Welcome to our New Patients

Our practice is a division of the **InStride Foot & Ankle Specialists, PLLC**. We have divisions across North and South Carolina, and we operate under one tax ID number. As such, if you have seen any of the following physicians in the past **three years**, we need to know so that we will not file a new patient code for your visit today. Since the insurance carriers look at us as one large practice, if you have been seen at any of the following divisions, you will not be considered a new patient in our practice. **Visits prior to 2017 do not need to be disclosed**.

Please review the names of the divisions and podiatrists below and indicate if you have been seen at any of these divisions by putting a **√** on the line to the left of the practice name. Thank you for disclosing this information to us – it will allow us to be in compliance with nationally mandated correct coding initiatives.

	DIVISION	PODIATRIST
	Alta Ridge Foot Specialists (Resigned from Group 1/1/20)	Robert van Brederode, William Broyles, Thomas Verla
	Ankle & Foot Center of Charlotte **(Resigned from group 7/1/2017)**	Scott Basinger
	Brunswick Foot & Ankle Surgery, PA	Joseph Kibler
	Capital Foot and Ankle Centers	Eldon Peters (eff: 10/1/2018)
	Carmel Foot Specialists **(Resigned from group 1/1/20)**	Barbara Kaiser, Richard Lind, Richard Miller, Kevin Molan, Tori Simmons-Lewis
	Carolina Foot & Ankle Health Center	Millicent Brown
	Carolina Foot Care Associates, PLLC	Ashma Davidson, Terry Donovan (ret 1/1/18), William O'Neill
	Carolina Podiatry Group	Brandon Percival, Julie Percival, William Harris, Katlin Jackson (eff:7/1/19), Robert Ezewuiro (eff:8/15/19)
	Central Carolina Foot & Ankle Associates	Melissa Hill, Gary Liao, Alan Sotelo
	Chapel Hill Foot & Ankle Associates, P.A.	Jane Andersen, Alan Bocko, Katherine Williams
	Charlotte Foot & Ankle Specialists, PLLC **(resigned from group 8/1/2017)**	Kristine Strauss
	Coastal Carolina Foot & Ankle	Thomas Hagan, Tyler Hagan
	Coastal Carolina Foot & Ankle Associates	Jeffrey Pupp(ret. 12/31/2019), Kevin Bachman (eff: 1/1/2019), Derek Pantiel
	Comprehensive Foot & Ankle Center, P.A.	Zack Nellas
	Crystal Coast Podiatry	Thomas Bobrowski
	Family Foot & Ankle Center, P.A.	Patrick Dougherty, Doug Smith
	Family Foot Care	Kevin McDonald, Neil Younce (eff: 10/1/2019), Erin Younce (eff: 12/19/2019)
	Foot & Ankle Center of Durham	Eric Simmons
	Foot & Ankle of the Carolinas, PLLC	Eric Ward, Blaise Woeste
	Gaston Foot & Ankle Associates, P.A. **(Resigned from Group 12/1/19)**	David Kirlin, Ryan Meredith, Wagner Santiago, Randell Contento
	Greensboro Podiatry Associates, P.A.	Martha Ajlouny, N'Tuma Jah (resigned 12/21/17), **Jonathan Simpson (eff: 1/1/18) term 5/10/18**
	Hendersonville Podiatry	Russ Barone(ret. 2/2/18), Pam Stover
	James Mazur, D.P.M., P.A.	James Mazur, Erin Younce (eff: 12/19/2019)
	Kinston Podiatry	Dale Delaney
	Matthews Foot Care	Brian Killian, Kevin Killian, David Ellenbogen(termed 10/23/19), Wesley Jackson (eff: 7/1/19)
	Mt. Airy Foot & Ankle Center, PLLC	Jim Shipley, David Collard, Walter Falardeau, Thurmond Siceloff termed 10/23/2018) , Jeffrey Hunter (eff: 7/1/19)
	Myers Podiatric Clinic	William Myers
	Piedmont Foot & Ankle Clinic **(Terming from Group 2/1/20)**	Rick Hauser, Rob Lenfestey (ret.), Jason Nolan, Joel Kelly, Elizabeth Bass Daughtry, Jacob Panici, Brian Futrell (eff:3/1/18)
	Piedmont Podiatry Associates	Subodh Choudhary, Nicholas Canoutas, Cassandra Pike, Sarah Fitzgerald
	Queen City Foot & Ankle Specialists, P.C.	Roxanne Burgess, Alison Garten(termed 11/6/19), Wesley Jackson (eff: 7/1/19)
	Raleigh Foot & Ankle **(Resigned from Group 1/1/2018)**	Alan Boehm, Robert Hatcher, Jordan Meyers, Kirk Woelffer
	Roberson Foot Care, PC	Ainsley Rusevlyan (eff: 2/1/2019)
	Ryan Foot & Ankle Clinic	David Garchar, Jeff Glaser, Michael Ryan, Scott Whitman, Matthew Borns, Bradley Lind (eff:7/23/19)
	Salem Foot Care	Scott Matthews
	Summit Podiatry	Derek Pantiel, Kevin Bachman
	Upstate Foot Care	Hans Blaakman
	Wake Foot & Ankle Center	Mike Hodos, Jim Judge
	Wilson Podiatry Associates, PA	Kendall Blackwell

