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:_____

Insurance Policyholder

Patient's Relationship with the Policyholder: ☐ 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

SHOAL CREEK
FOOT & ANKLE CENTER

Patient Name:_____ DOB:_____ Chart #:_____

Encounter

Chief Complaint

Explain your foot/ankle problem:_____

_____

_____

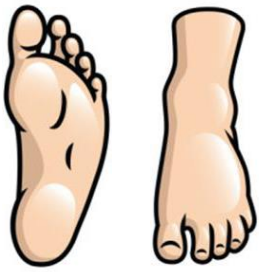
When did the problem first start?_____ (days, weeks, months, years)

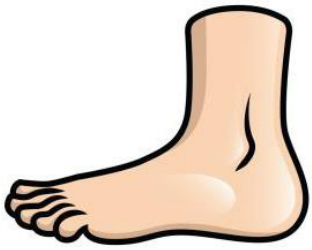
What treatments have you tried?_____

_____

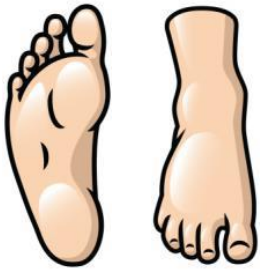
Mark the area of injury or discomfort on the images:

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:_____

_____

_____

_____

_____

_____

_____

SHOAL CREEK
FOOT & ANKLE CENTER

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:_____

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 Consent for Care & Treatment

Patient Name:_____ DOB:_____

I understand that I have the right to be informed about my medical condition and any recommended tests, procedures, or treatments so that I can make an informed decision about whether to undergo care. At this stage, no specific treatment plan has been recommended. This consent authorizes Shoal Creek Foot & Ankle Center to perform necessary evaluations to identify an appropriate diagnosis and treatment plan for any condition(s) found.

By signing below, I acknowledge and agree that:

1. This consent is ongoing and applies to all future evaluations and treatments related to my care, even after a specific diagnosis is made and a treatment plan is recommended.
2. I consent to receive care at this office or any other satellite office under common ownership.
3. I have the right to discuss any recommended tests, procedures, or treatments, including their purpose, risks, benefits, and alternatives. I understand that I may refuse any recommended treatment or request alternative options at any time.
4. I understand that all medical procedures and evaluations carry inherent risks, and I have had the opportunity to discuss these risks with my healthcare provider.
5. I voluntarily request a physician to perform reasonable and necessary medical examinations, testing, and treatment for my condition. Additional or more invasive procedures or surgery will require separate consent before being performed.
6. I understand that in urgent or emergent situations, my provider may administer necessary care as deemed appropriate.
7. I may revoke this consent in writing at any time and may discontinue services if I choose.

I certify that I have read, understand, and voluntarily agree to this consent.

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

Relationship to Patient:_____

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

Acknowledgment of Privacy Practices

I acknowledge that Shoal Creek Foot & Ankle Center offered me a copy of "Notice of Privacy Practices for Protected Health Information" and that I understand its contents. I am aware that additional copies are available in the clinic lobby and on the clinic website.

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

Relationship to Patient:_____

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 Financial & Attendance Agreement

Patient Name:_____ DOB:_____

Thank you for choosing Shoal Creek Foot & Ankle Center as part of your healthcare team. Our goal is to provide the highest quality care while respecting your time and ours. This agreement outlines your financial and attendance responsibilities, so we can deliver safe, timely, and effective care. Please review carefully and ask any questions before signing.

Financial Responsibility

Insurance. Your insurance plan is a contract between you and your insurance company. You are responsible for understanding your coverage, including copays, deductibles, coinsurance, out-of-pocket limits, in-network vs. out-of-network coverage, authorizations, and referrals. Some insurance plans, including Medicare Advantage, Medicaid, or VA, may have additional rules; you are responsible for understanding and following your plan's requirements. Please contact your insurance provider with any questions.

Non-Covered Services. Some services may not be covered or considered medically necessary by Medicare or other insurers. Payment for non-covered services is due at the time of service.

Proof of Insurance. Please provide current and accurate insurance information for each visit. A copy of your driver's license and all active insurance cards must be on file. If you cannot provide valid insurance, self-pay fees will apply or your appointment may be rescheduled.

Insurance Claims. We accept assignment from most major insurance companies. If we are out-of-network, you may choose to be seen; we will file a claim as a courtesy, but any remaining balance is your responsibility.

Copays, Deductibles, and Coinsurance. These amounts are due at the time of service per federal and insurance guidelines.

Deposits and Estimates. Deposits or estimates may be required for new patient visits, non-covered services, procedures, or surgery. Remaining balances will be billed after insurance processes the claim. Overpayments will be refunded.

Payments and Accepted Methods. Payment is due at the time of service unless prior arrangements are made. We accept cash, check, and major credit cards (Discover, Mastercard, Visa). A $35 fee applies for returned checks. Refunds for overpayments or billing errors will be processed promptly after insurance claims are finalized and your account has been reviewed; please allow up to 90 days for processing.

Uninsured Patients/Self-Pay. Patients without insurance must pay in full at the time of service.

Outstanding Balances and Credit Card on File. Statements are sent following visits; balances are due upon receipt. Payment plans are available; please contact our billing department to discuss before balances become overdue. All patients must keep a credit card on file for any patient-responsible balances, including copays, deductibles, uncovered services, and attendance-related fees. You will be notified prior to any charge.

Delinquent Accounts. Balances over 90 days may be considered delinquent and sent to collections or pursued legally. Patients may also be dismissed from the practice if a resolution cannot be reached.

SHOAL CREEK
FOOT & ANKLE CENTER

Special Forms & Medical Records

Special forms (FMLA, disability, or other documentation) may incur a $25 completion fee.

Requests for medical records may include copying fees in accordance with Missouri law.

Attendance & Appointment Agreement

When you schedule an appointment, we reserve dedicated provider time, staff, and clinical resources specifically for you. In return, we ask that you honor this commitment by attending as scheduled or providing adequate notice if you need to reschedule. Our staff may remind you of this agreement and record any missed or late appointments to ensure consistency.

- Timeliness: Arriving late (15 minutes or more) may require rescheduling to maintain clinic efficiency.
- Notice Requirements:
    - Office visits: 24 hours' notice to cancel or reschedule
    - Surgical procedures: 7 days' notice to cancel or reschedule
    - Notice should be provided by phone or voicemail.

Missed appointments or late cancellations limit access to care for other patients and result in unused clinical time. Therefore:

- Late cancellations or no-shows for office visits may result in a $35 missed appointment fee.
- Late cancellations or no-shows for surgical procedures may result in a $200 fee.
- Emergencies may be considered for fee waiver with documentation.

Repeated failure to keep scheduled appointments may result in additional fees or dismissal from the practice.

Patient Dismissal

Shoal Creek Foot & Ankle Center reserves the right to dismiss a patient from the practice for legitimate reasons, including but not limited to:

- Repeated missed appointments or late cancellations
- Unpaid balances after reasonable attempts to resolve
- Abusive, threatening, or unsafe behavior toward staff or providers
- Failure to follow treatment recommendations that put the patient's health at risk

If a patient is dismissed, the practice will provide written notice and a 30-day period for the patient to arrange care with another provider. Emergency care will not be withheld, and medically necessary care required to stabilize a patient will be provided in accordance with applicable laws.

Acknowledgement

I certify that I have read, understand, and agree to the terms outlined in this Patient Financial & Attendance Agreement.

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

Relationship to Patient:_____