

Amberly Paradoa, DPM, FACFAS
3735 11th Circle
Vero Beach, Florida 32960

Advanced Foot and Ankle of Indian River
Timothy Caballes, DPM, FACFAS
13852 US Hwy 1
Sebastian, Florida 32958
(772)299-7009

Robby Caballes, DPM, AACFAS
13852 US Hwy 1
Sebastian, Florida 32958

Patient Name: _____ Date of Birth: ____/____/____

Age: _____ Phone: _____ OK to leave a detailed message? Yes [] No []

Address: _____

City, State, Zip: _____ SSN: _____

Email Address (For patient portal) patient will receive an email to register: _____

Name as Printed on Insurance Card: _____

Primary Insurance and ID #: _____

Secondary Insurance and ID #: _____

Insured Name and Date of Birth: _____

Guarantor for Minors:

Name: _____ Phone: _____

DOB: _____ Relationship: _____

Primary Care Physician: _____ Date of Last Visit: _____

Pharmacy (Location and Phone Number): _____

Emergency Contact:

Name: _____ Phone: _____

Name: _____ Phone: _____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I wish to give the following person(s) access to the use or disclosure of my health information, appointments and/or account information.

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Signature: _____ Date: _____

Name: _____ DOB: _____ Date: _____

Current foot problem(s) _____ Was this an accident? (circle) **Yes/No**

If yes, was it on the job? (circle) **Yes/No** (If you answered yes, please inform the receptionist/call office immediately)

Date of accident: _____ Has your employer been informed? (circle) **Yes/No**

Description of pain _____ How long have you had the pain/problem? _____

Where on foot/ankle: _____ Caused by _____

Aggravated by _____ Relieved by: _____ Prior treatment (circle) **Yes/No** If yes, what type of treatment and by whom? _____

Flu Vaccine: (circle) **Yes/No** When? _____ Pneumonia Vaccine: (circle) **Yes/No** When? _____

Living Will or Power of Attorney: (circle) **Yes/No**

Height: _____ feet _____ inches Weight: _____ Occupation: _____ Shoe Size: _____

Social History: Please CIRCLE

Tobacco Use:	Non-Smoker	Smoker _____ packs per day	Smokeless Tobacco	Quit _____ Years ago.	Smoked _____ years.
Exercise:	None	Walking Everyday/Occasionally	Jogging/Running	Aerobic Activity _____ times per week.	Other:
Alcohol consumption:	None	Occasionally	Moderately	Heavy	Type:
Caffeine?	Yes	No	Recreational Drug use	Yes	No

Medical History: Please CIRCLE the box to the right that applies to YOUR Medical/Surgical History.

Diabetes Type I/Type II (circle)		Arthritis (type)		Cancer (type)	
Date of diagnosis:					
Last A1c or BGL:					
Heart Attack/Heart Disease (circle)		GERD/ulcer/Colitis (circle)		Depression/Anxiety	
High Blood Pressure		COPD/Asthma/Emphysema (circle)		HIV/AIDS	
Epilepsy/Seizures/Stroke (circle)		Neuropathy		PAD	
Bleeding Disorder		Gout		Hearing Aids	
Phlebitis/Blood clots/DVT (circle)		Liver Disease/Hepatitis A/B/C (circle)		Dentures	
Hypothyroidism		Wound current/history (circle)		Corrective Lenses	
Foot or Ankle injuries/surgery (type)		Vascular Surgery		Other Surgery:	

Family History. Please CHECK the box to the right if it applies to YOUR FAMILY (Blood Relatives Only)

Diabetes TYPE I/TYPE II		Heart Attack/Heart Disease		High Blood Pressure		Adopted/No Knowledge	
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Please list all Medications you are currently taking:

MEDICAION NAME	DOSAGE	HOW MANY TIMES A DAY

Allergic to (circle) Penicillin, Sulfa Drugs, Aspirin, Codeine, Iodine, Tape, Cortisone, Local Anesthesia, Other: _____

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Dear Patient:

We look forward to seeing you in our office. Thank you for giving us the opportunity to care for your medical needs. In order for us to provide you with the best care possible, we must follow a few guidelines and government regulations.

Office hours:

Monday – Thursday: 9:00- 5:00
Friday: 9:00- 12:00
By appointment only

By law we are required to have a copy of your Insurance card(s) & Photo ID on file.

Dr. Paradoa, Dr. T. Caballes and Dr. R. Caballes use Medical Billing Connection as an outside billing company.

Initial: _____ **Medicare:** Dr. Paradoa/Dr. T. Caballes/Dr. R. Caballes are providers for Medicare. Your secondary insurance will be filed as a courtesy. However, if your secondary insurance has not made payment within 90 days of Medicare payment you will be responsible for any remaining balance.

