ORTHOPEDIC SURGERY OF THE FOOT AND ANKLE, PA

SARAH E. DEWITT, MD

Welcome Letter

Dear Patient:

We look forward to seeing you. Enclosed is a set of forms that we need filled out for you to be seen. Your wait can be shortened by sending these to us prior to your appointment (email frontdesk@orthopedicfootandankle.com, fax 919-838-5201). If you forget your forms, we are happy to have you fill them out when you come.

Your appointment with Dr. DeWitt is scheduled for

_____

Please bring insurance card, photo ID, and shorts

No show fee - $25 if less than 24 hour notice

Parking

We have a gated parking lot. The parking lot is there for patients and we want you to have a close parking spot and a close walk to the door. Gate is open most of the time, but if it is closed just us from your cel phone and we will buzz you in. We look forward to seeing you!

Covid

As a medical clinic, we are mandated to wear masks. Please comply.

Insurance reminder

Some insurances require referral (for example, Carolina Access, Medicaid, Aetna Duke plan, a very few United (UHC)); this is your responsibility to get this prior to your appointment.

We are *out of network* for Humana. There are several companies that have small plans that we are excluded from. These include Blue Value/Blue Local (we take all BCBS, just not Blue Value/Blue Local), Cigna Surefit, Aetna Duke Select, Aetna Medicare Advantage.

There are several Cigna plans that require a referral from your primary care provider prior to being seen by a specialist: Cigna HMO, POS, or HMO POS; Network POS, and Connect Network.

If you have a plan that we do not take, we would be happy to see you out of network (which may cost more). And we have a cash pay option that we try to make affordable.

Questions about insurance can often be answered prior to your appointment, just give us a call.

We are so glad you are coming to see us, and we look forward to meeting you in person!

OSFA
ORTHOPEDIC SURGERY
FOOT & ANKLE

Payment

I understand that I am responsible for my bill regardless of insurance coverage. Insurance contracts are between the patient and his/her insurance company. The insurance company is responsible to the patient and the patient remains responsible to the physician or clinic. I authorize assignment to benefits to OSFA of payments due for medical services rendered to myself or my dependents. If my account becomes delinquent, I agree to pay reasonable costs incurred in collecting the account, including reasonable attorney's fees. I also understand that I am responsible for any amount not covered by insurance carriers.

Release of Information and Authorization of Payment

I hereby authorize OSFA to release my medical information to my insurance company and other health care providers that are involved with my care.

HIPAA Privacy Acknowledgement

I have had the opportunity to review the HIPAA information brochure on the Notice of Privacy Practices for OSFA (a laminated copy is permanently displayed at front desk). I understand I can have a copy of the financial or HIPPA policy for OSFA at any time. I understand that OSFA uses a sign in list at front desk and that I will be called back by name. I understand that OSFA uses recorded phone call appointment reminders sent to the phone number you provide us.

Staff

I understand that it is part of the mission of OSFA to mentor students. We consistently have college students doing internship work.

Other fees

No show: $25 fee. We will not reschedule after 3 no show or late cancellation events. There is a After hours calls: $25/call fee not covered by insurance.

Review of scans/studies

If Dr. DeWitt reads a study for you (for example a CT scan, MRI scan, bone scan), Aetna and United, for example, do not pay. You will be responsible for a flat fee of $40 for each scan.

Referrals

We are happy to provide you with referrals to providers whom we think do good work and are convenient to you. But you are responsible for figuring out whether they are in or out of network. There is just no way for us to be knowledgeable about which groups take which plans as these are always changing. You can call your insurer for help with determining this.

_____

Date

_____

Signature of the Patient, Parent or Guardian (if under 18 years old)

ORTHOPEDIC SURGERY
FOOT & ANKLE

Electronic Communication Policy

E-mail

We are happy to use e-mail (with patient's consent) to send documents, work notes, etc. ideally that do not have protected health information in them.
What we will *not* do: answer clinical questions, like "what do I do if the swelling is not going down?" by email. These should be handled by phone.

____ I do consent to the above communication by email

Cell phones

We do allow patients to use their cell phones in the office. We would never record anything that occurs in our office without the patient's consent. And, for any visitor, patient or family member to photograph, video, or record anything in our office, they have to have OSFA's consent. It is not appropriate at this time to email or text photos or clinical information to us. Our office handles medical issues by phone and in person.

Facetime

If you want to include family for the visit, we are happy to do this as long as we discuss it and set up appropriate time and location. We have to be thoughtful of the other patients and protect their and your privacy.

Social media like Facebook

OSFA does not participate in these currently.

Fax

This is the standard means that we use to communicate to other physician practices and hospitals. As new electronic options to communicate become available, we will evaluate to see if they are safe and reasonable for our practice.

