W. Aaron Broyles, DPM
Robert van Brederode, DPM
Thomas Verla, DPM

We're taking your foot care to the highest level!

105 Chestnut Street, Mars Hill, NC 28754 | Tel: (828) 680-1161 | Fax: (828) 680-1191
440 Altapass Hwy, Spruce Pine, NC 28777 | Tel: (828) 766-7667 | Fax: (828) 766-7668
2211 NC Hwy 105, Boone, NC 28607 | Tel: (828) 386-1849 | Fax: (828) 386-1851

Please print out the following forms, fill in the information and bring it along with your photo ID and insurance card(s) for your scheduled appointment time.

Full Name: _____ Preferred Name: _____

Street _____ City _____ State & Zip _____

Mailing Address: _____

Home Phone ( ) _____ Work Phone ( ) _____ Cell ( ) _____

Birth Date: _____ SS# \ \ _____ Marital Status: _____ Sex: F or M

Employer Name & Address: _____

Emergency Contact: _____ Relation: _____

Emergency Contact Phone ( ) _____

Family Physician: _____ Date of Last Visit: _____

Preferred Pharmacy: _____

Reason for Today's Visit: _____

Email Address: _____

How did you hear about us? (please circle one): Office Signs, Newspaper, Billboard, Google search, Yahoo Search, Bing Search, Facebook Ad, Radio Ad, Doctor Referral, Word of Mouth , Other: _____

Name of person/ Dr. that is referring (Who can we thank?): _____

INSURANCE INFORMATION:

I hereby authorize the release of any medical information necessary for the processing insurance claims and payment of medical benefits to myself or the party who accepts assignments. I understand that a claim will be filed with all contracted carriers, however I am responsible for any amount not paid by my insurance company. It's our policy at Alta Ridge Foot Specialists to identify & verify benefits for service. The benefits discussed represent information currently available to us at the time of service.

Your insurance company **WILL NOT GUARANTEE** payments of benefits under **ANY** plan. Claims are subject to all plan terms and provisions. This means that the benefits payable are determined according to the insured's eligibility, the limitations and exclusions (including pre-existing limitations) and conditions of the plan. Benefit determination of the claim payment will be made at the point the claim is processed unless otherwise excluded from your plan. We will not file for those services excluded or non authorized as determined by your carrier. Therefore **NON-COVERED or UNAUTHORIZED SERVICES** are not subject to negotiated rates & you will be responsible for these charges.

Date: _____ Signature of Patient/Guardian: _____

Patient Medical History

Name _____ Date _____

Shoe size _____ Weight _____ Height _____

Occupation _____ Race _____

Please check if you currently have, or have ever been treated for any of the following problems:

- ☐ AIDS / HIV Positive
- ☐ Allergies,

Describe: _____

- ☐ Alzheimers
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial heart valves
- ☐ Artificial joints
- ☐ Asthma
- ☐ Back problems
- ☐ Blood disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Cholesterol issues
- ☐ Circulation problems
- ☐ Cortisone treatments
- ☐ COPD
- ☐ Diabetes
- ☐ Depression
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Food allergies,

Describe: _____

- ☐ Glaucoma
- ☐ Gout
- ☐ Headaches, migraines
- ☐ Hearing/Ear disorder
- ☐ Heart murmur
- ☐ Heart problems,

Describe: _____

- ☐ Hemophilia
- ☐ Herpes
- ☐ Hepatitis A B C
- ☐ High blood pressure
- ☐ Keloid/Thick Scars
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Lyme disease
- ☐ Mitral valve prolapse
- ☐ Multiple Sclerosis
- ☐ Nerve disorder
- ☐ Pacemaker
- ☐ Phlebitis
- ☐ Poor circulation
- ☐ Psychiatric disorder/care
- ☐ Radiation treatment
- ☐ Respiratory disease
- ☐ Rheumatic fever
- ☐ Sciatica
- ☐ Seizure disorders
- ☐ Shingles
- ☐ Shortness of breath
- ☐ Skin rash
- ☐ Stroke
- ☐ Surgical implants
- ☐ Swelling, feet or ankles
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Ulcers/colitis
- ☐ Vascular disease
- ☐ Vascular graft/stent

List any surgeries or procedures performed: _____

_____

_____

_____

List any medications you are currently taking: _____

_____

_____

_____

Known Drug Allergies:

- ☐ Local anesthetic
- ☐ Aspirin
- ☐ Adhesive Tape
- ☐ Penicillin
- ☐ Codeine
- ☐ Sulfa
- ☐ Iodine
- ☐ Latex
- ☐ Motrin
- ☐ Advil
- ☐ Aleve
- ☐ Other:

Do you have a family history of:

- ☐ Diabetes
- ☐ Cancer
- ☐ High Blood Pressure
- ☐ Arthritis
- ☐ Foot Problems
- ☐ Birth Defects
- ☐ Stroke
- ☐ Heart Attack
- ☐ Other:

Do you:

- ☐ Smoke/Dip/Chew/Snuff
- ☐ Drink alcoholic beverages
- ☐ Use recreational drugs

Alta Ridge Foot Specialists

Acknowledgement of Receipt Of Notice of Privacy Practices

Patient Name & Address: _____

_____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason:

  _____
- ❑ Other:_____

  _____

Prepared By _____

Signature _____

Date _____

Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____

NCPPSG, DBA ALTA RIDGE FOOT SPECIALISTS, PLLC is authorized to release protected health information about the above named patient in the following manner and to persons listed.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
▫ Voice Mail	▫ Results of lab tests/x-rays Other_____
▫ Spouse (provide name and phone number) _____	▫ Financial ▫ Medical
▫ Parent (provide name and phone number) _____	▫ Financial ▫ Medical
▫ Email communication-Provide email address* _____ *In order for email communication to occur, please accept the disclosure below:	▫ Financial ▫ Medical ▫ Appointment reminders ▫ Breach notification
▫ For **email communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to move forward to allow email communications to occur.	

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

_____Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

_____

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