Welcome to Acadia Foot & Ankle!

Thank you for giving us the opportunity to get you started toward good foot and ankle health.

The following is paperwork that will need to be completed and returned prior to your appointment on_____ at _____. The paperwork includes insurance information, medical history, our financial policy and our confidentiality policy.

Please arrive 15 minutes early for your appointment to complete your registration.. Please bring any information you have that may help in diagnosing and treating your condition (i.e. X-rays, blood studies, previous records, drug and allergy history)

Also, please remember to bring your state license or ID and your insurance card(s) with you for us to copy. For your convenience we do bill most insurance companies and we participate in several HMO plans as well. Payment is expected at the time of service for all copays and charges not covered by your insurance plan. (i.e. Co-insurance and/or deductibles) Likewise, if you do not have insurance coverage, payment is expected at the time of service. Please remember if you are covered by an HMO insurance plan, it is your responsibility to obtain an appropriate referral from your PCP prior to your appointment with us.

We require all new patients to confirm their initial appointment 1-2 days prior to their appointment date. We will call up to 3 days prior to your appointment to confirm. If we are unable to reach you we will leave a message with instructions for you to call back to confirm. We reserve the right to cancel your appointment if not confirmed. If you are unable to keep your appointment for any reason please kindly give our office a call as soon as possible.

Be advised that our office has a 15-minute no show policy and if you are more than 15 minutes late you will need to reschedule your appointment.

We are confident you will be happy with the care we provide. If there are any questions about your care or information that you still need about insurance coverage, feel free to give us a call and we will be happy to help you.

Our office has a commitment to you and your foot and/or ankle problems. Our goal is to offer excellent care and follow-up attention, so you will have no reservations about referring others to us who have similar needs.

Please call with any questions.

Thank you,

__ Dr. F. Douglas Reynolds, D.P.M.
__ Dr. Adam W. Darcy, D.P.M.
__ Dr. Keith S. Kendall, D.P.M.
__Dr. Winston S. Harper, D.P.M.

Practice: ACADIA FOOT AND ANKLE **Today's Date:**

Name: _____ **Chart #:** _____ **Date of birth:** _____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Declined to specify

Race: ☐Asian ☐American Indian or Alaska Native ☐Black or African American

☐White ☐Native Hawaiian or other Pacific Islander ☐Declined to specify

Preferred Language: English ☐Declined to specify

Pharmacy Name: _____ **Pharmacy Phone:** _____

Pharmacy Address: _____ City, State, Zip: _____

Primary Care Physician: _____ Phone: _____ Date Last Seen: _____

Address: _____

Referring Physician: _____ Phone: _____ Date Last Seen: _____

Address: _____

Privacy Information Preferences

Do you want to be exempt from public reporting? ☐Yes ☐No Can we send mail to the address on file? ☐Yes ☐No

Can we call the phone number on file? ☐Yes ☐No Can we leave voicemail on machine? ☐Yes ☐No

Will you allow us to send internet based (e-mail) delivery of reminders and newsletters? ☐Yes ☐No

If yes, please provide your e-mail address: _____

Who can we leave messages with? ☐Wife ☐Husband ☐Daughter ☐Son ☐Other: _____

Name(s): _____

Smoking Status

☐Current Every Day ☐Smoker, Current Status Unknown

☐Current Some Day ☐Heavy Tobacco ☐Unknown If Ever

☐Former ☐Never ☐Light Tobacco ☐I decline to answer

Vital Signs

Blood Pressure: _____ / _____

Height: _____ Weight: _____

Current Medications

☐ No Known Medications ☐ I take the following medications:

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Use the back of this form if more room is needed

Allergies

☐ No Known Allergies ☐ No Known Drug Allergies

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Did you get a pneumococcal vaccination? ☐Yes ☐No

Have you fallen in the last 12 months? ☐Yes ☐No **Were you injured from the fall?** ☐Yes ☐No

Have you completed any Advanced Directives? ☐Yes ☐No

PLEASE READ AND SIGN: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. *(Assignment of Benefits)*: I authorize payment of medical benefits to the practice named above. *(Release of Information)*: I authorize the release of any medical information necessary to process this claim. *(HIPAA Privacy)*: I acknowledge that I received my HIPAA Privacy Practices Notice. *(Medication History)*: I authorize the Doctor's office to retrieve my medication history.

Patient Signature: _____ Date: _____

History and Physical

Name: _____ **DOB:** _____ **Chart Number:** _____

Medical History:
☐ Alcoholism ☐ Blood disorders ☐ Circulation problems ☐ Musculoskeletal ☐ Breathing issues
☐ Liver ☐ Sleep apnea ☐ Gout ☐ Allergies ☐ Heart disease ☐ Asthma
☐ Heart murmur ☐ Stomach/bowel ☐ Depression ☐ Anxiety disorder ☐ Mental illness ☐ Kidney disease
☐ Blood clot ☐ High cholesterol ☐ High blood pressure ☐ Cancer ☐ Hepatitis
☐ Neuropathy *(specify)* _____ ☐ Thyroid disease *(specify)* _____ ☐ Diabetes (type 1, type 2)
☐ Arthritis *(specify)* _____ ☐ other *(specify)* _____ ☐ HIV ☐ CVA
Are you pregnant? ☐ Yes ☐ No **Are you nursing?** ☐ Yes ☐ No ☐ Skin disorders ☐ Stroke

Surgical History ☐None ☐Appendectomy ☐ C-Section ☐Angioplasty ☐Bypass ☐Cataracts ☐ Cholecystectomy
Have you ever had any surgical procedures on foot/ankle or anywhere else on your body? ☐ Yes ☐ No
If yes, please describe: _____
Do you have any artificial joints? ☐ Yes (where? _____) ☐ No Do you have an artificial heart valve? ☐ Yes ☐ No

Social History
Do you smoke? ☐Yes ☐No If yes how many packs per day? ☐1 ☐2 ☐3 ☐4 ☐5 For how long?
Do you drink alcohol? ☐Yes, everyday (5-7 days/week) ☐Yes, occasionally/socially ☐No/Rarely
Substance abuse: ☐Yes, I have a current substance abuse problem. Please specify: _____
☐Yes, I had a past substance abuse problem. Please specify: _____
☐ No, I have never had a substance abuse problem
What is your occupation? _____ Does it involve mostly ☐ standing or ☐sitting
Do you exercise regularly? ☐ No, I do not exercise regularly ☐ Yes, I do the following regular exercise: _____
_____

Family History Is there any family history *(blood relative)* of: *(Please indicate family member)*
☐ Alzheimer's _____ ☐ Depression _____
☐ Arthritis _____ ☐ Diabetes _____
☐ Bleeding disorders _____ ☐ Emphysema _____
☐ Blood clot _____ ☐ Heart disease _____
☐ Cancer _____ ☐ High Blood Pressure _____
☐ Cataracts _____ ☐ Neurological _____
☐ Circulation problems _____ ☐ Strokes _____
☐ Other (specify): _____

Review of Systems *(Please check the box if you currently have any of these symptoms or check "NONE")*

Cardiovascular	☐leg pain when walking ☐fainting	☐fever ☐ palpitations	☐ chest pain/pressure ☐vascular disease	☐leg swelling ☐valve problems	☐cold hands/feet ☐**NONE**
Genitourinary	☐blood in urine ☐decreased frequency	☐hesitancy ☐excessive urination	☐incontinence ☐kidney disease	☐increased urgency ☐kidney stones	☐**NONE**
Gastrointestinal	☐abdominal pain ☐diarrhea	☐heartburn ☐trouble swallowing	☐blood in stool ☐decrease appetite	☐vomiting ☐increase appetite	☐ulcers ☐constipation ☐**NONE**
Integumentary	☐athletes foot	☐nail abnormalities	☐keloids	☐itchiness ☐dry, scaly skin	☐**NONE**
Hematologic	☐lower leg ulcers	☐sickle cell disease ☐anemia	☐blood thinners	☐clotting disorders	☐**NONE**
Neurological	☐tingling ☐tremors	☐weakness ☐paralysis	☐seizures	☐numbness	☐headaches ☐**NONE**
Musculoskeletal	☐back pain ☐sciatica	☐joint swelling ☐joint stiffness	☐muscle weakness ☐joint pain	☐muscle pain ☐joint instability	☐neck pain ☐arthritis ☐**NONE**
Respiratory	☐chest pain ☐shortness of breath	☐wheezing ☐emphysema	☐COPD	☐coughing	☐snoring ☐**NONE**

PLEASE READ AND SIGN
The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____ Date: _____

Practice: ACADIA FOOT AND ANKLE **Today's Date:**

Name: _____ **DOB:** _____ **Chart Number:** _____

Sex: ☐M ☐F **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced **SS#:** _____

E-mail: _____ **Spouse/Partner Name:** _____

E-mail newsletters, reminders, statements, etc. **Emergency Name:** _____ **Phone:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home #: _____ **Cell #:** _____ **Other #:** _____

Employer: _____ **Phone:** _____

Employer Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Primary Insurance: _____ Are you the insured? ☐Yes ☐No

