BAY AREA FOOT & ANKLE
SCARLETT KINLEY, DPM
321 South Lincoln Avenue
Clearwater, FL 33756
Telephone: (727) 441-8640 • Fax: (727) 441-8651
DrScarlettfootdoc.com • drscarlettkinley@gmail.com

We Make Your Feet Smile

PATIENT NAME _____
First Middle Initial Last

Home Phone # (___)_____ Cell # (___)_____ Work # (___)_____

Birth Date:_____/_____/_____ Age:_____ Sex:_____ Nationality:_____

SSN# _____-____-_____

Home Address:_____
Street House/Apt. # City State Zip

REFERRED TO DR. KINLEY BY: _____

EMERGENCY CONTACT_____ Phone#_____ Relationship to Patient_____

PHARMACY: STORE/MAIL ORDER_____ Phone/Fax#_____

PRIMARY INSURANCE: _____ SUPPLEMENTAL/SECONDARY INSURANCE_____

PREFERRED CONTACT: Home _____ Cell _____ Work _____ E-mail Address:_____

MARITAL STATUS: Single_____ Married_____ Partnered_____ Separated_____ Divorced_____ Widowed_____

SPOUSE NAME:_____ Phone#_____

EMPLOYER:_____ Occupation:_____

PRIMARY CARE PHYSICIAN:_____ Phone#_____ Date Last Seen_____

RELEASE OF INFORMATION/ PRIVACY NOTICE:

In order to protect your privacy, please list up to 3 (three) people who are allowed to discuss your medical information with our office. If at any time you wish to change this list, please notify us.

1)_____ 2)_____ 3)_____

PATIENT/AUTHORIZED PERSON'S SIGNATURE:
I authorize Dr. Kinley to release any information acquired in the course of my examination necessary to process any insurance claim. I agree that medical photographs may be taken in the course of treatment and that photocopies of this form will be as valid as the original. I request payment of benefits either to myself or to the party who accepts assignment. I agree that any balance not covered by my insurance company will be paid by me. Also, I realize that it is my responsibility to make Dr. Kinley's office aware of any changes in my insurance coverage prior to any future visits; otherwise, I will be responsible for treatments not covered by other insurance companies for which Dr. Kinley is not a provider.

I acknowledge that I have received a copy of Dr. Scarlett Kinley's "Notice of Privacy Practices". I have read and answered the above information truthfully and agree to comply.

_____ _____
Signature Date

SCARLETT KINLEY, D.P.M., BAY AREA FOOT & ANKLE

Patient Name_____

Date_____

MEDICAL HISTORY (CHECK THOSE THAT APPLY)

Cardiovascular
_____ Angina
_____ Congestive Heart Failure
_____ Hypertension
_____ Blood Clots
_____ Coronary Artery Disease
_____ Anticoagulant Treatment
_____ Calf Pain when walking
_____ Cold Feet/ Raynaud's
_____ Stroke/CVA
_____ Swelling of Legs/Feet
_____ Poor Circulation/PVD/PAD
_____ Hypercholesterolemia
_____ Arrhythmia/Irregular Heart Beat
_____ Heart Attack/M.I.

Respiratory:
_____ Asthma
_____ Bronchitis
_____ Emphysema
_____ Lung CA
_____ COPD

Dermatologic:
_____ Eczema
_____ Basal Cell CA
_____ Squamous Cell CA
_____ Melanoma of Skin
_____ Chronic Fungus Infections
_____ Thick Scarring/Keloids
_____ Psoriasis
_____ Dermatitis

Gastro-Intestinal
_____ Hepatitis
_____ Acid Reflux
_____ Hiatal Hernia
_____ Stomach Ulcers
_____ Colon Cancer

Genito-Urinary
_____ Enlarged Prostate
_____ Prostate Cancer
_____ Ovian/Uterine/Cervical CA
_____ Breast Cancer
_____ Frequent Urination
_____ Incontinence
_____ Kidney Dialysis
_____ Kidney CA
_____ Kidney Disease
_____ Chronic UTI's