_____
Date

_____
Signature of the Patient, Parent or Guardian

PATIENT INFORMATION

Date _____

Identification

_____
Last Name

_____
First Name

_____
Middle name Suffix

Male ___ Female ___

Date of Birth _____

Social xxx-xx- _____ (we just need the last 4)

Address

Address line 1 _____

Address line 2 _____

City _____ State_____ Zip _____

Telephone numbers

Home _____
Cel _____
Work _____
email _____

Marital Status

__ Single
__ Married
__ Divorced
__ Widowed

Emergency Contact

_____
Name Phone relation

_____
Name Phone relation

Reminder calls

Do you want automated reminder call for appointment

O yes O no

Work

Employer _____

Insurance (Primary)

Policy # _____ Group # _____
If you are on someone else's insurance policy:

_____
Name of Insured

_____
DOB of Insured

Insurance (Secondary)

Policy # _____ Group # _____
If you are on someone else's insurance policy:

_____
Name of Insured

_____
DOB of Insured

Reason for Visit

Tell us what you have come today to have evaluated or treated (check all that apply)?

Left		Right
O	foot pain	O
O	foot swelling	O
O	ankle pain	O
O	ankle swelling	O
O	bump	O
O	foot fracture	O
O	ankle fracture	O
O	sprain	O
O	ulcer	O
O	numbness	O
O	infection	O
O	Other	O

Pharmacy you would like us to use:

_____

How did you know to come to us-did someone refer you to us?

_____

Who is your primary care doctor (or regular provider)

_____

Other doctors with whom we should keep in communication with (rheumatologist, cardiologist, neurologist, etc)

_____

_____

_____

For several insurances (and hospitals, if you are going to have a procedure) we need:

Height_____ Weight_____

Allergies **Reaction**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Medications (do include things like calcium, vit D, fish oil, etc)

Name	Dose	How many times/day

COVID Vaccine

Date of first vaccine _____

O Not vaccinated

O Booster shot

Social History

Smoking status/nicotine/tobacco

- O never a smoker
- O former smoker
- O current every day smoker
- O if applicable, how
- O chew tobacco
- O pipe-cigar
- O e-cigarette/vape
- O nicotine

Alcohol

- O never drink
- O occasional drink
- O moderate drink
- O heavy drinker

Illicit drugs?

_____

Attorney involved?

_____

Job requirements

- O I am currently working
  - employer _____
  - Occupation _____
- O This is work related injury
- O Last date worked
- O I am on disability or applying for it

Living situation (check all that apply)

- O live alone
- O live with others
- O single parent
- O caring for elderly relative
- O I have children?
  - If so what age?_____

Activity related to work

- O desk or sitting
- O some walking and standing
- O strenous walking/standing/lifting
- O driving commercial vehicle
- O uneven ground
- O climbing or roof work

Activity outside of work

- O walk
- O walk the dog
- O treadmill
- O golf
- O yardwork
- O house projects
- O jog/run
- O bike
- O elliptical
- O gym/weights
- O swim
- O water
- O tennis
- O pickle ball
- O soccer
- O cross
- O basketball
- O yoga/pilate
- O exercise
- O crossfit/boo
- O other

Surgery History

Date	Surgery	Locatio

Past Medical History & Family History

Please check all that apply to you (on left) and your family history (on right)

You	CARDIOVASCULAR	Family
O	High Blood Pressure	O
O	Murmer	O
O	stents placed	O
O	Coronary Heart Disease (CAD)	O
O	Irregular beat	O
O	a-fib	O
O	on blood thinner	O
O	Pacemaker	O
O	defibrillator	O
O	angioplasty	O
O	angiogram	O
O	valve problem	O
O	chest pain	O
O	congestive heart failure	O
O	High Cholesterol	O
O	other	O

You	LUNG DISEASE	Family
O	Shortness of breath	O
O	Asthma	O
O	pneumonia	O
O	Bronchitis	O
O	Emphesema (COPD)	O
O	Use oxygen	O
O	Sleep apnea	O
O	Use CPAP at night	O
O	other	O

You	DIABETES	Family
O	Borderline/pre-diabetes	O
O	Diabetes Type I	O
O	Diabetes Type II	O
O	on insulin	O
O	oral medication	O
O	Gestational diabetes	O
O	glucose checking	
O	never (my doctor checks)	
O	weekly	
O	daily	
O	multiple times a day	
O	recent A1C < 6.0	
O	A1C 6-7 range	
O	A1C 7-8 range	
O	A1C > 8	
O	Diabetic neuropathy	O
O	Diabetic kidney problems	O
O	Diabetic eye problems or surgery	O
O	Ulcer on foot	O
O	amputation part of foot	O
O	amputation toe	O
O	amputation of whole foot	O

You	KIDNEY/BLADDER	Fan
O	Kidney stones	O
O	decreased kidney function	O
O	on dialysis or was on dialysis	O
O	bladder infections	O
O	prostate problems	O
O	Kidney transplant	O
O	other kidney & bladder	O

You	BLEEDING & CLOTTING	Far
O	Anemia	O
O	easy or free bleeding	O
O	easy bruising	O
O	aspirin	
O		
O	coumadin/warfarin	
O	plavix	
O	xerelto/brillinta/eliquis	O
O	blood clot/DVT	O
O	pulmonary embolus (PE)	O
O	bleeding disorder	O
O	other bleeding/clotting	O