_____I attest that I have been seen in the above indicated division of the InStride since 0**1/01/2017.**

_____I attest that to my best recollection, I have not been seen by any of the above divisions/physicians since **01/01/2017.**

Signature of patient:_____Date: _____

Welcome to Drs. Kevin Killian, Brian Killian & Wesley Jackson's office.

InStride Foot & Ankle Specialists, PLLC *How did you hear about us?* _____

PATIENT INFORMATION			
Last :	First:		MI:
Home Address:			
City:	State:		Zip:
SS# _____-_____-_____	Date of Birth: _____/_____/_____	Sex:	Marital Status:
Race:	Ethnicity:	Primary Language:	
Email:		Employer Name:	
Please check the primary number in which you would like to be contacted:			
☐ Home Phone: ( )	☐ Work Phone: ( )		☐ Cell Phone: ( )
EMERGENCY CONTACT			
Full Name:	Relationship:		Phone: ( )
PRIMARY POLICY HOLDER (If different from patient) on INSURANCE CARD			
Full Name:	Relationship:		Date of Birth: _____/_____/_____
PRIMARY CARE PHYSICIAN INFORMATION			
Doctor:	Practice/Group Name:		Phone: ( ) Date Last Seen: _____

FOOT/ANKLE HISTORY

1. What is the main problem with your feet or ankles? _____
2. When did you first notice the condition? _____
3. Is this an injury? Y or N If yes, when? _____ If yes, did it happen at work? Y or N
   Will this be filed with Workers' Compensation? Y or N
4. Have you ever been hospitalized other than for surgery? Y or N Explain:

_____

5. Have you ever had an injury to the lower extremity? Y or N Explain:

_____

MEDICAL HISTORY

Surgical Procedures: _____ Date: _____

_____

Height: _____ Weight: _____ Shoe Size: _____ Pregnant: Y or N

Use Tobacco: Y or N Former Smoker: Y or N / Drink Alcohol: Y or N Former User: Y or N Frequency: _____
Flu Vaccine: Y or N Year:_____ / If Diabetic A1C: Y or N Last Date:_____

Check if You Have Any of the Following:

[ ] Diabetes	[ ] Heart Condition	[ ] Acid Reflux	[ ] Thyroid Disorder
[ ] Neuropathy	[ ] Anemia	[ ] GERD	[ ] High Cholesterol
[ ] Arthritis	[ ] Stroke	[ ] Gout	[ ] High Blood Pressure
[ ] Cancer	[ ] Poor Circulation	[ ] Hepatitis	[ ] Low Blood Pressure
[ ] COPD	[ ] Heart Attack	[ ] Alzheimer's/Dementia	[ ] Kidney Disease
[ ] HIV	[ ] Stents	[ ] Asthma	[ ] Crohns/Ulcerative Colitis
[ ] Fibromyalgia			

Pacemaker: Y or N If Yes, please provide documentation card to the front desk to scan.

