Ace Medical & Podiatry Intake Form
(this is a click-fillable form)

Patient Information	Home Phone:
Name:	Work Phone:
Address:	Cell Phone:
City, State, Zip:	Date of Birth:
Sex: Male ☐ Female ☐	Social Security #:
Employer/School:	E-mail Address:
Occupation:	Marital Status: M ☐ S ☐ D ☐ W ☐

Policyholder Info: (Self/Parent/Spouse)

Last Name:	Home Phone:
First Name: M.I.:	Work Phone:
Address:	Date of Birth:
City, State, Zip:	Social Security #:
Employer:	Marital Status: M ☐ S ☐ D ☐ W ☐

Local Friend/Relative Not Living with You:

Name:	Relationship:
Address:	
Phone#	

Who May We Thank for Referring You?

Name:
Address:
Phone:

Insurance Info:

Primary	*Secondary:*
Name:	Name:
ID#:	ID#:
Group#:	Group#:
Phone #:	Phone #:
Address:	Address:
In Network?	In Network?
Date Info Updated:	Date Info Updated:
Point of Contact:	Point of Contact:

HMO ONLY INFO:

Copayment:
Effective Dates:
PCP:
PCP Phone #:

Authorization Requirements:

PAYMENT AT TIME OF SERVICE:

IT IS OUR OFFICE POLICY THAT PAYMENTS ARE DUE AT THE TIME OF SERVICE. IF WE HAVE A CONTRACT WITH YOUR INSURANCE COMPANY, WE WILL FILE YOUR INSURANCE. HOWEVER, YOU ARE RESPONSIBLE FOR ALL COPAYS, DEDUCTIBLES, AND NON-COVERED SERVICES AT THE TIME OF SERVICE.

I UNDERSTAND AND AGREE THAT, REGARDLESS OF MY INSURANCE STATUS, I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT. I CERTIFY THAT THE INFORMATION PROVIDED IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE, AND I WILL NOTIFY YOU OF ANY CHANGES. A PHOTOSTATIC COPY OR OTHER REPRODUCTION OF THIS WILL BE AS VALID AS THE ORIGINAL.

DATE: _____ **SIGNATURE:** _____

Initial: _____

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE ON MY BEHALF TO ACE MEDICAL, LLC FOR ANY SERVICES FURNISHED BY ME. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO BE RELEASED TO THE CENTERS FOR MEDICARE AND MEDICAID SERVICES AND ITS AGENTS. ALSO ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

I UNDERSTAND MY SIGNATURE REQUESTS THAT PAYMENT BE MADE AND AUTHORIZE RELEASE OF MEDICAL INFORMATION NECESSARY TO PAY CLAIM. IF OTHER HEALTH INSURANCE COVERAGE IS INDICATED IN ITEM 9 OF THE CMS-1500 CLAIM FORM OR ELSEWHERE ON OTHER APPROVED CLAIM FORMS OR ELECTRONICALLY SUBMITTED CLAIMS, MY SIGNATURE AUTHORIZES RELEASING OF THE INFORMATION TO THE INSURER OR AGENCY SHOWN. ACE MEDICAL, LLC ACCEPTS THE CHARGE DETERMINATION OF THE MEDICARE CARRIER AS THE FULL CHARGE, AND I AM RESPONSIBLE ONLY FOR THE DEDUCTIBLE, COINSURANCE, AND NONCOVERED SERVICES. COINSURANCE AND DEDUCTIBLES ARE BASED UPON THE CHARGE DETERMINATION OF THE MEDICARE CARRIER.

DATE: _____ **SIGNATURE:** _____

Initial: _____

CONSENT/AUTHORIZATION FORM/RELEASE OF INFORMATION

CONSENT FOR TREATMENT I AUTHORIZE ACE MEDICAL, LLC. TO PERFORM THE TREATMENT/PROCEDURE(S) DESCRIBED BELOW. I HAVE BEEN INFORMED OF THE REASONS FOR THE TREATMENT/PROCEDURE(S), ALONG WITH THE EXPECTED BENEFITS, RISKS, POSSIBLE ALTERNATIVE METHODS OF TREATMENT, AND POSSIBLE CONSEQUENCES INVOLVED.

THE TREATMENT/PROCEDURE(S) WAS EXPLAINED TO ME IN DETAIL AND ALL MY QUESTIONS WERE FULLY ANSWERED. UNDERSTANDING THIS, I AUTHORIZE ACE MEDICAL, LLC. TO PERFORM SUCH EXAMINATIONS, TREATMENTS, LABORATORY TESTS, AND TO ADMINISTER SUCH MEDICATIONS AS, IN THEIR OPINION, ARE NECESSARY OR ADVISABLE FOR ME.

I ALSO CERTIFY THAT NO GUARANTEE OR ASSURANCE HAS BEEN MADE AS TO THE RESULTS THAT MAY BE OBTAINED.

RELEASE OF MEDICAL RECORD IN ORDER TO ENSURE PROPER FOLLOW-UP AND CONTINUITY OF CARE, I AGREE THAT A COPY OF MY MEDICAL RECORD MAY BE RELEASED TO MY PHYSICIAN, A DESIGNATED REFERRAL PHYSICIAN, AND/OR THE PROVIDER, IF ANY, WHO REFERRED ME TO THIS FACILITY.

