WELCOME TO THE OFFICE OF

DR. PAMELA KIRBY PA

4606 S. CLYDE MORRIS BLVD #1J - PORT ORANGE, FLORIDA 32129–(386)-788-4111

Pamela E. Kirby, DPM

PATIENT INFORMATION

Legal Name _____ ▫ Male ▫ Female

Date of Birth: _____Age:_____ Social Security #:_____

Address:_____ City/St/Zip:_____

Phone: (HM) _____ (CELL)_____

Employer/Occupation:_____(WK#)_____

▫Child ▫Single ▫Married ▫Divorced ▫Widowed ▫Partnered Email Address:_____

Information Required for EHR (Electronic Health Record) which is mandated by the Government to comply with Meaningful Use:

ETHNICITY: ▫ Caucasian ▫ African American ▫ Hispanic ▫ Pacific Islander ▫ American Indian ▫ Other_____

LANGUAGE: ▫English ▫ Spanish ▫ Other_____

Emergency Contact:_____ Relation:_____ Phone:_____

How Did You Hear of Our Office:_____

FINANCIAL RESPONSIBILITY AND INSURANCE INFORMATION

Responsible Party:_____ Relation to Patient:_____

Social Security#:_____ Date of Birth:_____

Driver's License #:_____ Phone #:_____

Address:_____ City/St/ Zip:_____

Primary Insurance:_____ ID#:_____GRP#:_____

Policy Holder:_____ Date of Birth:_____

Secondary Insurance:_____ ID#:_____GRP#:_____

Policy Holder:_____ Date of Birth:_____

MEDICARE PATIENTS ONLY- MEDICARE SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to: **Dr. Pamela Kirby, PA** for any services furnished me by that provider. I authorize any holder of information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____ _____

MEDICARE # PATIENT SIGNATURE DATE SIGNED

Is your visit today related to: **Worker's Comp** ▫ Yes ▫ No **Auto Accident** ▫ Yes ▫ No **Liability** ▫ Yes ▫No

What is the reason for your visit today? _____

How long has it been problematic? _____

Have you been treated for this problem in the past? YES/ NO If yes, when? _____

Where and by whom were you treated? _____

Was this caused by an injury? YES/NO If yes, date of injury: _____

PERSONAL AND FAMILY HISTORY

HEIGHT _____ WEIGHT_____ SHOE SIZE_____

Are you a DIABETIC? ▫NO ▫ YES How Long?_____ Insulin Type I_____ Non-Insulin Type II_____

Primary Doctor: _____ Last Visit_____ Next Visit_____

Endocrinologist: _____Last Visit_____ Next Visit_____

Do You Smoke Cigarettes/Cigars? ▫ No ▫ Quit # Yrs _____ ▫ Yes ▫ How Many Packs/Day_____

Do You Drink Alcohol/Beer/Wine? ▫ No ▫ Quit # Yrs _____ ▫ Yes ▫ Rarely ▫ Social ▫ Daily

Do You Drink Caffeine/Coffee/Tea? ▫ No ▫ Yes Do You Use Illegal Drugs? ▫ No ▫ Yes

Does anyone in your family (Mother, Father, Brothers, Sisters) have any of the following?

▫ Adopted/Unknown ▫ Bunions ▫Cancer ▫ Diabetes ▫ Gout ▫ Heart Disease

▫ High Blood Pressure ▫ Hypertension ▫ Neuropathy

PATIENT MEDICAL HISTORY

ALLERGIES ▫ NO Known Allergies ▫ YES, I have allergies to the following:

▫ Adhesive Tape ▫ Aspirin ▫ Betadine/Iodine ▫ Codeine ▫ Contrast Dye ▫Demerol ▫IVP Dye ▫ Latex

▫ Lidocaine ▫ Local Anesthetic ▫ Metals/Nickel ▫ Novocain ▫ Penicillin ▫Sulfa ▫ Others:_____

▫Others:_____

MEDICATIONS AND DOSAGE **Pharmacy:**_____ **Phone:**_____

▫ NO, Not Taking Any Medicine **▫YES, I am taking the following medicines for (reason)**

Medication	**Reason**	**Dosage**
Medication	**Reason**	**Dosage**
Medication	**Reason**	**Dosage**
Medication	**Reason**	**Dosage**
Medication	**Reason**	**Dosage**
Medication	**Reason**	**Dosage**
Medication	**Reason**	**Dosage**
Medication	**Reason**	**Dosage**
Medication	**Reason**	**Dosage**
Medication	**Reason**	**Dosage**
Medication	**Reason**	**Dosage**
Medication	**Reason**	**Dosage**

Patient Name_____

PAST MEDICAL HISTORY:

