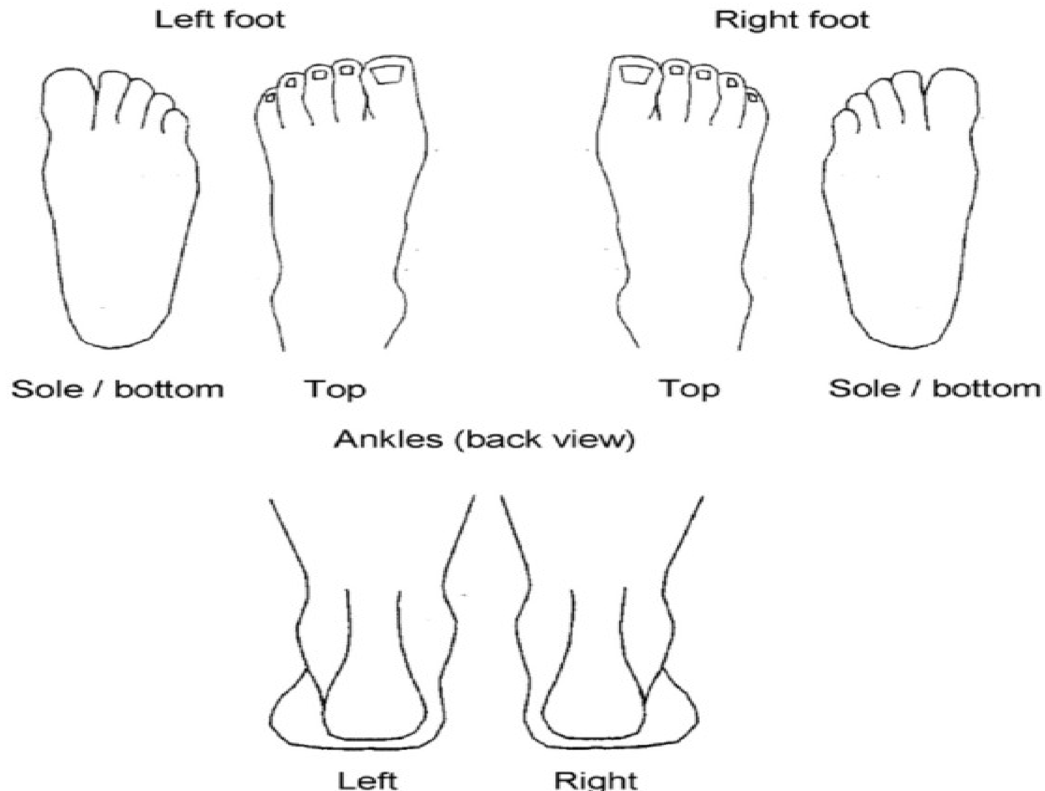
PATIENT HISTORY FORM *(FORMA DE HISTORIA DEL PACIENTE*)

Patient Name *(Nombre del Paciente*):____
Date of Birth (*Fecha de Nacimiento*):__________ Race (*Raza*):__________ Gender (*Genero*):______
Height (*Altura*):_________ Shoe Size (*Tamaño del zapato*):________
SSN(*Numero Social*) _________________Marital Status(*estado civil*) Single Married Widow Divorced
Current Foot or Ankle Problem (*Pie o Tobillo Problema)*:____
Nature of Pain eg. Sharp, Dull, Achy, etc. (*Naturaleza del Dolor eg. intenso, leve, dolorido, etc.*)____
Location of Pain (*Localización del Dolor*):____
Onset/What happened (*El inicio/Que paso?*):____

Please fill out the following confidential form for our records. Please circle where you feel pain on the foot, ankle OR toe diagram below.

Por favor rellene el siguiente formulario confidencial para nuestros registros. Por favor marque el dolor en el pie y tobillo o dedo del pie en el diagrama.



