

New Patient Questionnaire

Patient Information

First Name: _____ Last Name: _____ Date of Birth: _____

Age: _____ Gender: _____ Ethnicity: _____ Race: _____

Mailing Address: _____ City: _____ State: _____

Zip Code: _____ Home Phone: _____ Cell Phone: _____ SSN: _____ - _____ - _____

Email: _____

Pharmacy: _____ Address: _____ Zip: _____

Height: _____ Weight: _____ Recent Blood Pressure: _____ / _____

Preferred Method of contact from our office: Email ☐ Home Phone ☐ Cell Phone ☐

Consent to be contacted via text or email: YES ☐ NO ☐

How did you hear about **Phoenix Foot & Ankle Institute**? _____ Referred By: _____

Facebook: _____ Website: _____ Insurance: _____ Word of Mouth: _____ Law Firm: _____

Employment Information

Employer's Name: _____

Employer's Address: _____

Other Contact Information

Primary Care/Referring Physician: _____ Phone: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

I am granting full permission for all medical information including medical records, imaging, surgical information, appointment information to be released to the person(s) listed below:

1. _____ 2. _____ 3. _____

Financial Information

☐ Self Pay ☐ Insurance ☐ Medicare ☐ Worker's Compensation ☐ Lien

Are you the primary policy holder of your insurance? Yes ☐ No ☐

Primary Insurance Carrier: _____ ID: _____

Subscriber: _____ Date of Birth: _____ Group #: _____ Phone #: _____

Secondary Insurance Carrier: _____ ID: _____

Subscriber: _____ Date of Birth: _____ Group #: _____ Phone #: _____

Consent to Evaluate/Treat:

I, for myself, or the patient named above, hereby consent to such medical evaluation and/or treatment and diagnostic procedures as necessary and appropriate for my condition or illness based on the judgment of my physician(s), to be performed by the physician(s), physician assistant(s), nurse(s) or other health care provider(s). I have had, and will continue to have, an opportunity to discuss treatment options with my healthcare provider, ask questions regarding such treatment options and understand the options discussed.

Signature of patient or patient's parent/ legal guardian

Date



Reason for Today's Visit

Have you seen Dr. McAlister in the past? ☐ Yes ☐ No

Please describe the foot/ ankle issue that brings you in today: ☐ Left ☐ Right

Duration of problem? _____

How would you rate your pain on a scale of 0 (no pain) – 10 (worst pain)? _____

What treatment have you attempted? _____

Does anything make it feel better? _____

Past Medical History

Are you Diabetic? ☐ Yes ☐ No If yes, how long _____ What type? _____

Most Recent A1C? _____ Date: _____

Do you have any of the following?

☐ **No Past Medical History**

☐ High Blood Pressure ☐ High Cholesterol

☐ Cancer: _____ ☐ Heart Attack ☐ Stroke

☐ Rheumatoid Arthritis ☐ Kidney Disease

☐ Heart Failure ☐ Stomach Bleeds ☐ Blood Clots

☐ Other: _____

Past Surgical History

Please list any past surgical procedures you have had.

☐ **No Past Surgical History**

1. _____ Year: _____

4. _____ Year: _____

2. _____ Year: _____

5. _____ Year: _____

3. _____ Year: _____

6. _____ Year: _____

Current Medication(s)

Please list any medications you are currently taking at this time:
(Including over the counter medications and supplements)

☐ **No Current Medications**

1. _____ Dose: _____

4. _____ Dose: _____

2. _____ Dose: _____

5. _____ Dose: _____

3. _____ Dose: _____

6. _____ Dose: _____

Allergies

Please List any allergies to medications, latex, or food:

☐ **No Known Allergies**

1. _____ Reaction: _____

3. _____ Reaction: _____

2. _____ Reaction: _____

4. _____ Reaction: _____

Social History

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Current Employment Status:

☐ Full-time ☐ Part-time ☐ Student ☐ Retired ☐ Disabled ☐ Unemployed

Occupation: _____

Do you smoke cigarettes?

☐ Never ☐ Current Smoker, _____ day for _____ years ☐ Past Use, quit _____ years ago

Do you drink alcohol? ☐ Yes, how much? _____ ☐ No

Do you use recreational drugs? ☐ Yes, what and how much? _____ ☐ No

Updated 09/2023

Family Health History

[] Diabetes: Relationship: _____
 [] High Blood Pressure: Relationship: _____
 [] High Cholesterol: Relationship: _____
 [] Rheumatoid Arthritis: Relationship: _____

[] Cancer: Relationship: _____
 [] Stroke: Relationship: _____
 [] Other: Relationship: _____
 [] None or Unknown

Review of Systems

General: [] Loss of appetite, [] Recent weight loss, [] Fatigue, [] Fever or chills, [] Weakness

Respiratory: [] Shortness of breath, [] coughing, [] coughing blood, [] difficulty breathing, [] wheezing

Cardiovascular: [] chest pain, [] tightness, [] palpitations, [] swelling, [] difficulty breathing lying

Head/Eyes/Ears/Nose/Throat: [] Headaches, [] neck pain, [] decreased hearing, [] ringing in ears, [] vision changes, [] Glaucoma, [] cataracts, [] blurry/ double vision, [] itching nose, [] sinus pain, [] nosebleeds, [] dentures, [] mouth sores/bleeding, [] sore throat, [] dry mouth

Neurological: [] Dizziness, [] fainting, [] seizures, [] numbness, [] tingling

Gastrointestinal: [] Nausea, [] Vomiting, [] Constipation, [] diarrhea, [] difficulty swallowing, [] heartburn

Endocrine: [] Sweating, [] Frequent urination, [] Excessive thirst, [] change in appetite

Psychiatric: [] nervousness, [] stress, [] depression, [] memory loss

Skin: [] Rashes, [] Itching, [] dryness, [] Hair and nail changes, [] skin color changes

Kidney/Bladder/ Urine: [] Frequency, [] urgency, [] burning or pain, [] blood in urine, [] incontinence

Musculoskeletal: [] Muscle and joint pain, [] stiffness, [] back pain, [] swelling of joints

 Signature of patient or patient's parent/ legal guardian
 Medical History Acknowledgement

 Date

Financial Acknowledgement and Agreement – New Patient Forms

Thank you for choosing the Phoenix Foot and Ankle Institute! The Financial and Office policy is an important part of your care. Due to increased insurance company demands, we ask you to read and agree to the following Phoenix Foot and Ankle Institute policies.

Self-Pay Patients: If you have no insurance coverage, **full payment** is expected at the time of service. Please contact an office team member for fees.

Commercial Insurance: As a courtesy, Phoenix Foot and Ankle Institute will file your claim to your insurance company; however, at the time of service you will be responsible for all fees that are not covered by your insurance, including co-pays, co-insurance, deductibles and non-covered services or items received. The co-pay **CANNOT** be waived by our practice, as it is a requirement placed on us by your insurance carrier. We strive to be as accurate as possible in calculating your responsibility but, with so many variations in policies and fee schedules, we are not always exact. You may receive a statement from our office for any balance due. For your convenience, we accept cash, checks, and most major credit cards.

Knowing and understanding your insurance benefits is your responsibility.

If you have any “Out of Network Benefits” with a plan we are not contracted with, we will bill your insurance as a courtesy. Any patient responsibility will be billed to the guarantor on file. Please contact your insurance company with any questions you may have regarding your coverage. I also authorize the release of any medical records or other information necessary to process a claim. To submit a claim to your insurance carrier, there must be complete patient and insurance information on file. It is your responsibility to notify Phoenix Foot and Ankle Institute if there is a change to your insurance coverage, residence, or phone number.

ASSIGNMENT OF BENEFITS: I authorize payment of medical benefits to Jeffrey E McAlister, PLLC dba Phoenix Foot and Ankle Institute. I also authorize the release of any medical or other information necessary to process a claim. To submit a claim to your insurance carrier, there must be complete patient and insurance information on file.

Acknowledgement of Financial Agreement

Signature of Patient

Date

HIPAA Acknowledgment

Our Centers Notice of Privacy Policies provide information about how we may use and disclose protected health information. You have the right to review our Notice before signing this consent. The terms of our Notice may change, and you may obtain a revised copy by contacting our office. By signing this acknowledgement, I understand and agree with the contents of the notice.

Signature of Patient

Date

If not signed by the patient, please indicate relationship to patient: _____

Financial and Office Policy

Return Check Fees: There is a **\$25** fee for any checks returned by the bank. Non-sufficient funds checks must be paid in full with certified funds (money order, credit cards, or cash). You will no longer be able to make payments on your account with a check instead, future payments will need to be cash, credit card or money order only.

Past Due Accounts: We will send three (3) statements. If no payment is then received, a final Pre- collection Courtesy Call will be made. After 30 days of no response, your account will be sent to a Collections agency.

Lateness: If you are late for our appointment time, please call to inform the staff. They will review the schedule to determine if the appointment will need to be rescheduled to another day or work an appointment behind other scheduled appointments. **After the 2nd late show a \$50 fee will be applied to your account.**

No Shows/ Cancellations: A missed appointment leaves an open appointment that could have been used by a patient in need of medical care. A no-show appointment occurs when a parents or legal guardian fails to give adequate notice that the appointment cannot be kept. The parent or legal guardian's failure to cancel or reschedule an appointment by 9:00am the day of the scheduled appointment will result in a no-show. If two (2) no-shows are incurred during a calendar year (January – December) a **\$50 fee** will be applied to your account.

Appointments: **All New patients need to arrive 15 minutes prior to their appointment, and all Established patients need to arrive 15 minutes prior to their appointment.**

Divorce/ Custody: We cannot and will not become involved with parental billing disputes in divorce and/or custody cases. Our policy is to hold the parent who brings the child in for medical treatment responsible for payment at the time of service

Laboratory Fees: You will receive a separate laboratory fee for outside lab services. Any lab services that are not covered by your insurance will be your responsibility. It is your responsibility to go to a contracted lab. Phoenix Foot and Ankle Institute is not affiliated with any labs.

Surgical Cancellation Fees: Our team works very hard to appropriately get you set up for surgery, which involves insurance verification, hospital scheduling, and assistance with pre-operative clearance. If you knowingly cancel your surgery within one week from the surgery date, there is a **\$250 fee**. If you knowingly cancel your surgery on the day of surgery, there is a **\$500** fee.

Medical Records Policy

Hard Copy Medical Records: Any printed medical records that are *less than 20 pages* are free. Medical records that are *21-41 pages* are **25 cents per page**, and medical records pertaining *more than 50 pages* are **\$10**.

Short Term Disability Form: There is a **\$25** charge for the completion of FMLA paperwork.

USB Medical Records: Any medical records requested on a USB (up to 2 GB) will be **\$15**. If more than 2GB of medical records an additional fee will be applied.

X-rays requested on a USB will have a **\$10 fee**.

Authorization for Release of Medical Information

I hereby authorize **Phoenix Foot & Ankle Institute** to furnish my medical records consisting of, but not limited to consultation notes, diagnostic test results, progress notes, operative reports, and other medical information to named individual below. This release is in effect for one year from the date noted

Your Signature: _____

Date: _____

I have read and understand Phoenix Foot and Ankle Institute Financial and Office Policies and agree by its terms. I understand that I am financially responsible for all charges incurred in the event my insurance denies payment after a claim has been submitted by Phoenix Foot and Ankle Institute.

Patient Printed Name: _____

If not the patient, please print your relationship to the patient and your name: _____

Your Signature: _____

Date: _____

Consent to Treat Patients under 18 years of age

Updated 09/2023

Date: _____
(Valid for 1 Calendar year)

Consent from Parents or Guardians for Authorized Persons:

As the parent or guardian of _____, I am granting permission for the below listed person(s) to bring my child in for treatment and/ or care

I am granting full permissions, meaning the below listed person(s) will be allowed to agree to:

- **Treatments**
- **Procedures**
- **Injections**
- **Referrals**
- **Medical Records**
- **Pre-Surgical Consent**
- **All medical history pertaining to my child**

_____ Initials

Please list person(s) here

Relationship

Consent to Leave Voicemail

I am granting permission for Phoenix Foot and Ankle Institute to leave phone messages regarding my child's medical health to the number(s) provided on the registration form.

Parent/ Guardian Signature

Date



Pain Medication Contract

This is an agreement between _____ (the patient) and Dr. Jeffrey E. McAlister concerning the use of opioid analgesics (narcotic pain-killers) for the treatment of a chronic pain problem and/or post-operative pain. The medication will probably not completely eliminate my pain but is expected to reduce it enough that I may become more functional and improve my quality of life.

1. I understand that opioid pain analgesics are NOT appropriate first, second, or third-line treatment medications for managing pain caused by osteoarthritis, rheumatoid arthritis, osteonecrosis, rotator cuff disease or minor soft tissue injuries (i.e. sprains).
2. I understand that opioid pain analgesics will only be used to control my pain in the following scenarios:
 - a. *after surgery for 30 days*
 - b. *a major injury requiring an emergency department evaluation that demonstrates a fracture or dislocation*
 - c. *rare circumstances in which surgery poses a high-risk for complications, such as infection or even death*
3. I understand that I will NOT be given opioid pain analgesics if Dr. McAlister recommends surgery for my pain & that, in his professional opinion, I am not at high-risk for surgical complications, BUT I elect against surgery.
4. I understand that Dr. McAlister has a "30-day policy" in which opioid pain analgesics will be prescribed by either him, or a provider representing him, only for 30 days after my surgery.
5. I understand that if I require opioid pain analgesics after this 30-day period, a referral for a Pain Management Specialist will be recommended for further managing my pain.
6. I understand that opioid analgesics are strong medications for pain relief and have been informed of the risks and side effects involved with taking them.
7. In particular, I understand that opioid analgesics could cause physical dependence. If I suddenly stop or decrease the medication, I could have withdrawal symptoms (flu-like syndrome such as nausea, vomiting, diarrhea, aches, sweats, chills) that may occur within 24-48 hours of the last dose. I understand that opioid withdrawal is quite uncomfortable, but not a life-threatening condition.
- I understand that if I am pregnant or become pregnant while taking these opioid medications, my child would be physically dependent on the opioids and withdrawal can be life-threatening for a baby.
8. Overdose on this medication may cause death by stopping my breathing; this can be reversed by emergency medical personnel if they know I have taken narcotic pain-killers. It is suggested that I wear a medical alert bracelet or necklace that contains this information.
9. If the medication causes drowsiness, sedation, or dizziness, I understand that I must not drive a motor vehicle or operate machinery that could put my life or someone else's life in jeopardy.
10. I understand it is my responsibility to inform the doctor of any and all side effects I have from this medication.



Pain Medication Contract

11. I agree to take this medication as prescribed and not to change the amount or frequency of the medication without discussing it with the prescribing doctor. Running out early, needing early refills, escalating doses without permission, and losing prescriptions may be signs of misuse of the medication and may be reasons for the doctor to discontinue prescribing to me.

12. I agree that the opioids will be prescribed by only one doctor and I agree to fill my prescriptions at only one pharmacy. I agree not to take any pain medication or mind- altering medication prescribed by any other physician without first discussing it with the above-named doctor. I give permission for the doctor to verify that I am not seeing other doctors for opioid medication or going to other pharmacies.

13. I agree that, consistent with Arizona Law and Medical Best Practices, I will acquire my opioid analgesic medications from a single physician and will not ask for this type of medication from more than one physician or physician's representative.

14. I agree to keep my medication in a safe and secure place. Lost, stolen, or damaged medication will not be replaced.

15. I agree not to sell, lend, or in any way give my medication to any other person.

16. I agree not to drink alcohol or take other mood-altering drugs while I am taking opioid analgesic medication.

17. I agree that I will attend all required follow-up visits with the doctor to monitor this medication and I understand that failure to do so will result in discontinuation of this treatment. I also agree to participate in other chronic pain treatment modalities recommended by my doctor.

18. I understand that there is a small risk that opioid addiction could occur. This means that I might become psychologically dependent on the medication, using it to change my mood or get high, or be unable to control my use of it. People with a past history of alcohol or drug abuse problems are more susceptible to addiction. If this occurs, the medication will be discontinued, and I will be referred to a drug treatment program for help with this problem.

I have read the above, asked questions, and understand the agreement. If I violate the agreement, I know that the doctor may discontinue this form of treatment.

Patient/Legal Guardian Signature

Date

Provider Signature

Date



Foot Function Index

Section 1: To be completed by patient. Name: _____ Age: _____ Date: _____

Occupation: _____

Number of days of foot pain: _____ (this episode)

Section 2: To be completed by patient.

This questionnaire has been designed to give your therapist information as to how your foot pain has affected your ability to manage in everyday life. For the following questions, we would like you to score each question on a scale from 0 (no pain) to 10 (worst pain imaginable) that best describes your foot **over the past WEEK**. Please read each question and place a number from 0-10 in the corresponding box.

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

1.	In the morning upon taking your first step?	
2.	When walking?	
3.	When Standing	
4.	How is your pain at the end of the day?	
5.	How severe is your pain at its worst?	

Answer all of the following questions related to your pain and activities **over the past WEEK**, how much difficulty did you have?

No Difficulty 0 1 2 3 4 5 6 7 8 9 10 **So Difficult unable to do.**

6.	When walking in the house?	
7.	When walking outside?	
8.	When walking four blocks?	
9.	When climbing stairs?	
10.	When descending stairs?	
11.	When standing tip toe?	
12.	When getting up from a chair?	
13.	When climbing curbs?	
14.	When running or fast walking?	

Answer all the following questions related to your pain and activities **over the past WEEK**. How much of the time did you:

None of the time 0 1 2 3 4 5 6 7 8 9 10

15.	Use an assistive device (cane, walker, crutches, etc) indoors?	
16.	Use an assistive device (cane, walker, crutches, etc) outdoors?	
17.	Limit physical activity?	

Section 3: To be completed by provider SCORE: _____/170 x100= _____%

SCORE: Initial _____ Subsequent _____ Subsequent _____ Discharge _____

Signature of patient or patient's parent/ legal guardian

Date