



Dr. Victoria S. Carroll

Dr. Joshua M. Carroll

6080 Dixie Highway • Suite C • Clarkston, MI, 48346

Phone (248) 602-3501 • Fax (248) 602-3502

This information is strictly confidential

Patient Fact Sheet

Today's Date: ____/____/____

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

Social Security Number: ____ - ____ - ____

If patient is a minor, name of responsible adult: _____

Home Address: _____ City: _____ State: _____

Zip Code: _____ Home Phone: _____ Cell Phone: _____

Email Address: _____ Occupation: _____

Employer: _____ Work Phone: _____

Circle One: Single Married Widow(er) Partner Divorce

Spouse's Name: _____ Spouse's D.O.B: ____/____/____

Spouse Primary Phone: _____

Emergency Contact Person: _____ Relationship: _____ Phone: _____

Primary Care Physician: _____ Location: _____ Phone: _____

Preferred Pharmacy: _____ Location: _____

How did you hear about our office? _____

ALL CHARGES FOR SERVICES ARE THE RESPONSIBILITY OF THE PATIENT

Due to the many changes in insurance policies; It is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. Therefore, we urge you, as the policyholder, to please check with your insurance company prior to any treatment or surgery. It is your responsibility to know your individual coverage. Failure to comply with this suggestion could result in you, the patient, being responsible for all costs incurred. Please remember your insurance policy is between you and your insurance company and not with the insurance company and your doctor.

If you have a high-deductible plan, **we may collect a \$125 deposit** to apply towards your deductible and co-insurance. Any remaining balance after submission to your insurance company is your responsibility.

A **\$45 fee** will be charged for cancelled or missed appointments without twenty-four-hour advance notice. Should the account be referred to a collection agency, the patient shall pay collection expenses and attorney's fees if applicable.

Language: _____ Race: _____ Ethnicity: Hispanic/Latino Not Hispanic/Latino

Patient Signature: _____ Date: _____

(Signature of Parent or Legal Guardian if patient is a minor or incompetent to give consent)



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Patient Medical History

Today's Date: ___/___/___

Patient Name: _____ Date of Birth: ___/___/___ Age: _____

Height: _____ Weight: _____ Shoe Size: _____

What is your foot/ankle problem? _____

When did you first notice the problem? _____

Have you been treated for this before? _____ If so, when/where: _____

Are you diabetic? _____ If yes, controlled by: Diet Insulin Medication: _____

Please provide a list of your medication(s) and dosage(s): _____

Allergies and Reactions: (Please check all that apply)

- Aspirin Bactrim Codeine Iodine Novocain Demerol Penicillin
- Sulfa Adhesive Tape Latex Antihistamines Food Other: _____

Medical History: (Please check all that apply)

- Anemia Arteriosclerosis Arthritis Asthma Bleeding Tendencies
- Cancer COPD Diabetes Epilepsy Eye Problems
- Gout Heart Disease Heart Stent Polio High Blood Pressure
- Stroke Scarlet Fever Numbness TBI High Cholesterol
- Tumors Kidney Disease Stomach Ulcers GERD Rheumatic Fever
- Hepatitis Tuberculosis Currently Pregnant Currently Breastfeeding

Surgical History: _____

Do you Smoke? Yes ___ pack/day x ___ years
 No Quit, but I smoked ___ pack/day x ___ years

Do you drink alcohol? Yes No If yes, How Often? _____ Recreational Drugs? Yes No

Is there anything else we should know? _____

I hereby authorize Joshua Carroll D.P.M and Victoria Carroll D.P.M to examine, perform diagnostic tests, and treat my feet medically, surgically, and or orthopedically. I also authorize the release of any medical information necessary to process this claim. All benefits are to be paid to the above-named physicians for any services rendered.

