RYAN MEDINA OAKLEY DPM LLC
10775 SW 56th Street ● Miami, FL ● 33165
Office: (305) 930-7934 ● Fax: (305) 203-4891
DoctorPodiatryHealthCare@gmail.com

PLEASE PRINT CLEARLY

FIRST/*NOMBRE*_____MI_____LAST/*APELLIDO*_____

ADDRESS/*DIRECCIÒN*_____SUITE/APT_____

CITY/*CUIDAD*_____STATE/*ESTADO*_____ZIP/*CÒDICOPOSTAL*_____

E-MAIL ADDRESS _____

HOME/*CASA*: ( ) _____-_____WORK/*TRABAJO*: ( ) _____-_____

CELL/*CELULAR: (*) _____-_____DATE OF BIRTH/*FECHA DE NACIMIENTO*_____

SOCIAL SECURITY/ *NÙMERO SOCIAL* #: _____--_____-- _____

FAMILY PHYSICIAN/*MÈDICO DE CABECERA* _____

PHONE/*TELÈFONO* ( ) _____-_____

WHO MAY WE THANK FOR THIS REFERRAL? _____

¿QUIÈN LO REMITIO USTED A NUESTRA OFICINA? _____

MARITAL STATUS/ ESTADO CIVIL:

SINGLE/*SOLTERO(A)* MARRIED/*CASADO(A)* *DIVORCED/DIVORCIADO(A)* WIDOWED/*VIUDO(A)* PARTNERSHIP/ *PAREJA*

EMERGENCY CONTACT/*CONTACTO DE EMERGENCIA* _____

PHONE/*TELÈFONO* ( ) _____-_____

EMPLOYER/*EMPLEADOR*: _____

I hereby authorize my insurance company to pay directly to Ryan Medina Oakley DPM LLC dba Doctor Podiatry any and all medical and/or surgical fees otherwise payable to me for their professional services. I acknowledge that I am personally responsible and liable to Ryan Medina Oakley DPM LLC dba Doctor Podiatry for any and all surgical and/or medical fees billed by them. Should Ryan Medina Oakley DPM LLC dba Doctor Podiatry accept payment directly from my insurance company; I understand that I am responsible and liable for any and all deductible/co-pay expenses for the insurance company. If in the event Ryan Medina Oakley DPM LLC dba Doctor Podiatry are required to retain the services of an attorney/collection agency to collect his bills I agree to pay Ryan Medina Oakley DPM LLC dba Doctor Podiatry's fees up through and including appellate fees. A copy of our office's Privacy Practices is available from the front desk upon request.

Por la presente autorizo a mi compañía de seguros a pagar directamente a Ryan Medina Oakley DPM LLC dba Doctor Podiatry cualquier y todos los gastos médicos y / o quirúrgicos de otro modo pagadero a mí por sus servicios profesionales. Reconozco que soy personalmente responsable y obligado a Ryan Medina Oakley DPM LLC dba Doctor Podiatry de cualquier y todos los honorarios quirúrgicos y / o médicos facturados por ellos. En caso de Ryan Medina Oakley DPM LLC dba Doctor Podiatry aceptar el pago directamente de mi compañía de seguros, yo entiendo que soy responsable y responsable por cualquier y todos los gastos deducibles / co-pago de la compañía de seguros. Si en el caso de Ryan Medina Oakley DPM LLC dba Doctor Podiatry están obligados a contratar los servicios de una agencia de abogado / colección para recoger sus cuentas Acepto pagar Ryan Medina Oakley DPM LLC dba Doctor Podiatry, honorarios de DPM arriba hasta e incluyendo los honorarios de apelación. Una copia de las prácticas de privacidad de nuestra oficina está disponible en la recepción bajo petición.

SIGNATURE / *FIRMA* _____ DATE / FECHA _____

DOCTOR PODIATRY

Payment Policy

Thanks for choosing our practice. Below is information to answer frequently asked questions regarding patient and insurance responsibility for services rendered. Please read it and ask us any questions that you may have before signing in the space provided. A copy will be provided to you upon request. Thanks for being our patient.

PAYMENTS ARE DUE AT THE TIME OF SERVICE UNLESS PAYMENT ARRANGEMENTS HAVE BEEN REQUESTED AND APPROVED IN ADVANCE. YOU ARE EXPECTED TO PAY ACCORDING TO THE ARRANGEMENT.

Insurance: We participate with most insurance plans. We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility.

Claims Submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

Referrals: Certain insurance plans with which we are contracted require referral authorization from your primary care physician/ pediatrician. If we have not received a referral prior to your arrival at the office, we have a telephone for you to use to call your primary care /pediatrician physician to obtain it. If you are unable to obtain the referral at that time, you will be rescheduled.

Co- payments and Deductible All co-payments, deductibles & co-insurances must be paid at the time of service. This arrangement is part of your contract with your insurance company.

Proof of Insurance All patients must complete the patient information form before seeing a provider. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. Failure to provide the correct insurance information in a timely manner may result in the balance of a claim being transferred to your personal responsibility.

