SHOAL CREEK
FOOT & ANKLE CENTER

Joplin Clinic
1801 West 32nd Street, Building C, Suite 102, Joplin, MO 64804
Phone (417) 622-0648 | Fax (417) 622-0497
Springfield Clinic
1911 South National Avenue, Suite 408, Springfield, MO 65804
Phone (417) 755-7612 | Fax (417) 755-7615
www.shoalcreekfac.com

Patient Registration

Patient Information

First Name:_____ Middle Name:_____ Last Name:_____

Date of Birth:_____ Social Security #:_____ Sex: ☐ Female ☐ Male

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other:_____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other:_____

Address, City, State, ZIP:_____

Marital Status: ☐ Never Married ☐ Married ☐ Partner ☐ Widowed ☐ Separated ☐ Divorced

Employment Status: ☐ Employed ☐ Unemployed ☐ Full-time Student ☐ Part-time Student ☐ Other
☐ Retired ☐ Child Employer Name:_____

Check preferred phone ☐ Home Phone:_____ ☐ Cell Phone:_____

Email:_____

Electronic Notifications: ☐ Email ☐ Text Messaging

Written Contact Preferences (select one): ☐ Email ☐ Postal Mail

Emergency Contact

Shoal Creek Foot & Ankle Center may verbally discuss your protected health information with the following person.

First Name:_____ Middle Name:_____ Last Name:_____

Phone:_____ Relation to Patient:_____

Insured's Information

Patient's Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other

First Name:_____ Middle Name:_____ Last Name:_____

Date of Birth:_____ Social Security #:_____ Sex: ☐ Female ☐ Male

Address, City, State, ZIP:_____

Associations

Primary Care Provider:_____ Date Last Seen:_____

Address, City, State, ZIP:_____

How did you find us: ☐ Event ☐ Facebook ☐ Friend ☐ Internet ☐ Referring Provider ☐ Other

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Patient Name:_____ DOB:_____ Chart #:_____

Encounter

Chief Complaint

Explain your foot/ankle problem:_____

_____

_____

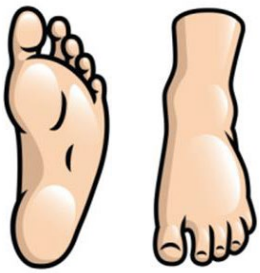
When did the problem first start?_____ (days, weeks, months, years)

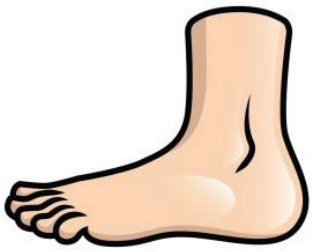
What treatments have you tried?_____

_____

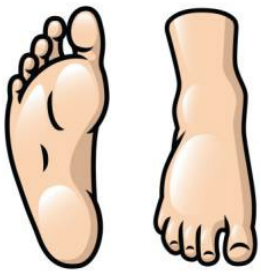
Mark the area of injury or discomfort on the images:

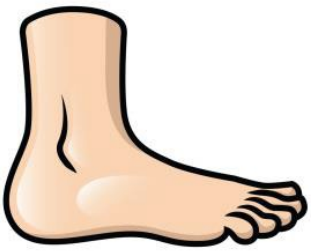
Left Foot





Right Foot





If you have diabetes, what was your last hemoglobin A1C?_____ Date:_____

Allergies

☐ No known allergies ☐ Drug Allergies:_____

_____

☐ Adhesive tape ☐ Latex ☐ Iodine ☐ Betadine ☐ Other:_____

☐ Anesthetic reactions:_____

Medication List

Pharmacy:_____ Phone:_____

Address, City, State, ZIP:_____

Shoal Creek Foot & Ankle Center may request your medications from your pharmacy or healthcare providers.

☐ No Medications ☐ Current Medications, Dose, & Frequency:_____

_____

_____

_____

_____

_____

_____

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Medical History

	You	Father	Mother	Sister	Brother	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather		You	Father	Mother	Sister	Brother	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather
Anxiety	☐	☐	☐	☐	☐	☐	☐	☐	☐	Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐	☐	Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐
COPD	☐	☐	☐	☐	☐	☐	☐	☐	☐	Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	Gout	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Attack	☐	☐	☐	☐	☐	☐	☐	☐	☐	Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Failure	☐	☐	☐	☐	☐	☐	☐	☐	☐	Hepatitis	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐	☐	High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐	☐
Urinary Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	Kidney Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐
Liver Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	Migraines	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	Thyroid Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐

Other conditions:_____

Social History

Do you use tobacco? ☐ Current everyday ☐ Current some days ☐ Former user ☐ Never

Type: ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Chewing Tobacco ☐ Dipping Tobacco ☐ Vape

Do you drink alcohol? ☐ Social ☐ Occasional ☐ Light ☐ Heavy ☐ Never

Type: ☐ Beer ☐ Wine ☐ Hard liquor

Do you use drugs? ☐ Current everyday ☐ Current some days ☐ Former user ☐ Never

Type: ☐ Marijuana ☐ Cocaine ☐ Heroin ☐ Meth ☐ Ecstasy ☐ Hallucinogens

Surgical History

☐ No Surgical History ☐ Past Surgeries & Approximate Dates:_____

_____

_____

_____

Vital Signs

Shoe Size:_____ Height:_____ Weight:_____

Acknowledgment of Accuracy

I confirm that the information I provided is accurate and complete. I understand that incomplete or inaccurate information about my health or medical history can lead to serious risks and complications in my care.

