

CHIEF COMPLAINT/HISTORY OF PRESENT ILLNESS FORM

Patient Name: _____ Date: _____

What specific issue brings you to our office today? Foot Pain Ankle Pain Ulcer(s) Soft Tissue Mass

Other: _____

Pain/Problem Location - Please indicate the affected area(s) on the diagrams below:

Left Foot:		Right Foot:	
Top	Bottom	Top	Bottom
			
Inside	Outside	Inside	Outside

Details of the Problem

How long ago did this issue begin? _____

(Days / Weeks / Months / Years)

Was this caused by an injury? No Yes — Describe: _____

• Date of Injury: _____ If yes, was it a work-related injury? Yes No

How did the issue develop? Started suddenly. Gradually worsened over time

How would you describe your pain? No pain Sharp Dull Aching Burning Radiating

Itching Stabbing Other: _____

Since the problem began, has it: Stayed the same Gotten worse Improved

Rate your pain on a scale from 0 to 10 (circle):

(0 = No Pain, 10 = Worst Pain Possible)

0 1 2 3 4 5 6 7 8 9 10

Triggers and Relief

What makes your symptoms worse? Walking Standing Daily activities Flat shoes High heels

Closed-toe shoes Running Resting Other: _____

What makes your symptoms better? _____

Treatment History

What treatments have you tried for this issue? _____

Were you evaluated at a hospital? No Yes — Describe: _____

Impact on Lifestyle

How has this issue affected your daily life or work? _____

Referring Doctor: _____ Specialty: _____

PAST MEDICAL HISTORY (PMHx)

SNOMED Code	Condition	Select
7973008	Abnormal vision	<input type="checkbox"/>
3723001	Arthritis	<input type="checkbox"/>
274135002	Arthritis/arthrosis	<input type="checkbox"/>
129839007	At increased risk for falls	<input type="checkbox"/>
49436004	Atrial fibrillation	<input type="checkbox"/>
254701007	Basal cell carcinoma of skin	<input type="checkbox"/>
105597003	Blindness AND/OR vision impairment level	<input type="checkbox"/>
64779008	Blood coagulation disorder	<input type="checkbox"/>
128045006	Cellulitis	<input type="checkbox"/>
370079006	Choriocarcinoma, metastatic	<input type="checkbox"/>
709044004	Chronic kidney disease	<input type="checkbox"/>
13645005	Chronic obstructive lung disease	<input type="checkbox"/>
191280003	Clotting and bleeding disorders	<input type="checkbox"/>
42343007	Congestive heart failure	<input type="checkbox"/>
128053003	Deep venous thrombosis	<input type="checkbox"/>
229844004	Deformity of foot	<input type="checkbox"/>
789507005	Delayed healing of wound	<input type="checkbox"/>
35489007	Depressive disorder	<input type="checkbox"/>
14560005	Dermal mycosis	<input type="checkbox"/>
73211009	Diabetes mellitus	<input type="checkbox"/>

SNOMED Code	Condition	Select
371087003	Diabetic foot ulcer	<input type="checkbox"/>
424736006	Diabetic peripheral neuropathy	<input type="checkbox"/>
1231460007	Dialysis	<input type="checkbox"/>
371915000	Diffuse disease of coronary artery	<input type="checkbox"/>
46177005	End-stage renal disease	<input type="checkbox"/>
243125009	Estrogen hormone therapy	<input type="checkbox"/>
397825006	Gastric ulcer	<input type="checkbox"/>
235595009	Gastroesophageal reflux disease	<input type="checkbox"/>
90560007	Gout	<input type="checkbox"/>
161466001	H/O: alcoholism	<input type="checkbox"/>
161470009	H/O: anxiety state	<input type="checkbox"/>
161527007	H/O: asthma	<input type="checkbox"/>
161692001	H/O: cardiac pacemaker in situ	<input type="checkbox"/>
161653008	H/O: chemotherapy	<input type="checkbox"/>
161469008	H/O: depression	<input type="checkbox"/>
161561009	H/O: eczema	<input type="checkbox"/>
275548000	H/O: gastric ulcer	<input type="checkbox"/>
161451004	H/O: gout	<input type="checkbox"/>
161501007	H/O: hypertension	<input type="checkbox"/>
161586000	H/O: injury	<input type="checkbox"/>
271396005	H/O: limb amputation	<input type="checkbox"/>
161535005	H/O: liver disease	<input type="checkbox"/>
266987004	H/O: malignant neoplasm	<input type="checkbox"/>
161453001	H/O: obesity	<input type="checkbox"/>

