OF SYSTEMS

CONSTITUTIONAL
- ❑ Recent Weight Gain
- ❑ Recent Weight Loss
- ❑ Fever
- ❑ Chills
- ❑ Night Sweats
- ❑ Nausea
- ❑ Vomiting
- ❑ Fatigue

CARDIOVASCULAR
- ❑ Chest Pain
- ❑ Palpitations
- ❑ Irregular Heart Beat
- ❑ Leg Pain when Walking
- ❑ Swelling of Hands/Feet
- ❑ Varicose Veins
- ❑ Poor Circulation
- ❑ Leg Cramps
- ❑ Blood Clots in Veins / DVT

MUSCULOSKELETAL
- ❑ Muscle Pain or Cramps
- ❑ Joint Pain
- ❑ Foot Pain
- ❑ Ankle Pain
- ❑ Stiffness
- ❑ Weakness
- ❑ Swelling Joints
- ❑ Redness
- ❑ Edema
- ❑ Low Back Pain
- ❑ Trouble Walking
- ❑ Tenderness
- ❑ Gout
- ❑ Arthritis

HEMATOLOGICAL
- ❑ Bruise Easily
- ❑ Slow to Heal
- ❑ Anemia
- ❑ Clotting Disorder

NEUROLOGICAL
- ❑ Migraines
- ❑ Frequent Headaches
- ❑ Numbness
- ❑ Tingling
- ❑ Burning
- ❑ Pins and Needles
- ❑ Dizzy Spells
- ❑ Tremors
- ❑ Paralysis

ENDOCRINE
- ❑ Diabetes
- ❑ Hormonal Problems
- ❑ Thyroid Problems
- ❑ Excessive Thirst
- ❑ Excessive Urination
- ❑ Too Hot
- ❑ Too Cold

GASTROINTESTINAL
- ❑ Indigestion/Heartburn
- ❑ Diarrhea
- ❑ Constipation
- ❑ Stomach Pains / Ulcers

INTEGUMENTARY
- ❑ Rash
- ❑ Itching
- ❑ Dry Skin
- ❑ Calluses
- ❑ Changes in Nails
- ❑ Change in Hair on Legs
- ❑ Change in Skin Color
- ❑ Fissures of Skin
- ❑ Cracked Skin
- ❑ Tatoo

STATS

Age _____ Height _____ Weight _____ Shoe Size _____

For Office Staff BMI _____

BP _____ P _____ O2 Sat _____ Temp _____

I understand that completing this paperwork is a chore. The information I have provided is true to the best of my knowledge. I recognize that the information I have provided will help me receive better care. I thank you for taking such an interest in my health.

X _____ _____

PATIENT/GUARDIAN SIGNATURE DATE

PATIENT QUESTIONAIRE

Name:_____

Please check any of the following condtions you are currently experiencing or suffering from:

- ☐ Flat Feet
- ☐ Poor coordination
- ☐ Heel or Arch pain
- ☐ Leg pain (shin splints)
- ☐ Achilles tendon pain
- ☐ Discoloration of toes/foot
- ☐ Ankle swelling or stiffness
- ☐ Pain in feet or legs with exercise
- ☐ Foot/Toes/Legs Burn
- ☐ Pain in feet getting out of bed
- ☐ "Toe-in" or "Toe-out" gait (walking)
- ☐ Pain or fatigue of feet or legs in ac ivity
- ☐ Ankle instability (easy twisting injuries)
- ☐ Difficulty/Pain with brisk walking or running
- ☐ Pain legs occurs at same distance every time
- ☐ Coldness in the legs or feet that is uncomfortable
- ☐ Non/Poor healing sore on the leg or foot
- ☐ Feet/Toes feel numb

Please answer the following about the above conditions:

Do the above conditions disrupt your lifestyle and activities of daily living? Yes / No

Is this condition causing or are you suffering with any of the following:

Tingling/Numbness In:	Pain Radiating Into:	Weakness of the:	Diffuculty with:
☐ Legs R / L	☐ Ankle R / L	☐ Legs R / L	☐ Standing
☐ Ankle R / L	☐ Feet R / L	☐ Ankle R / L	☐ Walking
☐ Feet R / L	☐ Toes R / L	☐ Foot R / L	☐ Sitting
			☐ Bending
			☐ Lifting
			☐ Kneeling

How long have you been suffering with this condition? Days / Weeks / Months / Longer

Is this condition affecting your ability to perform daily tasks? Yes / No

Would you like to get rid of or reduce this problem? Yes / No

There may be treatment options or solutions for the pain you are experiencing. Please let us know what you would like to do today.

☐ I would like to discuss the above condi ions with the Doctor so I can make an educated decision about my health.

☐ If it were available, I would be interested in receiving treatment for this condition in this office.

☐ If available, I would be open to have a medical test to further evaluate my problem.

_____

Patient Signature

Henderson Foot and Ankle Center, LLC
1485 W. Warm Springs, Suite 102 Henderson, NV 89014
Office: 702-435-7987 Fax: 702-435-7616

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Henderson Foot and Ankle Center LLC, to disclose my protected health information as described below. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I understand that I may see and copy the information described on this form if I ask for it, and that I will receive a copy of this form after I sign it. I understand that I may revoke this authorization at any time by giving notice in writing at the address found above, but if I do it will not affect any actions taken before receipt of my revocation.

I understand that my treatment will not be conditioned on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Patient name: _____ Date of birth: _____

Persons/organizations to receive the information: _____

The specific information to be released/disclosed is specified below:

☐ **Complete Medical Record**

Or specify one or more of the following:

☐	Operative Reports	☐	X-rays
☐	Progress Notes	☐	Billing and Claim Records
☐	Laboratory	☐	(Other – specify) _____

This information is to be used/disclosed for the following purposes(s) only: _____
_____

(no purpose need be stated if the request is made by the patient and the patient does not wish to state the purpose).