Patient/Patient Representative Signature:_____ **Date:**_____

Relationship to Patient:_____

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Patient Consent for Care & Treatment

Patient Name:_____ DOB:_____

To the patient: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may decide whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you are indicating that:

1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and
2) you consent to treatment at this office or any other satellite office under common ownership.

The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician to perform a reasonable and necessary medical examination, testing, and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive, or interventional procedures are recommended, I will be asked to read and sign additional consent forms before the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient/Patient Representative Signature:_____ **Date:**_____

Relationship to Patient:_____

SCFAC Representative Signature:_____ **Date:**_____

Patient Receipt of Privacy Practices

I acknowledge that I have received a copy of the Privacy Practices for Shoal Creek Foot & Ankle Center and understand its terms. I am aware that additional copies are available in the lobby and on the clinic's website.

Patient/Patient Representative Signature:_____ **Date:**_____

Relationship to Patient:_____

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Patient Financial Policy

Patient Name:_____ DOB:_____

Thank you for choosing Shoal Creek Foot & Ankle Center to be part of your healthcare team. We are committed to providing you with the best possible care and will help you receive your maximum allowable insurance benefits. It is important that you understand your financial responsibilities with respect to your healthcare. Please ask if you have any questions about our fees, our policies, or your responsibilities.

Regardless of any personal arrangements that a patient might have outside of our office, you are responsible for payment of the service. Our prices are representative of the usual and customary charges for our area.

Insurance. Your insurance plan is a contract between you and your insurance company. Knowledge of your plan is your responsibility. This includes but is not limited to copays, deductibles, coinsurance, out-of-pocket, limitations, in-network, out-of-network, authorizations, and referrals. Contact your insurance company if you have any questions about your plan.

Non-covered services. Please be aware that some, perhaps all, of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurance plans. Payment is due at the time of service.

Proof of insurance. It is your responsibility to provide us with current and correct insurance information. We must have a copy of your driver's license and insurance card(s) in your file. If you fail to provide current insurance information, you will be responsible for your balance.

Insurance claims. We participate and accept assignments from most major insurance companies, which means covered charges will be paid directly to us. If we do not participate in your insurance plan, you may still choose to be seen by the practice. As a courtesy to you, we will file a claim with your insurance company on your behalf. Any remaining balance will be billed to you once we have received payment from your insurance company.

Copays, deductibles, and coinsurance. Due to current federal and insurance regulations, all copays, deductibles, and coinsurance must be paid at the time of service.

Deposit and estimate. You may be required to pay a deposit or estimate that will be applied to your account. This includes but is not limited to new patient visits, non-covered services, in-office procedures, and surgery. There may be a remaining balance once we have received payment from your insurance company. If the deposit or estimate exceeds actual charges once treatment has been completed, then a refund will be issued.

Payments. Unless other arrangements have been made in advance by you or your insurance company, payment is due at the time of service. We accept cash, check, American Express, Discover, Mastercard, and Visa. If you are unable to pay at the time of service, your appointment may be rescheduled. A $35 fee will be billed to your account for a returned check.

Uninsured patients/self-pay. If you do not have insurance, payment is due at the time of service.

Outstanding balances. After your visit, we will send you an account statement. All outstanding balances are due upon receipt. If you are unable to pay your outstanding balance in full, please contact us regarding a payment plan agreement.

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Credit card on file. All patients must keep a credit card on file to be used for their outstanding balances. We will contact you in advance prior to charging your credit card.

Delinquent account. Outstanding balances more than 90 days are considered delinquent and are eligible for collections and legal action. If acceptable terms cannot be reached to satisfy the delinquent account, the patient may be dismissed from our practice.

Late arrival, cancellations, and no-shows. If you arrive 15 minutes late or more for your appointment, you will be asked to reschedule. If it is necessary for you to cancel your appointment, we require at least 24 hours in advance notice. A $35.00 fee will be billed to your account for late arrival, cancellations, and no-shows. If it is necessary for you to cancel surgery, we require at least seven days advance notice. A $200.00 fee will be billed to your account for late surgery cancellations and no-shows.

Special forms. A $25.00 fee will be billed to your account for FMLA forms, disability paperwork, and other documentation completed by a physician.

Request for medical records. You are entitled to receive a copy of your medical record. Upon request from the patient or their personal representative, we will provide copies of the requested information. You may be charged in accordance with Missouri law.

Patient dismissal. There are several reasons that a patient may be dismissed from our practice. This includes but is not limited to failure to keep scheduled appointments, being verbally or physically abusive to staff, and failure to meet financial obligations.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient/Patient Representative Signature:_____ **Date:**_____

Relationship to Patient:_____