Insured Information

Subscriber Name: _____ Relationship to insured: ☐Spouse ☐ Child ☐Self ☐ other

Phone #: _____ Sex: ☐Male ☐Female DOB: ___/___/___

Address: _____

Policy ID: _____ Group ID: _____ Employer: _____

Secondary Insurance: _____ Are you the insured? ☐Yes ☐No

Insured Information

Subscriber Name: _____ Relationship to insured: ☐Spouse ☐ Child ☐Self ☐ Other

Phone #: _____ Sex: ☐Male ☐Female DOB: ___/___/___

Address: _____

Policy ID: _____ Group ID: _____ Employer: _____

How did you find out about our practice? ☐ Physician ☐ Internet ☐ Telephone book ☐ Family member ☐ Friend ☐ Other: _____

What is the reason for your visit today? _____

_____ **Result of accident or work injury?** ☐Yes ☐No

How long has this bothered you? 1 2 3 4 5 6 7 ☐ days ☐ weeks ☐ months ☐ years

What treatments have you tried & have they been effective? _____

_____

On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain? ___/10

The pain quality is: ☐burning ☐constant ☐dull ☐sharp ☐shooting ☐throbbing ☐tingling Other:_____

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____ Date: _____

Acadia Foot & Ankle, P.A.
Comprehensive Medical and Surgical Treatment of the Foot and Ankle

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This Notice takes effect on 4/14/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy policies, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

Required by Law: We may use or disclose your health information when we are required to do so by law.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

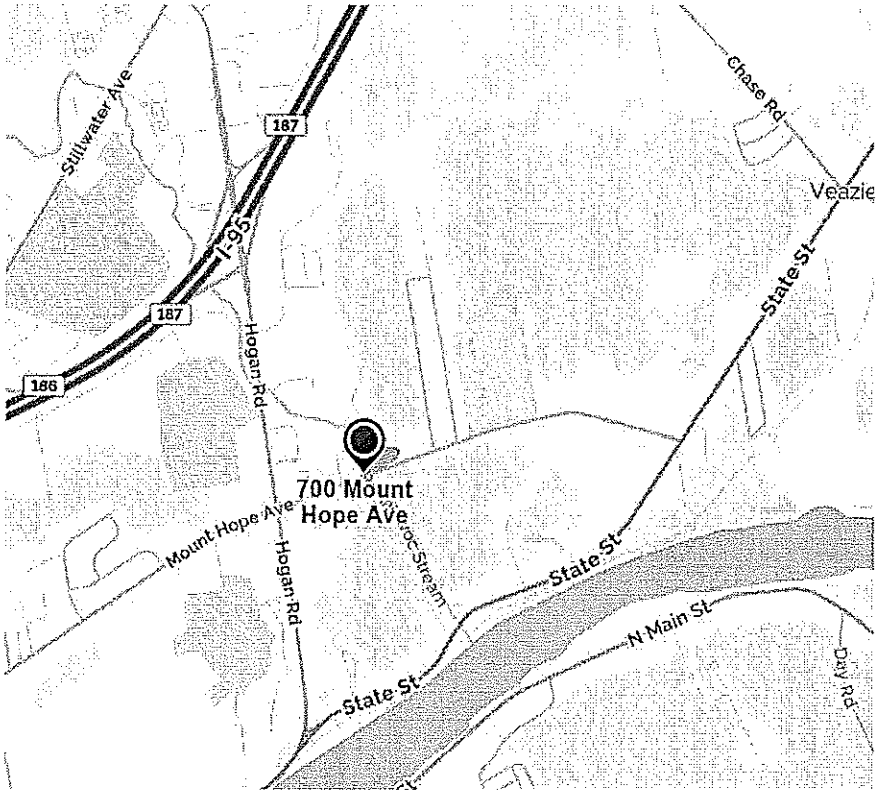
Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certifications, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

DIRECTIONS TO
ACADIA FOOT &
ANKLE AT
EVERGREEN
WOODS
207-947-2220



From the North on I-95:
Take exit 187 and turn left onto Hogan Rd. At your 4th traffic light turn left onto Mt Hope Ave. Drive 0.2 miles and Evergreen Woods, 700 Mt Hope Ave is on your left.
Enter the park and bear right over the bridge, travel to the last building on the left for Suite 620

From the South on I-95:
Take exit 187 and turn right onto Hogan Rd. At your 3rd traffic light turn left onto Mt Hope Ave. Drive 0.2 miles and Evergreen Woods, 700 Mt Hope Ave is on your left.
Enter the park and bear right over the bridge, travel to the last building on the left for Suite 620

From State St:
Travel onto Hogan road and at your 1st traffic light turn right onto Mt Hope Ave. Drive 0.2 miles and Evergreen Woods, 700 Mt Hope Ave is on your left.
Enter the park and bear right over the bridge, travel to the last building on the left for Suite 620

From Stillwater Ave:
Travel onto Hogan road and at your 7th traffic light turn left onto Mt Hope Ave. Drive 0.2 miles and Evergreen Woods, 700 Mt Hope Ave is on your left.
Enter the park and bear right over the bridge, travel to the last building on the left for Suite 620