Coverage Changes If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Methods of Payment We accept payment by cash, check, Visa, MasterCard, American Express and Discover.

Patient Statements If you have unpaid balance you will receive a statement by mail every two weeks. The statement amount is due and payable when the statement is issued, and past due if not paid upon receipt. Balances over 90 days will be turned over to a collection agency for collections. All payments go towards the oldest outstanding balance.

No Show Fee Please cancel/reschedule your visits with 24 hours notice. At our discretion, a fee equal to the cost of your office visit will be charged.

Collection Fees: Balances that have not had a payment made within 90 days will be turned over to collections. Guarantor will be responsible to pay all costs of collections including reasonable interest, reasonable attorney's fees and reasonable collection agency fees not to exceed 33.33%.

Patient's Name: _____

Responsible Party: _____

Signature: _____ **Date:** _____

Office Use: Received By: _____ **Date:**_____

PATIENT HISTORY

*** Please fill out all forms to the best of your ability. The staff will go over the form and answer any questions you may have.**

Full Name: _____ Height: _____ Weight: _____

1) What is the main problem with your feet or ankles? _____

2) When did you FIRST notice the condition? _____

3) Is this an injury? ____Yes ____No If Yes, when did it occur? _____/_____/_____

If Yes, did it happen at work? __Yes __No Are you claiming Workman's Comp? __Yes __No

4) Check all of the following that apply:

Type of Pain __Burning __Tingling __Sharp __Dull Ache __Throbbing __Shooting __Stabbing

When Painful ___Upon Standing __During Walking __After Walking __During Sports

__Worse with Activity __Better as Activity Continues ___Worse when standing __With Shoes __Without Shoes ___A.M ___P.M

___Lying in Bed ___Always

5) How painful is your condition? If **0** = "no pain" and **10** = "the worst pain you have ever experienced", please circle your pain level: **0**

1 2 3 4 5 6 7 8 9 10

6) Have you had foot care before? __Yes __No By whom and when: _____

SURGICAL HISTORY

Procedure or Hospitalization	Date	Complications

MEDICATIONS (Please list all current prescription, over the counter, and supplements you are taking)

Medication	Dosage	How Often	Medication	Dosage	How Often
1.			4.		
2.			5.		
3.			6.		

Pharmacy: _____ Number: _____-_____-_____

MEDICAL HISTORY

Please place a **CHECK MARK** next to which of the following you suffer from and if indicated, please write in the space following what type.

Anemia		Foot Deformity	
Arthritis		Frost Bite	
Artificial Joint		Gout	
Asthma		HIV/AIDS	
Back Pain		Headaches/Migraines	
Bleeding Disorder		Heart Disease	
Blood Clots		Hepatitis	
Cancer		Hernia	
Coronary Artery Disease		Hypertension	
DVT		Kidney Disease	
Diabetes		Leg/foot ulcer	
Dialysis		Liver Disease	
High Cholesterol		Lung Disease	
Swelling		Organ Transplant	
Fibromyalgia		Osteoporosis	
Pacemaker		Seizures/Epilepsy	
Peripheral Vascular Disease		Stroke	
Polio		Substance Abuse	

SOCIAL HISTORY

Do you drink alcohol? ____Yes ____No; If yes, how much? ☐ 1-2 per week ☐ 5-6 per week ☐ > 3 per day

Recreational drug use

* Any type of drug use is a personal choice and will in no way adversely effect your relationship with the doctor. However, many drugs can interact with other medications and treatments with potential life threatening effects. Therefore, it is extremely important that you answer honestly. Your response will be held in the most strict patient-doctor confidentiality.

Answer: ____Yes ____No

If Yes: What substance and how often used? _____

What is your occupation? _____

What is your marital status? ☐Married ☐Single ☐Divorced ☐Separated ☐Widow ☐Partner

Do you smoke tobacco? ____Yes ____No

If Yes: _____ # of years smoking? _____Packs per day? ____Cigarettes per day?

If No: Did you ever smoke? ____Yes ____No

If you quit: How long ago did you stop smoking? _____

FAMILY HISTORY * **Please check all that apply**

	Diabetes 1 or 2	Heart Disease	Hypertension	Gout	Cancer and Type	Age of Death
Father						
Mother						
Brother						
Sister						

ALLERGIES Please list all allergies and the types of reactions you have:

_____

Primary Care Physician: _____Phone: _____
Approximate date of last physical exam ____/____/____

Which other physicians would you like us to share a copy of your visit with?

_____

☐ Diabetes; What is the name and phone number of the doctor treating you for Diabetes?