PREFERRED PHARMACY________________ **PRIMARY CARE DOCTOR**_____________
(Farmacia) (*doctor de atención primera*)

PATIENT AND FAMILY MEDICAL HISTORY (INCLUDE YOURSELF, Mother, Father, Siblings only)
(Historia Medico de USTED y familia no más madre, padre, hermanos/hermanas)

Father (*Padre*): Living(*Viviendo*) Deceased(*Muerte*) Age(*Edad*)____Cause of Death(*causa*)_______________
Mother (*Madre*): Living(*Viviendo*) Deceased(*Muerte*) Age*(Edad)*____ Cause of Death(*causa*)________________
Sibling(*hermanos*) Living*(Viviendo*) Deceased(*Muerte*) Age(*Edad*)____ Cause of Death(*causa*)________________

CIRCLE ALL THAT APPLY *(CÍRCULO TODAS QUE APLICAN)*

Acid Reflux	Diabetes (Type 1 or 2?)	Migraine	Bleeding Disorder
Anemia	Fibromyalgia	Muscular Disorders	Arthritis
Anxiety	Heart Disease	Neuropathy	Thyroid Disorder
Asthma	High Blood Pressure	Stroke	Tuberculosis
Cancer (Type)	Kidney Disease	Immune Diseases (HIV/AIDS)	
Depression	Liver Disease	Heart Attack	

List any other medical problems not mentioned above *(enumere cualquier problema medico que no ha enumerados anteriormente)*____

ALLERGIES(*alergias***)**____
____

MEDICATIONS(*Medecinas***)**____
____
____

<u>**SOCIAL AND ENVIRONMENTAL HISTORY*(HISTORIA SOCIAL Y AMBIENTAL*)**</u>

Pregnant(embarazado) YES(si) NO(no) # of Children?___(# de niños)?___ Ages of children? (edad de niños)_

Tobacco User	YES	NO	How much? ___	When did you quit?____
(Usted Fumar)?	*Si*	*No*	*Cuanto?* ___	*(Cuando dejaste)?* ____
Drink Alcohol	YES	NO	How much per week?__________	
Beber alcohol?	*Si*	*No*	*Cuanto en un semana?*_________	
Drink Caffeine	YES	NO	How much per week?__________	
Beber cafeina?	*Si*	*No*	*Cuanto en un semana?*_________	

Whom may we thank for referring you to our office?*(¿A quién podemos agradecerle por remitirlo a nuestra oficina?)*

Family Physician?*(médico de familia?)*_________________ Last seen?(*¿Última vez visto?)*__________
Emergency Contact (*contacto de emergencia*) ____

I hereby give The Foot and Ankle Clinic of Albuquerque permission to diagnose and administer treatment of my foot and/or ankle condition and I authorize any release of information obtained in the course of treatment.
(Por la presente doy permiso a The Foot and Ankle Clinic de Albuquerque para diagnosticar y administrar el tratamiento de mi condición de pie y / o tobillo y autorizo cualquier divulgación de información obtenida en el curso del tratamiento.)

PATIENT COMMUNICATION CONSENT FORM TEXT OR EMAIL MESSAGE ACCOUNT ALERTS

(FORMULARIO DE CONSENTIMIENTO DE COMUNICACIÓN DEL PACIENTE MENSAJE DE TEXTO O CORREO ELECTRÓNICO ALERTAS DE CUENTA)

I authorize The Foot and Ankle Clinic of Albuquerque, P.C. to send text or email appointment reminders to me on my provided cell phone number. By accepting these terms, I agree that all individuals associated with my account may receive alerts referencing the guarantor and/or dependents. Text message charges from my cell phone provider may apply.
My signature below indicates that I represent and warrant that I am the person legally responsible for all use of the accounts, that I am at least 18 years of age, and that I agree to all terms and conditions of use for the text messaging services. I understand that this authorization can only be revoked in writing.
(Autorizo The Foot and Ankle Clinic de Albuquerque, P.C. para enviar recordatorios de citas por mensaje de texto o correo electrónico al número de teléfono celular proporcionado. Al aceptar estos términos, aceptó que todas las personas asociadas con mi cuenta pueden recibir alertas que hagan referencia al garante y / o dependientes. Es posible que se apliquen cargos por mensajes de texto de mi proveedor de telefonía celular.
Mi firma a continuación indica que represento y garantizo que soy la persona legalmente responsable de todo uso de las cuentas, que tengo al menos 18 años de edad y que acepto todos los términos y condiciones de uso de los servicios de mensajería de texto. Entiendo que esta autorización sólo se puede revocar por escrito.)

