Raymond J. Abdo, DPM, CWS
St. Louis Foot and Ankle, LLC.

521 N. Virginia Ave.
Eureka, MO 63025
314-849-7600

12152 Tesson Ferry Road
St. Louis, MO 63128
314-849-7600

PATIENT APPOINTMENT

PLEASE ARRIVE 15 MINUTES PRIOR TO YOUR SCHEDULED APPOINTMENT TIME

Please bring the following information with you:

PAPERWORK FULLY COMPLETED

PHOTO ID
INSURANCE CARD (S)
CO-PAYMENT
REFERRAL (IF APPLICABLE)
CURRENT LIST OF MEDICATIONS (PRESCRIPTION AND OVER-THE-COUNTER)

A mask is required at all times while in this medical building. It must cover your nose and mouth at all times.

You will not be called to the exam room if you are on your phone. Cell phones need to be off or on vibrate while you are seeing the physician.

Patients are encouraged to come to the appointment without visitors, but one person will be allowed to accompany the patient to a visit, if needed, to ensure appropriate understanding and implementation of care plans discussed at the visit or to support physical needs of the patient.

Visitors must be healthy with no signs of active illness (no fever, cough, shortness of breath or flu-like symptoms).

Kindly give our office a ***minimum of 24 hours notice*** if you find you are unable to keep this appointment or wish to change/cancel the appointment.

If you have any questions, or if we can be of any further assistance, please feel free to call the office.

Thank You

ST. LOUIS FOOT AND ANKLE, LLC.
RAYMOND J. ABDO, DPM

NAME: _____ SEX F____ M ____
(FIRST) (MIDDLE) (LAST)

ADDRESS _____CITY _____STATE/ZIP _____

SOCIAL SECURITY NUMBER _____ EMAIL _____

HM PHONE _____ WRK PHONE _____CELL PHONE _____

DATE OF BIRTH _____ AGE _____ MARITAL STATUS _____

PT EMPLOYER _____ OCCUPATION/JOB TITLE _____

IN CASE OF EMERGENCY CONTACT (NAME) _____ RELATIONSHIP _____

FIRST PHONE NUMBER _____ALTERNATE PHONE NUMBER_____

PRIMARY CARE DOCTOR_____ OFFICE PHONE _____
(FIRST) (LAST)

PRIMARY PHARMACY _____PHARMACY PHONE_____

INSURANCE CARRIER INFORMATION

PRIMARY INSURANCE:

MEDICARE UNITEDHEALTHCARE ANTHEM BC/BS CIGNA AETNA HEALTHLINK ESSENCE

PRIMARY INSURED NAME: _____ DATE OF BIRTH _____

EMPLOYER NAME _____
(IF INSURANCE COVERAGE IS THROUGH AN EMPLOYER)

PLEASE READ CAREFULLY

I agree to pay, in addition to the amount billed for services rendered, a collection fee of not more than thirty percent (30%) of the principal balance, if St. Louis Foot and Ankle, LLC. employs a collection agency to attempt to collect an unpaid balance.

I consent to be called on any telephone number I give St. Louis Foot and Ankle, LLC. including cellular telephone numbers. I understanding St. Louis Foot and Ankle, LLC. and or its agency will be calling my contact numbers, including any cellular telephone numbers, using an automated telephone dialing system.

I hereby authorize release of information necessary for my insurance company to process any claim. The above information is correct to the best of my knowledge.

I hereby authorize payment directly to St. Louis Foot and Ankle, LLC. . insurance payments otherwise payable to me. I understand that I am financially responsible for charges not paid in a timely manner by my insurance company.

I have received, or was offered a copy of, the HIPAA Privacy Policy.

PATIENT SIGNATURE _____ DATE _____

ST. LOUIS FOOT AND ANKLE, LLC
Raymond J. Abdo, DPM, CWS

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notices before signing this consent.
The terms of the notice may change. If so, you will be notified at your next visit to update your signature/date.
You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement.
The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.
By signing this form, you consent to our use and disclosure of your protected health information and potentially anonymous usage in a publication. You have the right to revoke the current in writing signed by you. However, such a revocation will not be retroactive.
By signing this form, I understand that:

* Protected health information may be disclosed or used for treatment, payment, or health care operations.
* The practice reserves the right to change the privacy policy as allowed by law.
* The patient has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
* The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
* The practice may condition receipt of treatment upon execution of this consent.
* I have received a copy of the Privacy Practices.

1. May we phone, email, or send a text to you to confirm appointments? YES NO
2. May we leave a message on your answering machine at home or on your cell phone? YES NO
3. May we discuss your medical condition with any other member of your family or other persons? YES NO

I authorize communication with the following person (s):

1._____ _____ _____
Name Phone number Relationship

2._____ _____ _____
Name Phone number Relationship

3.._____ _____ _____
Name Phone number Relationship

This consent was signed by:

_____
PRINT NAME

Signature:_____ Date:_____ Witness: _____

NAME: _____ DATE: _____

SURGICAL HISTORY:

Have you ever had surgery: _____ Yes _____ No
If yes, please list:

1. _____ Date: _____
2. _____Date:_____
3. _____Date:_____
4. _____Date:_____
5. _____Date:_____
6. _____Date:_____
7. _____Date:_____
8. _____Date:_____
9. _____Date:_____
10. _____Date: _____

NAME: _____ DATE: _____

PREFERRED PHARMACY _____ Phone: _____

City: _____Zip code: _____ Cross streets_____

ARE YOU ALLERGIC TO LATEX? ____Yes ____ No

ARE YOU ALLERGIC TO ANY MEDICATIONS ? ____Yes ____ No

Drug: _____ Reaction: _____

Drug: _____ Reaction: _____

Drug: _____ Reaction: _____

ARE YOU TAKING ANY OF THE FOLLOWING OVER-THE-COUNTER MEDS: ___Yes ___ No

_____ ALLERGY _____ ANTACIDS _____ ASPIRIN/TYLENOL _____ LAXATIVES _____ DIET PILLS

NAME OF MEDICATION	STRENGTH (mg or mcg)	HOW MANY	HOW OFTEN

PRESCRIPTION MEDICATIONS

NAME OF MEDICATION	STRENGTH (mg or mcg)	HOW MANY	HOW OFTEN

VITAMINS, HERBS AND SUPPLEMENTS

NAME: _____ DATE: _____

HEIGHT: _____ WEIGHT: _____ SHOE SIZE: _____ WIDTH: _____

EYES:
Eye disease or injury.....Y N
Glaucoma.....Y N
Macular Degeneration.....Y N

CARDIOVASCULAR:
High blood pressure.....Y N
Congestive heart failure.....Y N
Heart disease .....Y N
Chest pain/palpitations.....Y N
Swelling feet/ankles/hands.....Y N

EAR/NOSE/THROAT:
Hearing loss/ ringing in ears.....Y N
Sore throat/voice change.....Y N
Swollen glands in neck.....Y N
Seasonal allergies.....Y N

PSYCHIATRIC:
Memory loss/confusion.....Y N
Anxiety.....Y N
Depression.....Y N
Insomnia.....Y N

RESPIRATORY:
Shortness of breath.....Y N
Chronic cough.....Y N
Asthma.....Y N
Emphysema.....Y N

AUTOIMMUNE DISORDERS:
Addison's, Crest Syndrome, HIV, Lupus, PMR,
Rheumatoid Arthritis, Psoriatic Arthritis, Scleroderma

Other _____

Other health issues not mentioned above:

MUSCULOSKELETAL:
Joint pain/stiffness.....Y N
Muscle pain/cramps/weakness.....Y N
Difficulty walking.....Y N
Back pain.....Y N
Numbness/tingling of the
Toes/feet/legs or fingers/hand/arms.....Y N
Osteoarthritis .....Y N

GASTROINSTESTINAL:
Ulcers (gastric, duodenal).....Y N
Reflux.....Y N

ENDOCRINE:
Diabetes.....Y N
Controlled by: Insulin Oral Meds Diet
Thyroid disease .....Y N
Underactive Overactive
Liver disease.....Y N
Kidney disease.....Y N

NEUROLOGICAL:
Headaches/Migraines.....Y N
Seizure/convulsions.....Y N
Tremors/stroke/paralysis.....Y N
Dementia/Alzheimer's disease .....Y N
Parkinson's Disease.....Y N

HEMATOLOGIC/LYMPHATIC:
Anemia.....Y N
Bleeding/bruising problems.....Y N
Phlebitis/blood clots.....Y N

CANCER:
Type:_____
Treatment received:_____
Date of last treatment: _____

_____

_____

Family history of any illness or disease:

Mother/Father: _____ Brother/sister: _____

Maternal Grandparent: _____ Paternal Grandparent: _____

Alcohol use: Never___ Rarely ___ Occasionally ___ Moderate ___ Daily ___ How much per week: _____

Tobacco: Never smoked ____ Less than 1 pack/day___ 1-2 packs/day ___ If you quit, when: _____

Recreational Drugs: Never ___ Rarely ___ Occasionally ___

Exercise: None _____ Walking ____ Running/jogging ____ Weight training ____ Cycling _____Other: _____

What brings you in to see the doctor today? (Briefly describe the type and duration of the problem)

_____

_____

Permission for Telehealth Visits

What is telehealth?

Telehealth is a way to visit with healthcare providers, such as your doctor.

Not all visits are appropriate, but we can use Telehealth to review test results or have other discussions that do not require you to be physically present with your doctor.

You can talk to your provider from any place, including your home. You don't go to a clinic or hospital.

How do I use telehealth?

- You talk to your provider by phone, computer, or tablet.
- Sometimes, you use video so you and your provider can see each other.

How does telehealth help me?

- You don't have to go to a clinic or hospital to see your provider.
- You won't risk getting sick from other people.

Can telehealth be bad for me?

- You and your provider won't be in the same room, so it may feel different than an office visit.
- Your provider may make a mistake because they cannot examine you as closely as at an office visit. (We don't know if mistakes are more common with telehealth visits.)
- Your provider may decide you still need an office visit.
- Technical problems may interrupt or stop your visit before you are done.

Will my telehealth visit be private?

- We will not record visits with your provider.
- If people are close to you, they may hear something you did not want them to know. You should be in a private place, so other people cannot hear you.
- Your provider will tell you if someone else from their office can hear or see you.
- We use telehealth technology that is designed to protect your privacy.
- If you use the Internet for telehealth, use a network that is private and secure.
- There is a very small chance that someone could use technology to hear or see your telehealth visit.

What if I try telehealth and don't like it?

- You can stop using telehealth any time, even during a telehealth visit.
- You can still get an office visit if you no longer want a telehealth visit.
- If you decide you do not want to use telehealth again:
    - call 314-849-7600 and say you want to stop
    - It will be as if you never signed this form.

How much does a telehealth visit cost?

- What you pay depends on your insurance.
- A telehealth visit will not cost any more than an office visit.
- If your provider decides you need an office visit in addition to your telehealth visit, you may have to pay for both visits.

Do I have to sign this document?

No. Only sign this document if you want to use telehealth, when it is appropriate.

What does it mean if I sign this document?

If you sign this document, you agree that:

- You have read and understand the information in this document.
- We answered all your questions.
- You want a telehealth visit, if/when it is appropriate.

If you sign this document, we will give you a copy.

Your name (please print) Date

Your signature Date