SEGALL FOOT & ANKLE, INC.
MELI ORTHOPEDIC CENTERS OF EXCELLENCE
ARTHUR SEGALL, JR., DPM, FACFAS
Plantation: 201 NW 82nd Ave, Suite 102, Plantation, Florida 33324 Phone: (954) 384-2555 Fax: (954) 900-5646
Ft. Lauderdale: 4800 NE 20th Terr, Suite 303, Ft. Lauderdale, Florida 33308 Phone (954) 771-8177 Fax: (954) 771-3629
Margate: 2825 State Road 7, Suite 204, Margate, Florida, 33063 Phone: (954) 580-4080 Fax: (954) 580-4081
Web: footandanklefocus.com **Email**: advfoot@bellsouth.net

Please Print & Answer All Questions

Today's Date: _____ (Office Use Only) Chart Number: _____

Patient Name: _____ Date of Birth: _____ Age:_____ SS# Last 4: _____

Address:_____ City _____ State: _____ Zip _____

Cell Phone: _____ Work Phone: _____ Home Phone: _____

Marital Status: [ ]Single [ ]Married [ ]Divorced [ ]Widowed [ ]Separated Sex M F

Race: Caucasion African American Hispanic American Indian Hawaiian Pacific Asian Ethnicity

Email Address _____ Languages Spoken: _____

Occupation: _____ Employer _____

Emergency Contact Name: _____ Relation: _____ Cell Phone: _____

Insurance Information: Company _____ Policy/Member # _____ Group _____

If Different From Above: Responsible Party's Name_____

Date of Birth_____ SS# Last 4: _____ Relationship to Patient _____

Who Referred You To Us? : _____

Primary Medical Doctor Name/Address/Phone/Fax: _____

_____

Please Send A Copy Of My Report To My Doctor: [ ] Yes [ ] No

Pharmacy Name_____ Address_____

Phone_____ Fax_____

Medical Information: Height: _____ Weight: _____

Description Of Problem: _____

_____

Date of Accident/Injury/Onset: _____ Previous Treatment: [ ] Yes [ ] No

If Yes, When? _____ Doctor's Name: _____ Hospital/Clinic: _____

What Type of Treatment? Physical Therapy _____ Medications _____ Casts/Braces _____ Injections _____

Types of Pain: Aching [ ] Yes [ ] No Tingling [ ] Yes [ ] No Numbness [ ] Yes [ ] No

Radiating/Shooting [ ] Yes [ ] No Sharp/Stabbing [ ] Yes [ ] No

Additional Tests: X-Rays MRI CT Scan Bone Scan Ultrasound EMG/NCS Other _____

History Of Similar Problems? [ ] Yes [ ] No, If Yes, Please List Treating Doctor and Treatment:

_____

If Motor Vehicle Accident: Driver _____ Passenger _____ Seat Belt [ ] Yes [ ] No Airbags [ ] Yes [ ] No

Car Was Hit: Front End: _____ Rear End: _____ Driver Side: _____ Passenger Side: _____

Patient Name: _____ Today's Date: _____

ALLERGIES To Medications or Dyes: _____

MEDICATIONS Taken Daily or Periodically with **DOSAGES**: _____

_____

DO YOU HAVE NOW OR HAVE YOU HAD IN THE PAST ANY OF THE FOLLOWING PROBLEMS?
If YES To Any Of The Questions Below, Please Briefly Explain. For Example: Cancer: Breast/Skin,
Lung Problems: Asthma, Blood Disorders: Anemia, Liver Problems: Hepatitis etc.

Arthritis _____	[ ] Yes	[ ] No	Lung Problems_____	[ ] Yes	[ ] No
Blood Disorders_____	[ ] Yes	[ ] No	Mental Health_____	[ ] Yes	[ ] No
Cancer _____	[ ] Yes	[ ] No	Neurological Diseases_____	[ ] Yes	[ ] No
Diabetes, Year Diagnosed_____ Sugar Levels AM:_____ PM:_____	[ ] Yes	[ ] No	Prostate Conditions_____	[ ] Yes	[ ] No
Elevated/High Cholesterol _____	[ ] Yes	[ ] No	Skin Disorders_____	[ ] Yes	[ ] No
Heart Disease _____	[ ] Yes	[ ] No	STD's_____	[ ] Yes	[ ] No
Hypertension _____	[ ] Yes	[ ] No	Stomach/Ulcer Problems _____	[ ] Yes	[ ] No
Urinary/Kidney Problems_____	[ ] Yes	[ ] No	Thyroid Problems _____	[ ] Yes	[ ] No
Liver Problems _____	[ ] Yes	[ ] No	Vascular/Circulation Problems_____	[ ] Yes	[ ] No
Any Other_____	___	__	_____	[ ] Yes	[ ] No

FAMILY HISTORY (Family Members With Any Of The Above Problems: Grandparents, Mother, Father, Brother, Sister etc: If yes, which problems: _____

_____

PAST SURGERIES? [ ] Yes [ ] No, If Yes, Please List: _____

_____

Have You Been HOSPITALIZED FOR ANY OTHER PROBLEMS? [ ] Yes [ ] No

If Yes, Please Describe Condition: _____

TETANUS SHOT With In The Past 10 Years? [ ] Yes [ ] No When? _____

Can You Take ASPIRIN? [ ] Yes [ ] No

Right Handed [ ] Left Handed [ ]