Signature(*Firma*):____ Date(*Fecha*):________________

CONSENT FOR PHOTOGRAPHY, VIDEOTAPING, OR OTHER IMAGING FOR MEDIA OR EDUCATIONAL PURPOSES

(CONSENTIMIENTO PARA FOTOGRAFÍA, VÍDEO U OTRAS IMÁGENES PARA MEDIOS O FINES EDUCATIVOS)

I give my consent to have photographs, videotaped images or other images made of my feet and/or ankles (NO FACE SHOTS). I understand and agree that these images may be used by The Foot and Ankle Clinic of Albuquerque, P.C. for the purpose outlined below.
(*Doy mi consentimiento para que se hagan fotografías, imágenes grabadas en video u otras imágenes de mis pies y / o tobillos (NO FOTOGRAFÍAS DE CARA). Entiendo y acepto que estas imágenes pueden ser utilizadas por The Foot and Ankle Clinic of Albuquerque, P.C. para el propósito que se describe a continuación).*

___________ Teaching purposes, which include being shown to other patients
(*Propósitos de enseñanza, que incluyen mostrarse a otros pacientes)*
___________ Advertisements by The Foot and Ankle Clinic of Albuquerque, P.C.
(Anuncios de la Clínica de Pie y Tobillo de Albuquerque, P.C.)
___________ Placement on The Foot and Ankle Clinic of Albuquerque, P.C. website
(Colocación en la Clínica de Pie y Tobillo de Albuquerque, P.C. sitio web)

Signature (*Firma*) ____________________ Patient Name (*Nombre del paciente*) ____________________ Date(*Fecha*) ____________

HIPAA NOTICE OF PRIVACY PRACTICES
(AVISO DE PRÁCTICAS DE PRIVACIDAD DE HIPAA)

I have received this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The notice includes:
(He recibido el Aviso de prácticas de privacidad de esta práctica escrito en un lenguaje sencillo. El aviso proporciona en detalle los usos y divulgaciones de mi información médica protegida que puede realizar esta práctica, mis derechos individuales y las obligaciones legales de la práctica con respecto a mi información médica protegida. El aviso incluye:)

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and healthcare operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  The right to complain to this practice and to the Secretary of Health and Human Services if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
  The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
  The right to receive confidential communications of protected health information.
  The right to inspect and copy protected health information.
  The right to amend protected health information.
  The right to receive an accounting of disclosures of protected health information.
  The right to obtain a paper copy of the Notice of Privacy Practices form this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.
(Esta práctica se reserva el derecho de cambiar los términos de su Aviso de prácticas de privacidad y de hacer efectivas nuevas disposiciones para toda la información médica protegida que mantiene. Entiendo que puedo obtener el Aviso de prácticas de privacidad actual de esta práctica si lo solicito).

Patient Name:________________________ Signature:___________________________ Date:_________
(Nombre de Paciente) *(Firma):* *(Fecha):*

CONSENT TO TREATMENT
(CONSENTIMIENTO PARA EL TRATAMIENTO)

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
(*RECONOCIMIENTO DE RECIBO DE AVISO DE PRÁCTICAS DE PRIVACIDAD)*

I acknowledge that I was provided with a copy of The Foot and Ankle Clinic of Albuquerque, P.C. 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*(iniciales)*______

ACKNOWLEDGMENT REGARDING PRIVACY POLICY
(RECONOCIMIENTO SOBRE LA POLÍTICA DE PRIVACIDAD)

Due to the recent implementation of Patient Privacy Act (HIPAA), I hereby authorize The Foot and Ankle Clinic of Albuquerque, P.C. to leave messages at my home with family members and /or answering machines regarding the following: (1) confirm appointments (2) results of testing ordered by the physician and/or (3) any pertinent information that may be relative to my care

Patient Initials*(iniciales)*_______

ACKNOWLEDGMENT OF RECEIPT OF FINANCIAL POLICY
(RECONOCIMIENTO DE RECIBO DE POLÍTICA FINANCIERA)

I acknowledge that I was provided a copy of the Foot and Ankle Clinic of Albuquerque, P.C. Financial Policy and that I have read (or had the opportunity to read if I so chose) and understand and will comply with the policies stated. Patient Initials*(iniciales)*___