You	BLOOD FLOW-VASCULAR	Far
O	cannot feel pulse	O
O	peripheral vascular disease	O
O	angiogram of legs	O
O	surgery to restore blood flow	O
O	varicose veins	O
O	edema or swelling in ankles	O
O	vascular other	O

You	NEUROLOGIC	Far
O	headaches	O
O	neuropathy	O
O	Parkinsons disease	O
O	stroke or TIA	O
O	head injury or cerebral palsey	O
O	Charcot-Marie-Tooth (CMT)	O
O	MS (multiple sclerosis)	O
O	restless leg syndrome	O
O	Neck pain	O
O	upper back pain	O
O	lower back pain	O
O	buttock area pain	O
O	chiropracter	O
O	neck or back surgery	O
O	nerve conduction test	O
O	pain clinic treatment	O
O	neurologic other	O

History Page 2

You	PSYCHIATRIC	Family
O	anxiety	O
O	depression	O
O	sleep disorder	O
O	ADD/ADHD	O
O	hospitalized for psychiatric	O
O	psychiatric other	O

You	BONE HEALTH	Family
O	had bone density test;	O
O	osteopenia	O
O	osteoporosis.	O
O	stress fracture in past	O
O	broken bone in past	O

You	CANCER	Family
O	breast	O
O	prostate	O
O	colon cancer	O
O	skin	O
O	chemo	O
O	radiation	O
O	other cancer	O

You	HISTORY OTHER	Family
O	problems with anaesthesia	O
O	serious or recurrent infections	O
O	fever/sweats/chills	O
O	IV antibiotics	O
O	History of MRSA infection	O
	other history	

You	ORTHOTICS/BRACES/SHOES	Family
O	hard plastic from podiastrist	O
O	over the counter arch support	O
O	orthotics from orthoticst/bracemaker	O
O	cane	O
O	crutches	O
O	wheelchair	O
O	knee walker	O
O	walker	O

You	ARTHRITIS	Family
O	Osteoarthritis	O
O	arthritis of hip or knee	O
O	arthrits of hands	O
O	rheumatoid arthritis.	O
O	lupus or SLE	O
O	Reiters Syndrome	O
O	gout.	O

You	Arthritis (continued)	Far
O	Lyme disease	O
O	pseudogout	O
O	psoriatic arthritis	O
O	joint pain or joint swelling	O
O	ankylosing spondylitis	O
O	stiffness in the morning	O
O	fibromyalgia	O
O	seen by rheumatologist in past	O
O	hip or knee replacement	O

You	SKIN PROBLEMS	Far
O	psoriasis	O
O	eczema	O
O	ulcers in mouth	O
O	dry eye/dry mouth	O
O	sun sensitivity	O
O	rash other	O
O	raynauds	O
O	hair loss	O
	skin other	

You	GI HISTORY	Far
O	reflux (GERD)	O
O	ulcer	O
O	problems with NSAID's	O
O	recurrent diarrhea	O
O	Chron's or Ulcerative Colitis	O
O	gastric bypass surgery	O
O	gluten sensitivity or celiac	O
O	GI other	O

You	LIVER & GALL BLADDER	Far
O	gallstones	O
O	hepatitis A	O
O	hepatitis B	O
O	hepatitis C	O
O	liver & gallbladder other	O

You	ENDOCRINE	Far
O	low thyroid	O
O	hyperthyroid	O
O	Hashimotos	O
O	thyroid nodule	O
O	Graves disease	O
O	endocrine other	O

History of Problem

Tell us a little about your problem, about what brings you in today?

_____

_____

_____

_____

Date of onset (please be specific as you can, date, time if an injury):

_____

Quality of pain (if you have pain)

Left		Right
O	aching	O
O	burning	O
O	stabbing	O
O	sharp	O
O	dull	O
O	superficial	O
O	deep	O
O	other	O

Timing of symptom

- O intermittant
- O constant
- O worse at night

Pain severity (if you have pain)

- O no pain
- O mild pain
- O moderate
- O sever
- O Pain level ____/10

Scale 1-10: _____

Do any of these make it better (alleviate)?

- O sitting/lying down
- O heat or ice
- O rest
- O over the counter medication
- O tennis shoes

Do any of these make it worse (aggravate)?

- O activity on feet
- O shoe
- O wearing high heel
- O hard surface
- O uneven ground

Check device you currently use

- O none
- O cane
- O walker
- O crutches
- O wheelchair
- O knee walker

Prior Treatments

- O emergency room/urgent care
- O cast
- O brace
- O surgery
- O podiatrist
- O orthopedic surgeon
- O primary care
- O physical therapy
- O injections
- O medication
- O nerve test
- O orthotics
- O pain management
- O other

Did you bring xrays or other radiographic studies wit

Left		Right
O	none	O
O	xrays	O
O	MRI	O
O	CT scan	O
O	bone scan	O

Date **Location where taken**

_____

_____

_____

_____