_____

When was your last visit? ____/____/____ What is your average blood sugar reading? _____

Are you pregnant? ____Yes ____No How many weeks? _____

REVIEW OF SYSTEMS ☐ **I am not experiencing any of the below symptoms.**

*If you are experiencing any of the following please check the appropriate boxes

General: ☐Fever ☐Night Sweats ☐Weight Gain ____Lbs ☐Weight Loss ____Lbs
Eyes: ☐Glasses ☐Contacts ☐Double vision ☐Blurred vision ☐Blindness ☐Cataracts
Ears: ☐Decreased or loss of hearing ☐Ringing in the ears ☐Chronic earaches
Nose: ☐Nose bleeds ☐Sinusitis P
Mouth/Throat: ☐Sore throat ☐Bleeding gums ☐Snoring ☐Dry mouth ☐Teeth Problems
Cardiovascular: ☐Chest pain ☐Shortness of breath when walking ☐Palpitations ☐Murmurs
☐Heart valve disease ☐Leg cramps
Respiratory: ☐Cough ☐Wheezing ☐Shortness of breath ☐Coughing up blood ☐Sleep apnea
Gastrointestinal: ☐Nausea ☐Vomiting ☐Diarrhea ☐Constipation ☐Bloody stool ☐Loss of appetite ☐Acid Reflex
Genitourinary: ☐Chronic kidney or bladder infections ☐Difficulty urinating ☐Pain with urination ☐Dark or bloody urine
Musculoskeletal: ☐Muscle Aches ☐Weakness ☐Joint Pain ☐Back pain ☐Leg swelling ☐Difficulty walking ☐Frequent falls
Skin: ☐Abnormal Mole ☐Rash ☐Dry skin
Neurologic: ☐Loss of consciousness ☐Tingling/Numbness ☐Seizures ☐Dizziness ☐Headaches
Psychiatic: ☐Depression ☐Sleep difficulties
Endocrine: ☐Fatigue ☐Heat intolerance ☐Cold intolerance ☐Hair loss

NOTICE OF PRIVACY PRACTICES (HIPAA REGULATIONS)

☐ You were provided with a document entitled "Notice of Privacy Practices." It is required by governmental regulations that all medical facilities provide you with this notice. Please check the box to acknowledge that you have read (or had the opportunity to read if you chose) and understand the notice. This is a copy of the notice that is yours to keep. If you do not want the copy, simply return it to the receptionist with your other materials.

CONSENT

I certify that the information above is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures, including therapeutic and diagnostic injections, as may be deemed necessary in the diagnosis and/or treatment of my feet.

Signature: _____ **Date:** _____/_____/_____

FSOA 08/20/08

RELEASE OF INFORMATION

PATIENT NAME: _____

(Print Name)

I hereby grant permission to _____ to disclose/ or

release any and all information conserning my illness and/ or treatment to

_____

_____ _____

Patient / Guardian Signature Witness Signature

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Name: _____ Date: _____

Age: _____

1. Have you traveled anywhere outside of the U.S. in the past 2-3 weeks? □ Yes or □ No
2. Have been in contact with anyone who was sick with COVID-19 symptoms? □ Yes or □ No
3. Have you attended any large group functions? □ Yes or □ No
4. Have you had any of the following symptoms within the last two weeks: FEVER, FATIGUE, DRY COUCH, ALTERED TASTE, ALTERED SMELL, TROUBLE BREATHING, PRODUCTIVE COUCH (MUCOUS IN COUCH), OR MUSCLE PAIN? □ Yes or □ No
5. Have you had the COVID-19 test done? □ Yes or □ No
6. Would you be interested in having the COVID-19 antibody 10 minutes test? □ Yes or □ No

We thank you for your cooperation and will contact you if we need further information.

Signature: _____

Thank you

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CREDIT CARD ON FILE POLICY
ADVANCE NOTICE OF APPOINTMENT CANCELLATION

If you absolutely must cancel your appointment, please do so as far in advance as possible so that we have time to schedule another patient in your place. Failure to notify our office in a timely manner will result in us not being able to refill your appointment time slot.

■ **In the event you are unable to keep your appointment, you must cancel 24 hour (1 business day) before the appointment date to avoid a cancellation fee of $25.00.**

NOTIFICACIÓN PARA CANCELACIONES DE CITA

Si usted necesita cancelar su cita, por favor hágalo lo antes posible, para poder utilizar ese turno con otro paciente. Si usted no nos notifica con suficiente anticipación, puede resultar que ese turno se quede vacío. Por favor lea este documento antes de firmarlo.

■ **Debe cancelar su cita por lo menos con 24 horas (un día laboral) de anticipación para evitar un cargo de cancelación de $25.00.**

☐Amex ☐Visa ☐Mastercard ☐Discover

Credit Card Number _____

Expiration Date _____ / _____ / _____ **CCV** _____

Cardholder Name _____

Signature _____

Billing Address _____

City _____ **State**_____ **Zip** _____

I (we), the undersigned, authorize and request Ryan Medina Oakley DPM LLC dba Doctor Podiatry to charge my credit card, indicated above, for balances due for failure to notify our office of a cancellation in a timely manner and/or services rendered that my insurance company identifies as my financial responsibility.

Patient Name (Print): _____

Patient Signature: _____ Date:_____ / _____ / _____