- ☐ NO Past History
- ☐YES, I have had the following conditions:
  - ☐ Anxiety
  - ☐ Arthritis
  - ☐ Asthma
  - ☐ Bipolar Disorder
  - ☐ Blood Clots
    - ☐ Pulmonary Emboli (lung clots)
    - ☐ DVT (leg clots)
  - ☐ Breast Disease
  - ☐ Cancer (type)
  - ☐ Chronic Fatigue Syndrome
  - ☐ Chronic Wounds
  - ☐ COPD (Emphysema, Bronchitis)
  - ☐ Depression
  - ☐ Diabetes (Type 1 or Type 2)
  - ☐ Erectile Dysfunction
  - ☐ Fibromyalgia
  - ☐ Gastrointestinal Bleeding
  - ☐ Glaucoma
  - ☐ Gout
  - ☐ Head Aches
  - ☐ Hearing Loss
  - ☐ Heart Burn, Reflux
  - ☐ Heart Disease
    - ☐ Coronary Disease
    - ☐ MI/heart attacks
    - ☐ Congestive Heart Failure
    - ☐ Atrial Fibrillation
    - ☐ Angina
    - ☐ Valve Disorder
  - ☐ Hepatitis (A, B, C)
  - ☐ High Blood Pressure
  - ☐ High Cholesterol
  - ☐ HIV / AIDS
  - ☐ Incontinence
  - ☐ Kidney Stones
  - ☐ Macular Degeneration
  - ☐ Osteoporosis
  - ☐ Pneumonia
  - ☐ Prostate Disease
  - ☐ Seizures
  - ☐ Stomach Ulcers
  - ☐ Stroke
  - ☐ Thyroid Disease (Low or High)
  - ☐ Urinary Tract Infections
  - ☐ Other_____

SURGICAL HISTORY:

- ☐ NO Past History
- ☐YES, I have had the following Surgeries:
  - ☐ Amputation
  - ☐ Angioplasty
  - ☐ Appendectomy
  - ☐ Arthroscopy
  - ☐ Back Surgery
  - ☐ Basal Cell
  - ☐ Bladder
  - ☐ Brain
  - ☐ Bunion
  - ☐ Bypass
  - ☐ CABG
  - ☐ Cancer
  - ☐ Carpel Tunnel
  - ☐ Cataract
  - ☐ Colon
  - ☐ Cosmetic Surgery
  - ☐ C-Section
  - ☐ Endoscopy
  - ☐ Foot Surgery
  - ☐ Gallbladder
  - ☐ Gastric Bypass
  - ☐ Heart Surgery
  - ☐ Intestinal
  - ☐ Jaw/Oral
  - ☐ Knee
  - ☐ Lung
  - ☐ Mastectomy
  - ☐ Neck
  - ☐ Ovarian
  - ☐ Pacemaker
  - ☐ Prostate
  - ☐ Rotator Cuff
  - ☐ Shoulder
  - ☐ Spinal
  - ☐ Spleen
  - ☐ Stent
  - ☐ Stomach
  - ☐ Tarsal Tunnel
  - ☐ Thyroidectomy
  - ☐ Tonsillectomy
  - ☐ Tubal
  - ☐ Uterine
  - ☐ Vein Stripping
  - ☐ _____
  - ☐ _____
  - ☐ _____

REVIEW OF SYSTEMS Do you currently have or have had any of the following problems.
Please check an answer "Yes" or "No" if present in past 6 months Circle ( ) if present today, to every item, do not skip

Constitutional (General)

Appetite	· yes	· no
Chills/Fever	· yes	· no
Sweats	· yes	· no
Fatigue	· yes	· no
Malaise (body weakness)	· yes	· no
Migraines/Headaches	· yes	· no
Unexplained weight loss	· yes	· no

Cardiovascular

Chest pains	· yes	· no
Cholesterol	· yes	· no
Palpitations	· yes	· no
Syncope (passing out)	· yes	· no
Difficulty breathing	· yes	· no
High Blood Pressure	· yes	· no
Peripheral edema	· yes	· no

Ear/Nose/Mouth/Throat

Earache	· yes	· no
Ear discharge	· yes	· no
Tinnitus (ringing in ears)	· yes	· no
Decreased hearing	· yes	· no
Nasal congestion	· yes	· no
Nosebleeds	· yes	· no
Sore throat or hoarseness	· yes	· no
Difficulty speaking	· yes	· no
Difficulty swallowing	· yes	· no

Endocrine

Cold intolerance	· yes	· no
Diabetes	· yes	· no
Dialysis	· yes	· no
Heat intolerance	· yes	· no
Thyroid Disorder	· yes	· no
Polyuria (excess urination)	· yes	· no

Eyes

Blurred vision	· yes	· no
Diplopia (double vision)	· yes	· no
Eye irritation/inflamed (AC)	· yes	· no
Eye discharge	· yes	· no
Vision loss	· yes	· no
Glasses	· yes	· no