This authorization will expire on _____ (state date or event).

SPECIFIC AUTHORIZATION

I understand that my health information to be released MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information, unless I have crossed it out, and initialed it.

☐ **Yes** ☐ **No** **_____Initials**

_____ _____

Signature of patient or patient's representative **Date**

(Form MUST be completed before signing.)

Printed name of patient's representative (if applicable):_____

Relationship to the patient (if applicable):_____

*** YOU ARE ENTITLED TO A COPY OF THIS DOCUMENT**

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CONSENT TO TREATMENT

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Henderson Foot and Ankle Center, LLC Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

Patient Initials: _____

AUTHORIZATION REGARDING PRIVACY POLICY

Due to the recent implementation of the Patient Privacy Act (HIPPA), I hereby authorize Henderson Foot and Ankle Center, LLC to leave messages at my home with family members and/or answering machines regarding the following: (1) Confirm or Change Appointment, (2) Results of testing ordered by the physician, and/or (3) Any pertinent information that may be relative to my care.

Patient Initials: _____

ACKNOWLEDGMENT OF RECEIPT OF FINANCIAL POLICY

I acknowledge that I was provided a copy of the Henderson Foot and Ankle Center, LLC Financial Policy and that I have read (or had the opportunity to read if I so chose), understand and will comply by the policies stated.

Patient Initials: _____

PATIENT CONSENT

I hereby voluntarily consent to outpatient care by Kenneth E. Fatkin, DPM encompassing routine care, diagnostic procedures, examination and medical treatment including, but not limited to, minor surgical procedures, routine laboratory work, x-rays, ultrasound, photographs and administration of medications and injections prescribed by Kenneth E. Fatkin, DPM. I agree to ask questions to clarify treatment should I not understand the treatment plan.

Patient Initials: _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance with the insurance company(ies) disclosed and assign directly to Henderson Foot and Ankle Center, LLC and its Podiatrist, all insurance benefits, if any, otherwise payable to me for service(s) rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I agree that should my account become delinquent and is referred to an attorney or collection agency for collection, I will be charged an additional 33 1/3% of any unpaid balance at the time of referral for all costs of collection and attorney's fees. I authorize the use of my signature below on all insurance submissions.

Henderson Foot and Ankle Center, LLC may use my health care information and may disclose such information to the disclosed insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Patient Initials: _____

DISCLOSURE OF SERVICES

I understand that Henderson Foot and Ankle Center, LLC is owned and operated by Dr. Kenneth E. Fatkin. During my course of treatment, products and/or services from these businesses may be recommended. I understand that I am under no obligation to patron these businesses and that I may find alternate sources to purchase these products and/or services.

Patient Initials: _____

I have read and fully understand this Consent to Treatment. This authorization is valid as of the date I have signed below and will remain in effect as long as I am a Henderson Foot and Ankle Center patient. I have read this complete page and agree to all of its contents.

Name of Individual/Legal Representative (Print)	Signature of Individual/Legal Representative	Date

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FINANCIAL POLICY

1. All co-payments are due at the time of visit. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered a violation of the contract you have with your insurance company. Our office accepts cash, checks (post-dated checks are not accepted), credit and debit cards.
2. Co-insurance and unmet deductibles are due prior to scheduled surgeries and procedures. Once benefits are verified and your financial responsibility calculated, you will be notified of the payment amount and due date.
3. You are ultimately responsible for payment of charges for services you receive from our office.
4. In accordance with your insurance member handbook, it is your responsibility to provide accurate insurance information and to present your insurance ID card at the time of your visit. If you do not have insurance or do not present a valid insurance card, you will be responsible for payment at the time of service. We will provide you with a copy of our billing form so that you can obtain reimbursement from your insurance company.
5. It is your responsibility to ensure that our physicians are in your insurance network.
6. If your plan requires a referral, it is your responsibility to obtain this prior to being seen by our provider.
7. Payment is due for rendered services 10 days from receipt of your billing statement. Outstanding balances must be paid in full prior to any additional visit unless arrangements have been made with our billing department.
8. There is a service fee of $35 for <u>each</u> time a check is returned. The bank may return your check up to three times before considering it nonnegotiable. Your insurance company does not cover this fee.
9. A scheduled appointment means that time has been reserved for you. Cancellations for appointments must be received at least 24 hours prior to the scheduled appointment. Cancellations for scheduled surgery and in-office procedures must be received at least 5 days prior to the scheduled surgery date and time.
10. Patients who fail to keep or fail to cancel a scheduled appointment may be charged a $25.00 No Show Fee. There is a $100.00 cancellation fee for scheduled surgeries or in-office procedures that are cancelled less than 5 business days from the date and time of surgery unless cancellation is due to insurance denial or medical necessity.
11. Medical records requests must be received in writing at least 72 hours prior to the date needed. Fees for medical records are set in accordance with allowable amounts as defined by the State of Nevada. Fees must be received prior to record delivery. No more than 5 pages may be faxed.
12. Administrative Services: There is a $25.00 charge for <u>each</u> required Administrative Service, payable prior to service completion. This Administrative Service Fee covers specific administrative services such as forms completion for family medical leave and disability, letters for insurance authorizations for brand or non-formulary drugs, letters for employers, school, health clubs, and any other administrative items not covered by insurance.
13. In the event your insurance company should happen to send payment to you (the patient), you agree to forward said payment to our office to be applied to your account.
14. SELF-PAY: Payment in full is due at the time of service if you do not have health insurance coverage.