SNOMED Code	Condition	Select
161562002	H/O: psoriasis	<input type="checkbox"/>
161567008	H/O: rheumatoid arthritis	<input type="checkbox"/>
161663000	H/O: tissue/organ recipient	<input type="checkbox"/>
15188001	Hearing loss	<input type="checkbox"/>
429367008	History of arterial bypass of lower limb artery	<input type="checkbox"/>
608848006	History of bariatric surgical procedure	<input type="checkbox"/>
10995761000119100	History of diabetic foot ulcer	<input type="checkbox"/>
399211009	History of myocardial infarction	<input type="checkbox"/>
620931000124102	History of patient immunocompromised	<input type="checkbox"/>
428375006	History of placement of stent for coronary artery disease	<input type="checkbox"/>
1237121007	History of venous ulcer of lower limb	<input type="checkbox"/>
278977008	HIV status	<input type="checkbox"/>
702172008	Home CPAP unit	<input type="checkbox"/>
426990007	Home oxygen therapy	<input type="checkbox"/>
170960008	HRT: combined estrogen/progestogen	<input type="checkbox"/>
86406008	Human immunodeficiency virus infection	<input type="checkbox"/>
13644009	Hypercholesterolemia	<input type="checkbox"/>
4093008	Hypothyroidism	<input type="checkbox"/>
34486009	Hyperthyroidism	<input type="checkbox"/>
38341003	Hypertensive disorder	<input type="checkbox"/>
239862000	Idiopathic osteoarthritis	<input type="checkbox"/>
22722001	Idiopathic peripheral neuropathy	<input type="checkbox"/>
372823004	Immunosuppressant	<input type="checkbox"/>
16055311000119100	Inhaled steroid-dependent asthma	<input type="checkbox"/>

SNOMED Code	Condition	Select
63491006	Intermittent claudication	<input type="checkbox"/>
197476001	Intestinal malabsorption	<input type="checkbox"/>
422504002	Ischemic stroke	<input type="checkbox"/>
93143009	Leukemia	<input type="checkbox"/>
233961000	Lower limb ischemia	<input type="checkbox"/>
128196005	Lumbar radiculopathy	<input type="checkbox"/>
234097001	Lymphedema	<input type="checkbox"/>
367391008	Malaise	<input type="checkbox"/>
118600007	Malignant lymphoma	<input type="checkbox"/>
363406005	Malignant tumor of colon	<input type="checkbox"/>
266096002	Methicillin resistant Staphylococcus aureus infection	<input type="checkbox"/>
386805003	Mild neurocognitive disorder	<input type="checkbox"/>
110352000	Minimal cognitive impairment	<input type="checkbox"/>
718636001	Minimal depression	<input type="checkbox"/>
702955000	Moderate cognitive impairment	<input type="checkbox"/>
22298006	Myocardial infarction	<input type="checkbox"/>
414941008	Onychomycosis	<input type="checkbox"/>
16584951000119100	Oral steroid-dependent asthma	<input type="checkbox"/>
28769004	Osteomyelitis of ankle AND/OR foot	<input type="checkbox"/>
64859006	Osteoporosis	<input type="checkbox"/>
370388006	Patient immunocompromised	<input type="checkbox"/>
840580004	Peripheral arterial disease	<input type="checkbox"/>
20696009	Peripheral venous insufficiency	<input type="checkbox"/>
705402006	Personal mobility assistive device	<input type="checkbox"/>

SNOMED Code	Condition	Select
31097004	Post poliomyelitis syndrome	<input type="checkbox"/>
262502001	Post-chemotherapy	<input type="checkbox"/>
700504007	Post-chemotherapy monitoring	<input type="checkbox"/>
77386006	Pregnancy	<input type="checkbox"/>
59282003	Pulmonary embolism	<input type="checkbox"/>
69896004	Rheumatoid arthritis	<input type="checkbox"/>
287006005	Rheumatoid arthritis of multiple joints	<input type="checkbox"/>
443524000	Secondary osteoarthritis	<input type="checkbox"/>
95662005	Sensory neuropathy	<input type="checkbox"/>
73867007	Severe major depression with psychotic features	<input type="checkbox"/>
108333003	Smoking AND/OR drinking habits	<input type="checkbox"/>
254656002	Squamous cell carcinoma in situ of skin	<input type="checkbox"/>
449615005	Swelling of lower leg	<input type="checkbox"/>
304120007	Total hip replacement prosthesis	<input type="checkbox"/>
609588000	Total knee replacement	<input type="checkbox"/>
95345008	Ulcer of foot	<input type="checkbox"/>
72866009	Varicose veins of lower extremity	<input type="checkbox"/>
399871005	Visually threatening diabetic retinopathy	<input type="checkbox"/>
(417662000 & 260413007)	None	<input type="checkbox"/>
417662000	Other: _____	<input type="checkbox"/>