Gastrointestinal

Nausea	· yes	· no
Vomiting	· yes	· no
Digestive dysfunction	· yes	· no
Change in bowel habits	· yes	· no
Indigestion	· yes	· no
Abdominal pain	· yes	· no
Bloody stool	· yes	· no

Genitourinary

Unusual Discharge	· yes	· no
Incontinence	· yes	· no
Difficult urination	· yes	· no
Urination blood	· yes	· no
Urinary frequency	· yes	· no
Amenorrhea (no cycle)	· yes	· no
Menorrhagia (heavy cycle)	· yes	· no
Pelvic pain	· yes	· no
Sexually transmitted disease	· yes	· no

Allergic/Immunologic

Asthma	· yes	· no
Hay fever	· yes	· no
Persistent infections	· yes	· no
AIDS	· yes	· no
HIV exposure	· yes	· no

Integumentary (Skin)

Rash	· yes	· no
Itching	· yes	· no
Dryness	· yes	· no
Suspicious lesions	· yes	· no
Skin infections	· yes	· no
Skin Growths	· yes	· no
Ulcers	· yes	· no

Hematologic/Lymphatic

Abnormal bruising	· yes	· no
Abnormal bleeding	· yes	· no
Blood Transfusions	· yes	· no
Enlarged lymph nodes	· yes	· no

Musculoskeletal

Arthritis	· yes	· no
Back pain	· yes	· no
Joint Pain	· yes	· no
Neck pain	· yes	· no
Shoulder pain	· yes	· no
Wrist/hand pain	· yes	· no
Fibromyalgia	· yes	· no
Stiff neck	· yes	· no
Hip/knee pain	· yes	· no
Muscle Weakness	· yes	· no

Neurologic

Intermittent paralysis	· yes	· no
Gait difficulties	· yes	· no
Weakness	· yes	· no
Paresthesia	· yes	· no
Seizure	· yes	· no
Syncope	· yes	· no
Tremors	· yes	· no
Vertigo (dizziness)	· yes	· no
Numbness	· yes	· no
Poor balance	· yes	· no
In coordination	· yes	· no
Difficulty walking	· yes	· no
Difficulty writing	· yes	· no

Psychiatric

Depression	· yes	· no
Anxiety	· yes	· no
Memory loss	· yes	· no
Mental disturbance	· yes	· no
Suicidal thoughts	· yes	· no
Hallucinations	· yes	· no

Respiratory

Hypotension	· yes	· no
Chronic cough	· yes	· no
Difficulty breathing	· yes	· no
Excessive sputum	· yes	· no
Hemoptysis	· yes	· no
Shortness of Breath	· yes	· no
Wheezing	· yes	· no

OFFICE & TREATMENT POLICIES

WELCOME TO OUR OFFICE! Please read the policy below carefully. If you have any questions in regards to any part of it please feel free to speak with one of our staff members. Our goal here in the office is to treat you with the finest quality of care. The doctors and staff welcome any concerns or questions you have about your treatment and/or quality of care you receive in our office. The definition of our policy is clear so that we may focus on treating your feet to a healthy and happy place. ***Please initial along each section and sign at the bottom.***

TREATMENT AGREEMENT- _____ As the patient you are here for treatment of your foot condition, the medical care and treatment that the **Doctors and Staff of Dr. Pamela Kirby PA** provide to you, requires your cooperation in return. This includes following the orders and instructions given to you, getting prescriptions filled and taking medication, scheduling and completing additional testing outside our office, keeping your appointments for follow-up care, and to contact the office and notify us of any changes that occur in your condition. Failure to follow this agreement falls under non-compliancy. I understand and give my consent for general routine treatment, and understand I will sign the appropriate consent form(s) prior to any specialized treatment being performed.

NOTICE OF PRIVACY PRACTICES (HIPAA):_____ I acknowledge that a copy of the Notice of Privacy Practices for the office of **Dr. Pamela Kirby, PA** has been made available to me, and that I have read (or had the opportunity to read if I so chose) and understood the notice. As the patient you understand your rights to privacy regarding protecting your health information. You may request in writing how you wish to restrict your health information and its use by our office, but also understand that we do not have to agree with these restrictions and you will be notified in writing of this decision and its reason for. If you have any further questions regarding your privacy and rights, you may request to speak with our ***Identity Theft Officer/Practice Administrator: Wendy Wallace***

RELEASE OF RECORDS (FOR CARE & MEDICAL CLAIMS) _____ As the patient you consent to the release of your medical records; including diagnosis and treatment plans to any third party payers, including Medicare, to be used for determining payment of claims pending for services rendered upon you. You agree to the release of your records from other facilities to aid in your continuing medical care; including hospitals, imaging facilities, laboratories, and other doctors treating you. You may designate and authorize any party to discuss/receive your medical records by listing:

NAME_____RELATIONSHIP:_____DOB:_____

NAME_____RELATIONSHIP:_____DOB:_____

RECORDS & FMLA LEAVE PAPERWORK: Our office requires 3-5 days for preparing your medical record, which includes filling out family medical leave or disability paperwork.