Initial: _____ **Blue Cross/Blue Shield:** Dr. Paradoa/Dr. T. Caballes/Dr. R. Caballes are providers of BC/BS. Any co-pay or deductible will be due at time of service.

Initial: _____ **United Health Care:** Dr. Paradoa/Dr. T. Caballes/Dr. R. Caballes are providers of UHC. Any co-pay or deductible will be due at time of service.

Initial: _____ **Private Insurance:** Dr. Paradoa/Dr. Caballes/Dr. R. Caballes requires payment at time of service. Your insurance company will be billed in a timely manner for you to receive any reimbursement you are entitled to.

Initial: _____ **Self-Pay:** Dr. Paradoa/Dr. Caballes/Dr. R. Caballes require payment in full at time of service. \$200.00 will be collected upon check-in and the remainder will be collected upon checking out.

Initial: _____ **Collections:** All unpaid balances will be sent to an outside collection agency or small claims court, after all practice efforts have been exhausted. Any & all small claims & collections cost will be the patient's responsibility.

Initial: _____ **Return Check fee:** A fee of \$45.00 will be charged to any patient account for a returned check.

Initial: _____ **Appointment No Call/No Show:** A fee of \$40.00 will be charged to any patient account for a missed appointment.

Initial: _____ **Fee for completing paperwork:** A fee of \$35.00 will be collected from the patient at time of service.

Initial: _____ **X-ray Policy:** X-ray CDs are \$10.00 each and require a 48-hour notice. If you decide not to pick up the disc your account will be charged for the \$10.00 fee regardless.

HIPAA: I agree to allow Dr. Paradoa/Dr. T. Caballes/Dr. R. Caballes to use or disclose the protected health care information of the listed patient to carry out treatment, payment or health care operations.

I have been informed of the Privacy Notice. The notice is a more complete description of the uses and disclosures of protected health information that may be made, and of my rights with respect to protected health information. I understand that I have the right to request a restriction on how protected health information is used or disclosed in order for Dr. Paradoa/Dr. T. Caballes/Dr. R. Caballes to carry out treatment, payment and health care operations. Further, I understand that this request for restriction must be in writing and if the health care provider agrees to the restriction, the restriction is binding. However, the health care provider is not required to agree to the requested restriction. I also understand that the office may call my home to confirm information, and will mail statements to the address I have listed, which is part of the health care operations of Amberly Paradoa DPM, FACFAS.

I understand that I have the right to revoke this consent at any time. The revocation must be in writing.

This consent meets the requirements of the Health Information Portability and Accountability Act of 1996 (HIPAA)

Patient Signature: _____ Date: _____

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Medical Records Release Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____

Date of Birth: _____

Address: _____

Phone: _____

I authorize the records release of the following information.

** Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/ alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

All medical records

Laboratory/pathology reports

X-rays/radiology records

Pharmacy/prescription records

Billing records

Office Visit and General Notes

Please send the requested records to:

Address: 3735 11th Circle Suite 201
Vero Beach, Florida 32960

Phone: (772) 299-7009

Fax: (772)562-7138

The information requested may be used for purposes of my continued health care. I understand that after the custodian of records discloses my health care information, it may no longer be protected by the federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign the authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment or eligibility for benefits unless allowed by law. By signing below, I represent and warrant that I have the authority to sign this document and authorize the use and disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

Signature of Patient

Date

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CONSENT FOR TRANSFER OF BIOLOGICAL SPECIMEN

Florida law (Section 817.5655, Florida Statutes) prohibits the sale or transfer of a person's biological specimen from which DNA can be extracted to a third party without the express consent of such person.

During the course of your care at Advanced Foot & Ankle of Indian River, it may be medically necessary to obtain a blood, urine, stool, tissue or other type of biological specimen for analysis. This analysis will not involve the examination of your DNA to identify the presence and composition of genes in your body. After the analysis has been performed and the sample is no longer needed, it will be stored as medical waste and then transferred to a third party for disposal in accordance with all local, state and federal requirements.

It may also be the case that a biological specimen (such as blood, urine, hair, bodily fluids, ect.) from you may be deposited on medical instruments, bedding, clothing or other objects. These objects may then be transferred to a third party for cleaning or disposal.

By signing this document, you affirmatively state that it is your intention decision to consent to the transfer of any and all biological specimens collected by or deposited with Advanced Foot & Ankle of Indian River to a third party as set forth above. This consent does not authorize the sale or transfer of a biological specimen for the purpose of DNA analysis.

Signature of Patient

Printed Name of Patient

____/____/____
Date