Raymond J. Abdo, DPM
St. Louis Foot and Ankle, LLC.
12152 Tesson Ferry Road
St. Louis, MO 63128
314-849-7600
Fax: 314-842-0106

PATIENT APPOINTMENT

*PLEASE ARRIVE **20 MINUTES** PRIOR TO YOUR SCHEDULED APPOINTMENT TIME*

Please bring the following information with you:

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

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.
A no show fee will be assessed for failure to notify our office.

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 COVENTRY CIGNA AETNA HEALTHLINK

PRIMARY INSURED NAME: ______________________________ DATE OF BIRTH ____________

SOCIAL SECURITY NUMBER ______________________ RELATIONSHIP TO PATIENT ____________

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.

PATIENT SIGNATURE ______________________________ DATE ______________

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 ____________________

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

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

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

Other health issues not mentioned above:

____

____

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)

____

____

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: __________

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: __________

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 We shall honor this agreement, (unless it conflicts with Federal or State laws). 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 or a copy has been offered to me.

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

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: ______________

LATE ARRIVAL
CANCELLATION / MISSED APPOINTMENT
POLICY

We pride ourselves in offering you personalized care and reserve appointment times to accommodate your needs. Late arrivals, missed appointments or cancelled appointments without sufficient notice, create a gap in our providers' schedule. These are appointments that could have been utilized to offer care to another patient.

Late Arrivals:

If a patient is more than **10 minutes late** for an appointment, the appointment may need to be rescheduled. This is to ensure that the patients who arrive on time do not wait longer than necessary to see the provider. You may be given the option to wait for another appointment time on the same day *if one is available.*
We will try to accommodate late-comers as best as possible, but cannot compromise on the quality and timely care provided to our other patients.

If a patient presents to the office **15 minutes late** for a scheduled appointment with our providers, the patient will be asked to reschedule their appointment..

If you are a **new patient** and you arrive at the scheduled appointment time and not early to complete your forms as instructed and it takes more than 10-15 minutes to complete the forms and the registration process, you may also be asked to reschedule.

Last Minute Cancellations and Missed Appointments:

We do require a ***24 hour notice*** on all cancellations. As a courtesy to our patients, we try to confirm all appointments. We do recognize that situations arise that are out of your control; however it is imperative that you contact our office immediately to notify us of your cancellation in a timely manner.

If it is your first time cancelling with less than a 24 hour notice or missing an appointment (NO SHOW) with our office, ***there will be a $25.00 fee.***
Any future last minute cancellations or
missed appointments will be assessed a fee of ***$50.00.***

We ask for your consideration and cooperation in scheduling your next appointment. Please understand that we are partners in your health care and we are committed to offering you appropriate care when you need it.

______________________________ ____________

Your signature acknowledges receipt *Date*

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