SURGERIES, ETC

Surgeries/Hospitalizations/Injuries	Date	Complications

Have you ever had general anesthesia? No Yes

Have any problems with anesthesia? No Yes — Description: _____

MEDICATIONS

(Include non-prescription, such as aspirin, herbal medications, vitamins)

Medication	Dose	Reason for Medication	Side Effects

(If you are taking more medications, circle Yes and ask for an additional sheet of paper)

ALLERGIES

Medication	Describe Reaction

Are you allergic to shellfish or iodine? No Yes

Are all your immunizations up to date? No Yes If no, which immunizations are due? _____

Family History

Member	Alive/Deceased	Age	Health Status or cause of death
Father	A D		
Mother	A D		
Sister/Brother	A D		

Are there any family members with similar problems to yours?

If yes, please describe: _____

SOCIAL HISTORY

(Please select the response that best applies to you.)

Smoking Status

- **Do you currently smoke?** No Yes — How much? _____ packs per day for _____ years
- **Have you quit smoking?** This year More than 1 year ago More than 5 years ago More than 10 years ago
If you previously smoked: _____ packs per day for _____ years

Alcohol Use

- **Do you drink alcohol?** No Yes — How much? _____ drinks per day _____ drinks per week

Substance Use History

- **Do you have a history of substance use or abuse?** No Yes — Please specify: _____





FINANCIAL AGREEMENT FORM

We are committed to providing high-quality care to all our patients. To ensure smooth processing of payments for services rendered, we ask that you carefully review and sign this Financial Agreement Form.

Patient Financial Responsibility

As a patient at STRIDE FORWARD MEDICAL GROUP, you are financially responsible for all charges incurred during your treatment. This includes co-pays, deductibles, coinsurance, and any non-covered services. Payment is due at the time of service. If your insurance plan does not cover certain services, you are responsible for paying the balance.

Insurance and Billing

We will verify your insurance information and submit claims on your behalf. However, if your insurance denies a claim or if there is any remaining balance after insurance payment, you are responsible for payment. It is your responsibility to provide accurate and up-to-date insurance information at each visit and notify us of any changes.

Payment at Time of Service

All co-pays and out-of-pocket expenses are due at the time of your visit. If you do not have insurance, full payment is required at the time of service. Payment plans are available by request and must be agreed upon before services are rendered.

Missed Appointments/No-Show Policy

Failure to cancel an appointment with at least 24 hours' notice will result in a no-show fee. This fee must be paid before rescheduling any future appointments.

Collection of Unpaid Balances

If your account becomes past due, STRIDE FORWARD MEDICAL GROUP may refer your account to a collection agency, and you will be responsible for any additional costs, including collection fees or attorney fees.

Authorization for Insurance Benefits

By signing below, I authorize STRIDE FORWARD MEDICAL GROUP to submit claims to my insurance company for services provided. I assign my medical benefits to STRIDE FORWARD MEDICAL GROUP and authorize the release of any necessary medical information to process my claims.

Acknowledgment and Agreement

I understand that I am financially responsible for all charges incurred during my treatment and that payment is due at the time of service. I agree to provide accurate insurance information and understand that I will be responsible for any balances not covered by insurance. I authorize STRIDE FORWARD MEDICAL GROUP to release information necessary to process insurance claims.

Patient Signature: _____

Patient Name: _____ **Date:** _____

For Minors or Legal Guardians (if applicable):

Guardian Name: _____

Guardian Relationship to Patient: _____

Guardian Signature: _____ **Date:** _____

NO-SHOW AND LATE CANCELLATION POLICY

At **STRIDE FORWARD MEDICAL GROUP**, we strive to provide the highest quality care to all our patients. To ensure that we can accommodate everyone effectively, we have established the following policy for missed appointments and late cancellations:

1. Definition of a No-Show or Late Cancellation

- A **no-show** occurs when a patient misses an appointment without prior notice.
- A **late cancellation** is when a patient cancels or reschedules their appointment less than **24 hours** before the scheduled time.

2. Importance of Keeping Appointments

When a patient misses an appointment, it prevents us from offering that time slot to another patient in need of care. Your cooperation helps us maintain efficient scheduling and provide the best service for everyone.

3. No-Show/Late Cancellation Fees

- Patients who miss an appointment or cancel with less than 24 hours' notice may be charged a **\$85 fee**.
- This fee is not covered by insurance and must be paid before scheduling a new appointment.