APPOINTMENTS: Our office policies allow us to be quite flexible with being able to make appointments for patients within a day or so. This is possible by giving you a "courtesy" reminder call the day before your appointment. If you are unable to make your scheduled appointments, please try to give the office at least 24 hours or more, notice of cancellation. We are well aware of emergencies that occur from time to time and accommodate fairly in these situations. Patients who are chronically "No-Show" for appointments will not be scheduled and will be discharged from the practice.

INSURANCE: _____Our office participates in most commercial insurance plans including Medicare. Please make sure you keep the office up-to-date with your current insurance and your cards. There are many plan options out there and it is your responsibility to know your individual plan and whether or not you need a referral authorization. If our office is denied payment because of non-coverage you are responsible.

I acknowledge and understand the office & treatment policies as listed above.

PATIENT / GUARDIAN PRINTED NAME	PATIENT /GUARDIAN SIGNATURE	DATE

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below

Date:	Initials:	Reason

FINANCIAL & PAYMENT POLICIES

VERIFICATION OF BENEFITS, REFERRALS & INSURANCE: ____ As the patient you are responsible for being knowledgeable of your insurance plan and their payment assignments. If you have a deductible or a co-pay portion, you are responsible for paying it at the time of visit. If your plan requires authorization for the visit, you are responsible for obtaining it. Our office does file claims to insurances that we are providers for, if we are not providers, you are responsible for the bill and we will provide you with a claim form for your own reimbursement.

ASSIGNMENT OF BENEFITS: ____You authorize and request your insurance company to authorize payment directly to any physician in the above named practice the amount due in any pending claims for basic medical, major medical and/or surgical treatment for services rendered.

NON-COVERED SERVICES: Be aware some services and products are not reimbursable by your insurance, you will be given notification

CO-PAYMENTS & DEDUCTIBLES: All co-payments, co-insurances and deductibles are your responsibility and are due at the time of services rendered. We do make payment arrangements in advance for those who need it, but this will be on a case by case basis.

CHILREN OF DIVORCED PARENTS: Responsibility for payment for treatment of minor children, whose parents are divorced, rests with the parent who seeks the treatment. Any court ordered responsibility judgment must be determined between the individuals involved, without the inclusion of **Dr. Pamela Kirby, PA.**

PAYMENT OPTIONS:

WE ACCEPT ALL MAJOR CREDIT CARDS, CASH, CHECK, AS WELL AS OFFER CARE CREDIT, which is a credit plan you can apply for here in our office online or by phone or mail in an application.

WE DO NOT ACCEPT WORKERS COMPENSATION, LETTERS OF PROTECTIONS, OR PERSONAL INJURY CASES

FEES:_____There is a $35.00 fee for any returned check, plus the amount of the check.

There is a $10.00 fee for duplicating x-rays onto CD

There is a $25.00 fee if your overdue account is sent to collections

PAST DUE ACCOUNTS & COLLECTIONS: _____You are responsible for any balances owed to the office and agree to pay these balances within 90 days or make a payment agreement. Unless other arrangements are approved and made in advance you are responsible to pay any monies owed upon receipt of a statement being issued. If you do not pay or make an agreement your account will be turned over to a collection agency with a $25.00 fee assessed from our office and will be responsible for any additional fees incurred including that of attorney's fees or court cost.

FINANCIAL AGREEMENT: This is an agreement between the office of **Dr. Pamela Kirby, PA**, a Florida corporation, the creditor and the Patient/debtor named on this form. The words "you", "your", and "yours" means the Patient/debtor. The words "we", "us", and "our", refers to the office of **Dr. Pamela Kirby, PA** and staff. By executing this agreement you are agreeing to be responsible for your share of services rendered and not covered.

Our office firmly believes that a good patient/physician relationship is based upon understanding and open communications. It is our hope that the above policies will allow us to provide the highest quality care to our patients. If you have any questions or need clarification regarding these policies please contact our Practice Administrator wendywallace@pamkirby.com .

_____	_____	_____
PATIENT / GUARDIAN PRINTED NAME	**PATIENT /GUARDIAN SIGNATURE**	**DATE**
_____	_____	_____
RESPONSIBLE FINANCIAL PARTY NAME	**RESPONSIBLE PARTY SIGNATURE**	**DATE**

(If other than the patient, the party listed as the responsible party on first page must sign above)