CONSENT TO VIEW EXTERNAL PRESCRIPTION HISTORY
(CONSENTIMIENTO PARA VER EL HISTORIAL EXTERNO DE RECETAS)

I authorize The Foot and Ankle Clinic of Albuquerque, P.C. to view my external prescription history via electronic prescribing services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies and pharmacy benefits managers, may be viewable by my provider and staff at The Foot and Ankle Clinic of Albuquerque, P.C. and it may include prescriptions back in time for several years. Patient Initials*(iniciales)*_______

PATIENT CONSENT
(CONSENTIMIENTO DEL PACIENTE)

I hereby voluntarily consent to outpatient care by The Foot and Ankle Clinic of Albuquerque, P.C. 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 the Doctor.

Patient Initials*(iniciales)*_______

INSURANCE ASSIGNMENT AND RELEASE
(ASIGNACIÓN Y LIBERACIÓN DEL SEGURO)

The Foot and Ankle Clinic of Albuquerque, P.C. may use my healthcare information and may disclose such information to the disclosed insurance company/companies and their agents for the purpose of obtaining payments for services and determining insurance benefits or the benefits payable for related services. Patient Initials*(iniciales)*_______

I HAVE READ AND FULLY UNDERSTAND THIS CONSENT TO TREATMENT. I AGREE TO ALL OF ITS CONTENTS. THIS AUTHORIZATION IS VALID AS OF THE DATE I HAVE SIGNED BELOW AND WILL REMAIN IN EFFECT AS LONG AS I AM A PATIENT AT THE FOOT AND ANKLE CLINIC OF ALBUQUERQUE, P.C.

______________________________	____________________________________	_______________
Patient Name *(Nombre de paciente)*	Signature *(Firma)*	Date *(Fecha)*

FINANCIAL POLICY
(POLÍTICA FINANCIERA)

Thank you for choosing The Foot and Ankle Clinic of Albuquerque, P.C. as your healthcare provider. The following is a statement of our Financial Policy that we ask you to read, agree to and sign prior to any treatment.

1. Payment is due at the time services are rendered, including copayment and deductibles. We accept several insurances, cash, checks,credit cards and debit cards with Visa or Master Card logos.
2. It is your responsibility to verify with your insurance plan/carrier PRIOR to each appointment that our group is a participating provider. Please verify if any services such as office visits, x-rays and procedures require pre-authorization. Some plans require referrals from your family physician.
3. Written or verbal authorization from insurance plans or management groups is not a guarantee of payment. All claims are reviewed by the insurance carriers after services are rendered and authorizations can be denied at the time of review. Denied claims become the patient's responsibility.
4. Statements are mailed after the insurance company has paid their portion. The account is then payable within 30 days. **Overdue accounts are subject to a $15 fee.** Accounts 90 days past due are subject to collection by an external agency unless financial arrangements are made with our billing office. (505) 717-1591. **A $25 fee OR interest and transfer fees will apply.**
5. All supplies or products dispensed which are not billable to insurance must be paid for at the time they are dispensed. There are no refunds/exchanges on any supplies dispensed.
6. We recommend you verify with your insurance whenever our office refers you to outside laboratories, hospitals, physical therapy or tests to insure that you do not require any pre-authorization.
7. There is a $25 charge for any and all forms filled out by our office. Please allow 15 days for completion of forms.
8. There is a $25 charge for requested, copied X-rays or medical records. All requests must be submitted in writing and please be advised, according to state law, copied records will be processed within 10 business days.
9. **NO pain or narcotic medication** will be refilled over the phone. You **MUST** make an appointment with the treating physician.
10. Complaints mUst be submitted in writing to: Medical Director--The Foot and Ankle Clinic of Albuquerque, P.C. 717 Encino Pl. NE, Suite 3 Albuquerque, NM 87102.

. *My signature below indicates that I have read, understand, and agree to the above statements.*
(Mi firma a continuación indica que he leído, entiendo y estoy de acuerdo con las declaraciones anteriores.)

Patient Name________________________ Signature____________________________ Date:_______________
(Nombre del paciente): *(Firma)*: *(Fecha)*: