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**New Patient Questionnaire**

**Patient Information**

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_ Recent

Zip Code: \_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_ Blood Pressure: \_\_\_\_\_\_/\_\_\_\_\_\_\_

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSN: \_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_ Preferred Method of contact from our office: [ ] Email [ ] Home Phone [ ] Cell Phone

Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_

How did you hear about **Apex Foot & Ankle Institute**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Facebook: \_\_\_\_\_\_ Website: \_\_\_\_\_\_\_\_\_\_ Insurance: \_\_\_\_\_\_\_\_\_\_Word of Mouth: \_\_\_\_\_\_\_\_\_\_Google: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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:

2

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 health care 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. Ryan M. Sherick 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** **[ ] Med List Attached**

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

**Family Health History**

[ ] Diabetes: Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Cancer: Relationship: \_\_\_\_\_\_\_\_\_\_\_\_

[ ] High Blood Pressure: Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Stroke: Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] High Cholesterol: Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Other: Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Rheumatoid Arthritis: Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] None or Unknown

**Review of Systems**

**Please check the box if you are currently experiencing any of the following:**

**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 Date**

**Medical History Acknowledgement**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Witness to patient signing Date**

**Medical History Acknowledgement form**

**Financial Acknowledgement and Agreement – New Patient Forms**

Thank you for choosing the Apex 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 Apex 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. If you would like to discuss a payment plan this must be discussed directly with Dr. Sherick and approved in writing with Dr. Sherick’s signature that he accepted the financial agreement.

**Commercial Insurance:** As a courtesy, Apex 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,most major credit cards, and have an online payment system which can be found on our website ApexFootAnkleSurgery.com .

**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 Apex 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 Dr. Ryan Sherick Foot & Ankle Inc, dba Apex Foot & 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. Apex 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. If you have placed a deposit with Apex Foot & Ankle Institute this will be deducted from that amount.

**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 **Apex Foot & Ankle Institute or Dr. Ryan M. Sherick** to furnish my medical records consisting of, but not limited to consultation notes, diagnostic test results, progress notes, operative reports, operative non-patient identifying photography use, 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 Apex 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 Apex 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**

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 Apex 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