INSURANCE AUTHORIZATION I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE TO ACE MEDICAL, LLC. ON MY BEHALF, FOR ANY SERVICES PROVIDED TO ME. I AUTHORIZED ANY HOLDER OF MEDICAL AND OTHER INFORMATION ABOUT ME TO RELEASE TO MEDICARE AND ITS AGENTS, ANY INSURANCE COMPANY, ANY OTHER THIRD PARTY PAYER, STATE MEDICAL ASSISTANCE AGENCY, OR ANY OTHER GOVERNMENTAL OR PRIVATE PAYER RESPONSIBLE FOR PAYING SUCH BENEFITS, ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS FOR RELATED SERVICES. I AGREE TO PAY FOR ALL CHARGES NOT COVERED BY A THIRD PARTY PAYER, I AUTHORIZED A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

SIGNATURE: _____ DATE: _____
(Patient or person authorized to consent for patient)

Initial: _____

HIPAA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complex text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with the quality professional service and care. Additional information is available from the U.S. department of Health and Human Services.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as necessary and appropriate for your patient care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. These records will not be available to persons other than office staff. You agree **to the normal** procedures utilized within the office for the handling of charts, patient records, PHI **and other documents or** information.
2. It is the policy of this office **to** remind **patients of their appointments.** We may do this by telephone, e-mail, U.S. mail, or by means **convenient for the practice and/or as requested** by you. We may send you other communication informing **you of** changes **to office policy** and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in **the** conduct of business. These vendors may have access to PHI but must agree to abide by the **confidentiality rules of HIPAA.**
4. You understand and agree to inspections **of the office and review** of the documents which may include PHI by government agencies **or insurance payers in normal** performance of their duties.
5. You agree to bring any **concerns or** complaints **regarding privacy to the** attention of the office manager or the doctor.
6. Your confidential information will not be used for **the purposes** of marketing or advertising of products, goods, or services.
7. We agree to provide patients with **access** to their **records in accordance with** state and federal laws.
8. We may change, add, delete, or **modify** any of the **provisions to** better **serve the** needs of both the **practice and** the patient.
9. You **have the** right to **request restrictions in the use of your** protected health information and to request change in certain **policies used within the office concerning** your **PHI. However,** we are not obligated to alter internal policies **to conform to your request.**

Signature: **Date;** Initial: _____

I do hereby consent and **acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and** any subsequent **changes in office policy. I understand that this consent shall remain in force from this** time forward.

ACE MEDICAL ADULT HEALTH HISTORY

DOCTOR:_____

NAME:_____

ADDRESS:_____

PHONE:_____

BIRTHDATE:_____ **AGE:**_____

GENERAL HEALTH:_____

Are you currently or have you ever been treated for any of the following:

Yes	No	Condition	Explain
		Asthma	
		Bleeding disorders	
		Blood Pressure	
		COPD	
		Diabetes	
		Ear/sinus	
		Fainting	
		Gastro-intestinal problems	
		Heart disease	
		Kidney disease	
		Learning disorders	
		Menstrual problems	
		Musculo-skeletal	
		Psychological/psychiatric	
		Seizures	
		Sickle cell disease	
		Sleep disorders	
		Stroke	
		Surgery	
		Thyroid disease	
		Serious injury	
		Other	
Allergies:			

SIGNATURE: _____

Initial: _____

MEDICATION LIST

Please List All Current Medications

	Medication Name	Amount/Interval
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10		

Would you like to appoint with an ACE Podiatrist? YES: ☐

Describe your foot problem:

Foot Problems:

- Corns Calluses ☐
- Cracked Heels ☐
- Warts ☐
- Athletes Foot ☐
- Toenail Fungus ☐
- Dry Skin ☐
- Psoriasis ☐
- Dermatitis ☐
- Bunions ☐
- Hammertoes ☐
- Heel Pain ☐
- Arch Pain ☐
- Flat Feet ☐
- Numbness ☐
- Burning feet ☐
- Cold Feet ☐
- Leg cramps ☐
- Swelling ☐

ACE MEDICAL
MEDICAL RELEASE FORM

Name of Patient: _____ Date(s) of Service: _____

Date of Birth: _____Social Security Number: _____

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above name patient.

Patient Information is Needed For:

___Continuing Medical Care	___Military	___Social Security/Disability
___Insurance	___Personal Use	___Other:_____
___Legal Purposes	___School	

INFORMATION TO BE RELEASED OR ACCESSED:

___History & Physical	___Consultation Report	___Emergency Room Record
___Operative Reports	___Discharge/Death Summary	___Face Sheet
___Lab/Path Reports	___X-Ray Reports/images	___Other:_____

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address):

TO: (Doctor, Hospital, Attorney, Insurance Company, Self, etc.):_____
Address (street, city, State, Zip):_____
Phone #:_____

FROM: (Doctor, Hospital, Attorney, Insurance Company, Self, etc.):_____
Address (street, city, State, Zip):_____
Phone #:_____

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization, The authorization will expire six (6) months from the date of my signature, unless I revoke the authorization prior to that time.

Date:_____

Signature (Patient or Legally Authorized Representative: _____

Printed Name of Patient/Legally Authorized Representative:_____

Relationship to Patient:_____

ACE MEDICAL
Information Collection

Are you a FL Resident? _____

Name _____

Date of Birth_____

Insurance_____

Medical records _____

Primary Care doctor _____

Previous Pain Management doctor _____

Reason for leaving/Discharged _____

Medication_____

Have you recently been discharged from a Meth Clinic? If yes, we need Discharge Letter

Are you taking Suboxone/Subutex _____

Who prescribed it _____

Name of Pharmacy_____

Recent Hospital or Urgent Care if yes Where (get records)_____

MRI/X-Ray_____

Labs _____

Sign medical release form_____

Was the injury due to an accident? _____

Brief history of how Injury happened_____

How recent/when did the accident occur _____

Are you being presented by an attorney, if yes Name _____

Telephone _____ Contact person _____

Insurance _____ Claim Number _____

Address_____

Case Manager _____

MRI/X-Ray /Who ordered them _____

Labs _____

Signature:_____ Initial: _____

PRINT

When completed, PRINT form and bring to your appointment.