LEDESMA
FOOT + ANKLE

4921 E Bell RD Suite 205, Scottsdale, AZ. 85254
Phone: (602) 753-9403 Fax: (602) 753-9453
E:emessages@ledesmafootandankle.com

Welcome To Ledesma Foot and Ankle!

Dear Patient,

On behalf of myself and staff, I would like to welcome you to our office. We realize that you have a choice when it comes to selecting a healthcare provider, and we want to thank you for choosing Ledesma Foot & Ankle. If you feel that we have met or exceeded your expectations with your visit today, please share your experience with others!

Here are some suggested internet sites that you can post a review:

www.facebook.com/ledesmafootandankle **www.yelp.com**

www.instagram.com/ledesmafootandankle **www.google.com**

www.ledesmafootandankle.com **www.healthgrades.com**

(search "Paul V. Ledesma, DPM", "Scott Shindler, DPM", or "Dr. Jaminelli Banks, DPM")

If you are not computer savvy, handwritten letters or notes are always appreciated as well.

Again, welcome and we look forward to "Caring for You One Step at A Time"!

Sincerely,

Paul V. Ledesma, DPM
Ledesma Foot & Ankle
Medical Director

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New Patient Questionnaire

Patient Name: _____ SSN: _____

Date of Birth: _____ Age: _____ Gender: □ Male □ Female

Phone: _____ Email: _____

Address: _____

_____

City State Zip

INSURANCE INFORMATION

____Self Pay/No Insurance ____Worker's Compensation ___Legal Representation ____Other: _____

PRIMARY

Ins: _____ Policy Holder: _____

Policy / ID #: _____ DOB: _____

Group #: _____ Phone: _____

SECONDARY

Ins: _____ Policy Holder: _____

Policy / ID #: _____ DOB: _____

Group #: _____ Phone: _____

Emergency Contact: _____

Phone#: _____ Relationship: _____

Preferred Pharmacy: _____

_____

RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT BENEFITS

1. I understand that I am responsible for charges not covered or reimbursed by the health insurance. I agree in the event of nonpayment, or partial payment, to assume the cost of interest, collection, and legal action (if required).

2. I authorize my insurance carrier to release information regarding my coverage to Ledesma Foot and Ankle.

3. My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing / physician services including major medical benefits are hereby assigned to Ledesma Foot and Ankle. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance, third party liability claims, medical liens, attorney-based claims, or any other health plans.

4. Acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to Ledesma Foot and Ankle.

Signature of patient or patient's Parent/legal guardian:

X_____ **Date:** _____

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Please carefully read and initial each statement and sign below.

1. _____ I understand if I DO NOT have any insurance card, referral, and/or co-payment, that my appointment may be rescheduled until such a time that I can provide the required documents or payments.

2. _____ I understand that if I am unable to make a scheduled appointment, I need to contact Ledesma Foot & Ankle at least 24 hours before my scheduled appointment time. Due to a high demand for appointments, missed appointments prevent us from scheduling appropriately and keep others in need of urgent care from being seen. A $50 FEE WILL BE ASSESSED FOR ALL MISSED APPOINTMENTS NOT CANCELLED WITH AT LEAST 24-HOUR ADVANCE NOTICE.

3. _____ I understand there will be NO RESULTS or SURGICAL PLANNING provided via phone, email or otherwise.
The patient is entitled to their written reports, but it will not include interpretation by any staff member other than the treating physician.

4. _____ I understand there will be a $25 fee for all FMLA and disability paperwork to be filled out and will be. completed within 7-10 business days.

5. _____ Request for pain medication refills will be reviews for necessity. Refills WILL NOT be filled on the same day if requested after 2pm Monday through Thursday and after 1pm on Fridays otherwise please allow 2 business days to process your refill request.

6. _____ Ledesma Foot & Ankle policy is to collect any co-pay, co-insurance and noncovered fees at the time. of service. I understand that if I do not have my responsible amount, my appointment may be rescheduled.

7. _____ As a courtesy to our patients, Ledesma Foot & Ankle will bill your insurance company. If payment is not received from your insurance company within 60 days of your visit, you will be notified to contact your insurance for payment. If payment is not received from your insurance company within 90 days of your visit, you will receive a statement notifying you that the balance due is your responsibility.

8. _____ I understand I will have 30 days to make payment in full or make payment arrangements. If the account is not paid within 120 days of your visit, your account will be sent to a collection agency and a 35% collection fee will be added to the balance on the account. Incidental costs incurred in the process collection a balance will also be added to your account.

9. _____ I understand that Ledesma Foot & Ankle will collect, 24 hours prior to any surgery or procedure, deductibles and coinsurance up to any amount equal to payment in full for the planned surgical procedure. Payment in full and expected coinsurance payment responsibility are determined by the anticipated surgical billing code(s), details of your insurance policy, and agreement between your insurance company and Ledesma Foot & Ankle.

10. _____ I understand I am financially responsible for all copayments, coinsurance, deductibles and any unpaid or denied services not covered by my insurance: TO INCLUDE DURABLE MEDICAL EQUIPMENT, IN OFFICE PROCEDURES OR ANYTHING SIMILAR.

11. _____ I understand that a $35 service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check.

12. _____ Ledesma Foot & Ankle will contact my insurance company to verify benefits. However, insurance companies do not disclose all information regarding policies. I understand it is my responsibility to contact my insurance provider to confirm actual benefits, coverage, inclusions, and exclusions. If I require a referral, it is my responsibility to obtain the referral authorization from my insurance carrier and provide that information to our office.

13. _____ If you are here for a work compensation injury, MVA, personal injury Ledesma Foot & Ankle will be responsible to bill the work compensation insurance company or the representing attorney.

I have read, and I understand the above office policies and I agree to abide by its terms.

Signature of patient or patient's Parent/legal guardian:

X_____ **Date:** _____

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Effective as of December 1st, 2023

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUTYOU MAY BE USED AND DISCLOSED AND HOW
YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This HI PAA Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you.

We may use of disclose your protected health information in the following situations without your authorization. These situations include as required by law, public health issues as required by law, communicable disease, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164-500.

I understand that I have the right to request and receive a HIPPA Notice of Privacy Practices from Ledesma Foot and Ankle at any time.

Signature of patient or patient's Parent/legal guardian:

X_____ **Date:** _____

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Medical History

Do you have any history of (please check box):

- □ Diabetes
- □ High Blood Pressure
- □ Hyperthyroid
- □ Heart Problems
- □ Epilepsy
- □ Arthritis
- □ Stroke
- □ Phlebitis
- □ Tuberculosis
- □ Valley Fever
- □ Anemia
- □ Kidney Problems
- □ Liver Disease
- □ Cancer
- □ HIV/AIDS
- □ Asthma
- □ Rheumatic Fever
- □ Bursitis
- □ Poor Circulation
- □ Pneumonia
- □ Bronchitis
- □ Emotional Problems
- □ Other serious illness

_____
_____
_____
_____
_____

If Diabetic, please list your most recent A1C: _____ Date: _____

Have you experienced any trauma, i.e. broken bones, MVA or surgeries? □ Yes □ No

Please describe:

_____

_____

Do you smoke? □ Yes □ No How Often? _____ Daily ____Weekly ___Monthly ___Occasionally

Do you drink alcohol? □ Yes □ No How Often? _____ Daily ____Weekly ___Monthly ___Occasionally

Do you use recreational drugs? □ Yes □ No How Often? _____ Daily ____Weekly ___Monthly ___Occasionally

Are you currently using any over the counter medications? _____

Do you experience leg cramps? _____ Low back pain? _____

Stiffness in feet or legs? _____Numbness in feet or legs? _____

Swelling of feet or legs? _____

_____

Any other symptoms we should know about?

_____

_____

_____

Thank you for this information. It is vital in helping us to help you.

Signature of patient or patient's Parent/legal guardian:

X_____ **Date:** _____

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Patient Name: _____ Date of Birth: _____

__ See attached medication list.

List current medications:

1. _____
2. _____
3. _____
4. _____
5. _____

___No Known Drug Allergies

List medications allergies:

1. _____
2. _____
3. _____
4. _____
5. _____

Signature of patient or patient's Parent/legal guardian:

X_____ **Date:** _____

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Patient Name: _____ **Date of Birth:** _____

Appointment with:

__Dr. Paul V. Ledesma, DPM ___Dr. Scott Shindler, DPM ___Dr. Jaminelli Banks, DPM

Who referred you to us? _____

Reason for visit:

_____

_____

Are your issues related to an injury? ___YES ____ NO if yes, what is the date of loss? _____

Is it a ___Work Comp Injury ___Personal Injury/Slip & Fall/MVA ___Other: _____

Description of
Incident:_____

Experiencing Pain?