Endocrine:
_____ Thyroid
_____ Diabetes Type 1 (Insulin)
_____ Diabetes Type 2 (Non-Insulin)

Eyes/Ears:
_____ Hearing Loss
_____ Hearing Aids
_____ Vision Loss
_____ Macular Degeneration
_____ Glaucoma

Musculo-Skeletal:
_____ Gout
_____ Osteoarthritis
_____ Rheumatoid Arthritis
_____ Muscle Weakness
_____ Fibromyalgia
_____ Polymyalgia Rheumatica(PMR)
_____ Autoimmune Disorder
_____ Chronic Back Pain
_____ Previous Back Surgery
_____ Osteopenia/Osteoporosis
_____ Joint Replacement

Hematologic:
_____ Anemia
_____ Leukemia
_____ Sickle Cell Anemia
_____ Hemophilia/clotting disorder
_____ Aids/HIV

Neurologic:
_____ Paralysis
_____ Neuropathy
_____ Vertigo
_____ Dementia
_____ Drop Foot Deformity
_____ Anxiety
_____ Depression
_____ Bi-Polar Disorder
_____ Poor Balance
_____ Parkinson's Dz
_____ Alzheimer's Dz

Allergies:

_____ _____ _____

_____ _____ _____

Surgical History Year

_____

_____

_____

_____

Year

_____

_____

_____

_____

SCARLETT KINLEY D.P.M., BAY AREA FOOT & ANKLE

Social History (Tobacco):

Current Tobacco Use? Y_____ N_____

Type of Tobacco _____

Daily Usage _____

Years of Use _____

Previous Tobacco Use? Y_____ N_____

Last Used(year):_____

Social History (Alcohol):

Current Alcohol Use? Y_____ N _____

Type of Alcohol:

Beer_____Wine_____ Liquor_____

Usage Amount:

Social_____ Occasional_____ Light____

Heavy_____ (More than 14/week)

Previous Alcohol Use? Y_____ N_____

Previous Alcohol Abuse? Y_____ N_____

Last Used Alcohol (year): _____

Medications:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Podiatric History:

Current Problem: _____

_____

When did this start?_____ Was the onset gradual?_____ or sudden? ____

Is there a history of Injury or Overuse? What type_____

Have you had this condition before? Y____ N____ Type of Treatment? _____

What is your activity level? None(condition) _____ Low_____ Moderate_____ High_____

Have you tried any home treatment? Type _____

Have you seen another physician for this? _____

Has any professional treatment been performed? _____

Have you ever seen a Podiatrist before? When & Why _____

Type of shoe most commonly worn: _____Shoes worn for work:_____

Do you walk barefoot? Y____ N_____ How often, % of time?:_____ Shoe Size: _____

Most common activity & frequency: _____

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Bay Area Foot & Ankle
Overview of Insurance & Financial Policy

Bay Area Foot & Ankle welcomes you to our practice. We strive to provide you with excellent medical care and make your visit as comfortable as possible.

We would like to bring to your attention that health care benefits today have become extremely complicated. Health benefit packages vary greatly based on company and individual selection. For this reason, as well as the ever changing federal healthcare law, our office has found it necessary to adopt the following policies:

- If you have an HMO you must verbally inform our front desk prior to treatment. I understand that Bay Area Foot & Ankle does not participate in many HMOs and that I may be responsible for full payment.
- Please realize our office does not know and cannot determine your individual healthcare benefits. We will do our best to maximize coverage for your visit within accepted rules and regulations. However, knowing your benefits and financial liability is ultimately your responsibility.
- Insuring that Dr. Kinley participates in your health plan is our responsibility. Our office will try to ensure that we accept your health plan prior to your visit, however due to increased plan options, our office cannot guarantee that we are participating in your plan. If we are unable to get reimbursement through your plan, you will be responsible for all service charges.
- Please inform our office of any insurance, address, email or telephone number changes.
- Our office performs what we feel is medically necessary for your health care based on established medical guidelines and discussions with you.
- Our office will prescribe and recommend those medications which we feel are best for your health. We will do our best to work within any known restrictions. However, please realize any problems concerning the cost or coverage of our medication is between you and your prescription plan. These are financial issues not medical (i.e. prior authorizations.)
- Not all services are covered benefits with all insurance plans. Any treatment, including the writing of prescriptions, is not covered under preventative care. Services not covered by your insurance plans are expected to be paid at time of service.
- You should always be aware of the services being performed and discuss them with Dr Kinley. You are responsible for applicable charges as per your insurance agreement (such as deductibles, percentage, after hour fees, copays, etc.) or any performed services not covered by your insurance policy.
- If you are turned over to a collection agency or write a bad check, you will be responsible for any costs incurred in collecting the balance.
- Be aware that payment is expected at the time of service and that our office accepts cash, checks, Visa, MasterCard and Discover.
- If you have an outstanding balance from a previous visit, you will be asked for payment at your next visit.
- There may be a fee for the completion of paperwork (disability forms, FMLA, prior authorizations, etc.)

As our physician, our relationship is with you and not your insurance company. We realize that problems may arise and we will do our best to work with you through these situations. Please do not hesitate to ask us if you have any questions as we are here to help you.

I have read and understand the above policy and I agree to meet all my obligations.

Print Patient Name	Patient Signature	Date

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PATIENT AUTHORIZATION FOR THE USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby authorize Bay Area Foot & Ankle to use and/or disclose to any party deemed reasonably necessary by Bay Area Foot & Ankle and its office staff, any and all of my protected health information. I understand that the purpose or use of the disclosure I am granting is to allow Bay Area Foot & Ankle to use and disclose my protected health information as needed via the communication methods that you have provided (phone, email, mail). You have the right to specify the preferred mode of communication. I expressly acknowledge that this authorization is voluntary. There are no other criteria or limitations that I make regarding this authorization. I understand that the office will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above. I understand that this authorization may be revoked by the authorizer, in writing, at any time in accordance with the attached authorization revocation procedure. I also understand that the revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation. I understand that the information used or disclosed pursuant to this authorization may be subject to being disclosed again by the recipient and that this information will no longer be protected by federal privacy regulations. I understand that my health care and payment for my healthcare will not be affected if I do not sign this form. I understand that I may see and copy the information described in this form if I request it. This form was completely filled in before I signed it. I certify that all of my questions were answered to my satisfaction and that I understand this authorization form and all of its contents. I acknowledge that I was provided a copy of the Notice of Privacy Practices from Bay Area Foot & Ankle and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I acknowledge that email provided is safe and will only be used by our office and never distributed or shared with other parties. This office has the right to use any email or phone number provided by you to contact you for any and all communication deemed necessary including appointment reminders and other communications from time to time.

PATIENT CONSENT

I hereby voluntarily consent to outpatient care by Dr Kinley at Bay Area Foot & Ankle, encompassing routine care, diagnostic procedures, examination and medical treatment including, but not limited to, minor surgical procedures, routine laboratory work, x-rays and administration of medication and injections prescribed by Dr Kinley. I agree to ask questions to clarify treatment should I not understand the treatment plan.

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance with the insurance company(ies) disclosed and assign directly to Bay Area Foot & Ankle all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions. Bay Area Foot & Ankle may use my health care information and may disclose such information to my insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

MEDICARE AUTHORIZATIONS

I request that payment of authorized Medicare benefits be made to Bay Area Foot & Ankle for any services furnished to me by Dr Kinley. To the extent permitted by law, I authorize any holder of medical or other information about me can be released to the Centers for Medicare Services. I understand that any deductibles, coinsurance, denied or non-covered services are my responsibility. This form has been explained to me and I fully understand this Consent to Treatment and agree to 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 of Bay Area Foot & Ankle. I have read this complete page and agree to all of its contents.

Patient Name Print	Patient Name Signature	Date