Patient Signature _____ Date: _____

(Signature of Parent or Legal Guardian if patient is a minor or incompetent to give consent)



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Today's Date: ____/____/____

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

Personal History: (Please check all that apply)

	Yes	No		Yes	No
Bunion/HAV			Broken Bones		
Thick Nails			Hammer Toes		
Dizziness			Joint Stiffness		
Peripheral Vascular Disease			Muscle Pain/Weakness		
Swelling of Feet			Painful Toe(s)		
Extremities Cold			Arthritis		
Numbness			Bursitis		
Varicose Veins			Foot Pain		
Persistent Cough			Heel Pain		
Tuberculosis			Low Back Pain		
Shortness of Breath			Stroke or CVA		
Athletes Foot			Developmental Delay		
Deformed Nails			Dementia		
Ingrown Nail			Anemia		
Wart			Bleeding Disorder		
Corns/Calluses			Anxiety		
Skin Cancers			Depression		
Ankle Pain			Fungal Nails		

Date of Last Mammogram: _____ Date of Last Influenza Vaccine: _____

Date of Last Colonoscopy: _____ Date of Last Pneumonia Vaccine: _____



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Today's Date: ____/____/____

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

Family Medical History: (Please provide medical history for your Mother OR Father)

Adopted Unknown

Name of Mother or Father: _____

Date of Birth: ____/____/____ Approximate Age: _____

Living: Yes No If no, cause of death: _____

Ethnicity: Hispanic/Latino Not Hispanic/Latino

Race: American Indian or Alaska Native Language: _____

Asian

Black or African American

White

Other: _____

Smoking Status: Current

Former

Never

Unknown

Family History of:

Diabetes

Cancer

Heart Disease

Hypertension

Other: _____



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ACKNOWLEDGEMENT 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 so chose) and understood the notice. *

Patient Name

Parent of Authorized Representative (if applicable)

Date of Birth

Signature

Today's Date

Notices of Privacy Practices is located behind this page. Copies are available at the desk.



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Patient Responsibility Form

I understand and agree that I am financially responsible for all charges for any and all services rendered.

I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance.

I understand and agree that it is my responsibility to know if my insurance has any deductible, copayment, co-insurance, out-of-network, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full.

I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered.

I agree to inform the office of any changes in my insurance coverage or insurance carrier. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

If I am a Medicare patient, I understand that I need to provide the office with my Medicare ID card and my secondary ID card. If the office does not have the proper information for a secondary insurance, the secondary will not be billed. It will be my responsibility to pay the balance and then file a claim with the secondary for reimbursement.

If I am a Medicare Advantage patient, I understand that I need to provide the office with my Medicare Advantage card. If I present my Medicare card instead of my Medicare Advantage card, I will be responsible for non-covered items or out-of-network fees.

By signing this form, I consent to the use and disclosure of protected health information about me for treatment, payment and health care operations, as required by law. I have the right to revoke this consent, in writing, signed by myself. However, such revocation shall not affect any disclosures already made in compliance with my prior consent. This form complies with the Insurance Portability and Accountability Act of 1996 (HIPAA).

Printed Name (Guardian Name if applicable)

Date of Birth

Patient or Guardian Signature

Today's Date



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Patient Provider Partnership Agreement

Patient-Centered Medical Home Model of Care

Carroll Foot and Ankle participates in a Patient-Centered Medical Home model of care. In this model, “Medical Home” refers to a team-based approach to managing your healthcare -- not a physical location – where health care providers work together to provide you with family-centered coordinated medical services and improve overall health outcomes. A medical home is about you and caring for you. It is where we can take care of most of your medical needs.

As part of your “Medical Home”, that means you can trust us to:

1. Provide short-term and long-term care and help direct you on where to go within the “Medical Home” for care for other problems
2. Discuss your goals and how you would like to improve your health
3. Listen to you and address your concerns
4. Provide information about your health in a way you can understand
5. Respond promptly to your calls, questions, and concerns.
6. Communicate test results and follow-up recommendation in a timely manner
7. Work collaboratively with your primary care provider and other specialists as needed

Being a part of a “Medical Home”, means we trust you to:

1. Take steps to achieve a healthy lifestyle
2. Follow the agreed treatment plan as best as you can
3. Provide complete and accurate medical information
4. Keep us updated on who your primary health care provider is so we can communicate and coordinate with them. (If you do not have a PCP, we would love to make a recommendation)
5. Ask questions if you do not understand any portion of your healthcare.
6. Keep scheduled appointments or notify us if rescheduling is needed.
7. Understand your insurance coverage so you know what services are covered
8. Understand your financial obligations and pay your portion at the time of the visit
9. Give us your feedback so that we can improve our services

Signature: _____

Date: _____