□ Yes □ No

Pain Scale

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

Minimal **Worse**

Signature of patient or patient's Parent/legal guardian:

X_____ **Date:** _____

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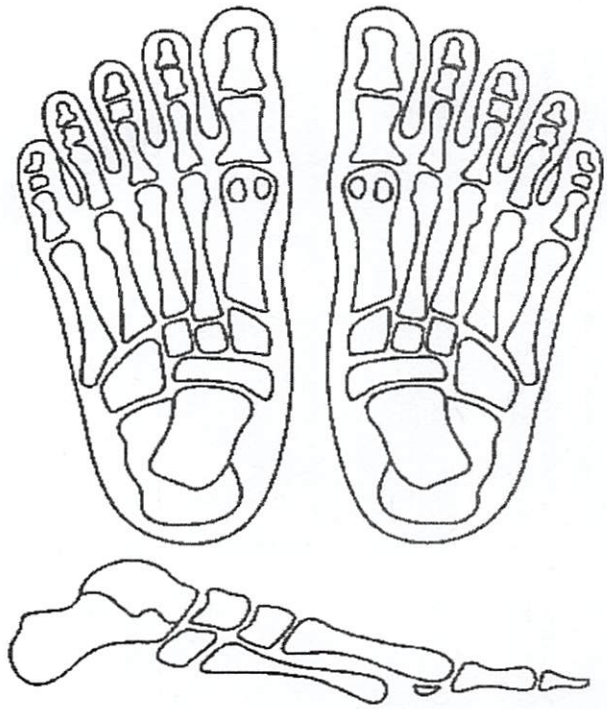
PLEASE CIRCLE WHERE YOUR PAIN IS ON THE FOLLOWING DIAGRAM AND INDICATE TYPE"

X for Numbness + for Pins & Needles
= for Stabbing Pain \\ for Aching Pain



Describe your concerns/issues: _____

_____

_____

Assignment and Release:

I, the undersigned have_____ insurance, and assign directly to Ledesma Foot and Ankle all medical benefits, if any, otherwise payable to me for any services rendered. I understand that I am financially responsible for all charges whether paid by insurance. I hereby authorize the doctor to release information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Medicare Authorization:

I request that payment of authorized Medicare benefits be made to Ledesma Foot and Ankle for any services furnished to me by that physician. I authorize the holder of medical information about me to release to Healthcare Financing Administration and its agents any information needed to determine these benefits of the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms of electronically submitted claims my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the INSURANCE TO CO-INSURANCE. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature of patient or patient's Parent/legal guardian:

X_____ Date: _____

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Peripheral Arterial Disease (PAD) Questionnaire

Today's Date: _____ Patient Name: _____

Date of Birth: _____ Age: _____ Gender: _____ Total Score: _____

1. Are you a male and over the age of 50? (5 pts)	Yes	No
2. Are you a female and over the age of 65? (5 pts)	Yes	No
3. Do you currently smoke? (10 pts) Former smoker? (5 pts)	Yes	No
4. Do you have high blood pressure, or do you take medication to reduce blood pressure? (10 pts)	Yes	No
5. Do you have Diabetes? (10 pts)	Yes	No
6. Do you have a history of heart disease (heart attack, MI)? (10 pts)	Yes	No
7. Do you have a history of stroke or mini stroke (TIA)? (10 pts)	Yes	No
8. Do you have high cholesterol or other blood lipid (fat) problems or require cholesterol medication? (10 pts)	Yes	No
9. Do you have a history of chronic kidney disease or dialysis? (10 pts)	Yes	No
10. Do you have a history of carotid stenosis, AAA (abdominal aortic aneurysm), and/or stent placement? (15 pts)	Yes	No
11. Do you have uncomfortable aching, fatigue, tingling, cramping or pain in your feet, calves, buttock, hip or thigh during walk or exercise? (15 pts)	Yes	No
12. If yes to #11, does the pain go away when you stop walking/exercising?	Yes	No
13. Do your feet get pale, discolored, or bluish at any time during the day? (15 pts)	Yes	No
14. Do you have an infection, skin wound or ulcer on your leg or foot that has been slow to heal over the past 8-12 weeks? (15 pts)	Yes	No

Scoring:
0-9 Unlikely problems with peripheral arterial disease
10-15 Questionable: Your physician can help determine if this may be a concern
15 > Likely benefit from a painless, non-invasive test for peripheral arterial disease.