FAMILY HISTORY

PLEASE CHECK ALL THAT APPLY

	Father	Mother	Brother	Sister
Diabetes				
Heart Disease				
High Blood Pressure				
Arthritis				
Gout				
Thyroid				
Cancer (what type)				
Other				

CURRENT LIST OF MEDICATIONS

NAME OF DRUG	DOSAGE	MEDICAL CONDITION

DRUG ALLERGIES

NAME OF PHARMACY	ADDRESS	PHONE NUMBER
		( )

Matthews Foot Care / Lincoln Foot Care / Waxhaw Foot Care
A division of InStride Foot & Ankle Specialists, PLLC
Kevin L. Killian, DPM / Brian L. Killian, DPM / Wesley A. Jackson, DPM

***CONSENT TO TREAT*:** I request and give consent to *InStride Foot & Ankle Specialists, PLLC*, it's employees and all other persons caring for me to treat me in ways they judge are beneficial to me for my health and well being. I understand that this care may include test, examinations, medical and surgical treatment, and consultations with appropriate specialists. No guarantees have been made to me about the outcome of this care.

Signature: _____ **Date:** _____

***FINANCIAL AGREEMENT*:** I understand that payment is due at time service is provided. I understand that *InStride Foot & Ankle Specialists, PLLC* , will bill most insurance carriers as a courtesy to me, if proper paperwork is provided to them. *InStride Foot & Ankle Specialists, PLLC* will also bill most secondary insurance companies for me, if applicable. In the event your account is past due, it will be sent to our collection agency. **I understand that my co-payment is due at the time of service. I understand that I am responsible for the payment of all charges not covered by my insurance.**

Signature: _____ **Date:** _____

***ASSIGNMENT OF BENEFITS*:** I authorize payment directly to InStride Foot & Ankle Specialists, PLLC of any benefits, which would otherwise be payable to me for their services as described, realizing I am responsible to pay non-covered services. I also *authorize InStride Foot & Ankle Specialists, PLLC* to release any information acquired in the course of my treatment necessary to process insurance claims. I authorize the use of this signature on all insurance forms and submissions.

Signature: _____ **Date:** _____

MEDICARE PATIENT PROVIDER NOTICE

Medicare will only pay for services that are determined to be "reasonable and necessary" under section 1862(a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service. I believe that in your case, Medicare is likely to deny payment for routine foot care for the following reason:

- **Medicare believes routine foot care is not a necessary procedure i.e., trimming of nails, corns, and/or calluses.**
- **Other Services – Post-operative shoes and supplies such as bandages; medications; shoe inserts; prescription orthotics and custom orthopedic shoes, lab handling fees.**

Signature: _____ **Date:** _____

BENEFICIARY AGREEMENT

I understand that Medicare is likely to deny payment for the services identified above, for the reasons stated. I agree to be personally and fully responsible for payment.

Signature: _____ **Date:** _____

MATTHEWS/LINCOLN/WAXHAW FOOT CARE

A division of InStride Foot & Ankle Specialists, PLLC

Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____

InStride Foot and Ankle Specialists, PLLC is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Appointment reminders ☐ Results of lab tests/x-rays ☐ Other_____
☐ Spouse (provide name and phone number) Name: _____ Phone Number: _____	☐ Appointment reminders ☐ Financial ☐ Medical
☐ Family Member (provide name and phone number) Name: _____ Phone Number: _____	☐ Appointment reminders ☐ Financial ☐ Medical
☐ Email communication-Provide email address* _____ Text communication-Provide number for text* _____	☐ Appointment reminders ☐ Medical ☐ Financial
☐ *For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I am willing to accept that risk and will not hold the practice responsible should such incident occur. I still elect to receive email and/or text communication as selected.	

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

_____Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

_____

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGMENT OF RECEIPT

MATTHEWS FOOT CARE/LINCOLN FOOT CARE
WAXHAW FOOT CARE
A division of InStride Foot & Ankle Specialists, PLLC

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

-Conduct, plan and direct my treatment and follow-up among the multiple health providers who may be involved in the treatment directly and indirectly
-Obtain payment from third-party payers
-Conduct normal healthcare operations such as quality assessments and physician certifications

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- ☐ I received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

- ☐ I declined to read the Notice of Privacy Practices

_____ _____
Patient Name (Printed) Date

_____
Parent or Authorized Representative (if applicable)

_____ _____
Signature Date