COULD YOU BE PREGNANT? [ ] Yes [ ] No

Do You SMOKE? [ ] Yes [ ] No If Yes, How Much? _____ Pack(s)/Cigarettes/Cigars Per Day

Do You Drink ALCOHOL? [ ] Yes [ ] No If Yes, How Much? _____

Do You Have A History Of DRUG OR SUBSTANCE ABUSE? [ ] Yes [ ] No

PATIENT OR GUARDIAN SIGNATURE: _____

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CONSENT TO MEDICAL CARE

I understand that I have a medical condition that requires medical treatment. I authorize the physicians at Segall Foot & Ankle, Inc. to determine what kind(s) of treatment and/or diagnostic procedures (tests) must be done in order to treat/learn more about my condition. These may include, but not limited to x-rays, diagnostic tests, MRIs, CT Scans, Bone Scans and/or other routine tests, and/or physical therapy. I understand that if my doctor advises a more complex test or tests with special risks that it will be explained to me. Further, I authorize the personnel of Segall Foot & Ankle, Inc to give, or assist in giving, the tests/therapy/treatments that the physicians may order. I fully understand that medical tests/physical therapy/treatments may involve certain unavoidable risks.

I also authorize the physicians at Segall Foot & Ankle, Inc. to determine what kind of treatment is to be given and to perform such procedures as they may deem necessary in their professional judgment to preserve my health.
I understand that the practice of medicine and surgery are not exact sciences and acknowledge that no guarantee or assurance has been made to me as a result of treatments and examinations.

I certify that I have read this form and I certify that I fully understand its contents.

Signature of Patient/Guardian:_____

Printed Name: _____

Date:_____

Relationship to patient (if signed by a personal representative of patient):_____

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ASSIGNMENT OF BENEFITS & FINANCIAL RESPONSIBILITY

I hereby authorize and direct my insurance carrier(s) and/or any other health/medical plan to issue payment directly to Segall Foot and Ankle, Inc for all medical and surgical services rendered to me and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for all medical/surgical charges, whether or not paid by my insurance company, and I will be responsible for paying any outstanding balances from services rendered by Segall Foot and Ankle, Inc that are not paid by my insurance company and/or attorney lien. If my account is referred to an agency or attorney for collection, I understand that I will be responsible for all collection cost, attorney fees, court cost, and any outstanding balances for service rendered.

I certify that I have read this form and I certify that I fully understand its contents.

Signature of Patient/Guardian:_____

Printed Name: _____

Date: _____

Relationship to patient (if signed by a personal representative of patient):_____

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Telemedicine Informed Consent

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
    a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
    a. I may revoke my right at any time by contacting Meli Orthopedics at (954) 771-8177.
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
    a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
    b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
    c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
7. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Florida and will be in Florida during my telemedicine visit(s).

Signature of Patient/Guardian:_____

Printed Name: _____

Date: _____

Relationship to patient (if signed by a personal representative of patient):_____

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MEDICAL RECORDS RELEASE FORM

By signing this form, I authorize you to release confidential health information, copy of my medical records, summary or narrative of my protected health information, to the physician listed below.

Patient Name: _____

Date of Birth: _____

The information you may release subject to this signed release form is as follows:

[ ] Complete Records	[ ] History & Physical	[ ] Progress Notes
[ ] Care Plan	[ ] Lab Reports	[ ] Radiology Reports
[ ] Pathology Reports	[ ] Treatment Record	[ ] Operative Reports
[ ] Hospital Reports	[ ] Medication Record	[ ] Other

From: _____ Fax #: _____

Release my protected health information to the physician listed below:

ARTHUR SEGALL, JR., DPM, FACFAS
201 NW 82nd AVENUE, SUITE 102
PLANTATION, FLORIDA 33324
Phone: (954) 384-2555
Fax: (954) 900 -5646

The records requested are to assist with ongoing treatment.

Signature of Patient/Guardian:_____

Printed Name: _____

Date: _____

Relationship to patient (if signed by a personal representative of patient):_____

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CONSENT FOR TRANSFER OF BIOLOGICAL SPECIMEN

Florida law (Section 817.5655, Florida Statutes) prohibits the sale or transfer of a person's biological specimen from which DNA can be extracted to a third party without the express consent of such person.

During the course of your care at Segall Foot & Ankle, Inc/Meli Orthopedic Centers of Excellence, it may be medically necessary to obtain a blood, urine, stool, tissue or other type of biological specimen for analysis. This analysis **will not** involve the examination of your DNA to identify the presence and composition of genes in your body. After the analysis has been performed and the sample is no longer needed, it will be stored as medical waste and then transferred to a third party for disposal in accordance with all local, state and federal requirements.

It may also be the case that a biological specimen (such as blood, urine, hair, bodily fluids, etc.) from you may be deposited on medical instruments, bedding, clothing or other objects. These objects may then betransferred to a third party for cleaning or disposal.

By signing this document, you affirmatively state that it is your intentional decision to consent to the transfer of any and all biological specimens collected by or deposited with Segall Foot & Ankle, Inc/Meli Orthopedic Centers of Excellence to a third party as set forth above. This consent does not authorize the sale or transfer of a biological specimen for the purpose of DNA analysis.

Signature of Patient/Guardian:_____

Printed Name:
_____

Date: _____

Relationship to patient (if signed by a personal representative of patient):_____