4. Exceptions

We understand that emergencies and unforeseen circumstances happen. If you miss an appointment due to an emergency, please contact our office as soon as possible, and we may waive the fee at our discretion.

5. Repeat No-Show Policy

- **First No-Show:** A courtesy call will be made to remind you of our policy.
- **Second No-Show:** The fee will be applied to your account, and future appointments will require confirmation.
- **Third No-Show:** You may be required to prepay for appointments or be placed on a same-day appointment basis.

6. Reminders

To help you keep your appointments, we offer:

- Appointment reminder calls, emails, or text messages.
- The option to confirm or reschedule appointments through our online patient portal or by phone.

7. How to Cancel or Reschedule

If you need to cancel or reschedule your appointment, please contact our office at **561-401-0422** at least 24 hours in advance. This allows us to offer your time slot to another patient.

Acknowledgment and Agreement

By signing below, you acknowledge that you have read and understand our No-Show and Late Cancellation Policy:

Patient Signature: _____

Patient Name: _____ **Date:** _____

AUTHORIZATION/CONSENT FORM

A. Authorization to Release Information / Assignment of Medicare Benefits

I authorize any holder of medical or other information about me to release to the Social Security Administration, its intermediaries, or carriers any information needed for this or related Medicare claim(s).

- I permit a copy of this authorization to be used in place of the original.
- I request payment of medical insurance benefits to either myself or **STRIDE FORWARD MEDICAL GROUP**.
- I certify the information provided in applying for payment under Title XVIII of the Social Security Act is correct.

This is a lifetime authorization.

Initial here: _____

B. Assignment of Insurance Benefits / Release of Information

I authorize **STRIDE FORWARD MEDICAL GROUP** to:

- Release necessary information, including diagnosis and records of my treatment, to my insurance company or its representatives.
- Direct my insurance company to pay **STRIDE FORWARD MEDICAL GROUP** for services rendered.

Initial here: _____

C. Financial Responsibility

- I understand that I am financially responsible for any charges not covered by my insurance.
- I agree to pay all copayments and coinsurance at the time of service.

Initial here: _____

D. Referrals and Authorizations

- I understand it is my responsibility to obtain all necessary referrals or authorizations for treatment.
- Visits may be rescheduled if proper authorization is not secured beforehand.

Initial here: _____

E. Consent to Treat

I authorize **STRIDE FORWARD MEDICAL GROUP** to:

- Perform diagnostic tests, including x-rays or other aids, to ensure a thorough diagnosis.
- Proceed with recommended treatments, medications, and therapies as mutually agreed upon.

I understand:

- There are risks associated with anesthetic agents.
- I am fully responsible for payment of medical services rendered, unless prior arrangements are made.

I agree to notify the office of any changes to the information provided.

Initial here: _____

F. Medical Release

- A photocopy of this form is sufficient to authorize any person holding medical records to release true copies to **STRIDE FORWARD MEDICAL GROUP** or insurance providers as needed.

Initial here: _____

G. Treatment of Minors

As the parent/legal guardian of a minor receiving treatment, I:

- Acknowledge I have been advised to remain on the premises during treatment.
- Waive any claim resulting from failure to remain on-site.

Initial here: _____

H. Liability Waiver

I release **STRIDE FORWARD MEDICAL GROUP**, its employees, and affiliates from any claims arising from:

- Loss or damage to personal valuables.
- Refusal of emergency services, including ambulance or physician care.

Initial here: _____

I. Insurance

- I agree to provide necessary insurance information at each visit.
- I understand my insurance policy is an agreement between myself and the insurance company, while my physician's bill is an agreement between myself and **STRIDE FORWARD MEDICAL GROUP**.
- If my insurance company does not cover services, I am responsible for full payment.
- Patients without health insurance are required to pay in full at the time of service.

Initial here: _____

J. Notice of Privacy Practices

I acknowledge receipt of the Notice of Privacy Practices. Also found on our website www.strideforwardpodiatry.com

Initial here: _____

K. Video Surveillance Authorization

At **STRIDE FORWARD MEDICAL GROUP**, we utilize video surveillance in public and shared areas of our facility to enhance security, monitor operations, and ensure patient and employee safety. Please read the following carefully:

1. Use of Video Surveillance
 - Video cameras are installed in public areas, such as hallways, waiting rooms, and physical therapy or treatment areas.
 - No cameras are installed in private spaces, such as restrooms or individual patient examination rooms.
2. No Audio Recording
 - No audio recording is conducted as part of the video surveillance. This ensures compliance with Florida law, which requires two-party consent for audio recording.

3. Patient Notification

- By signing this form, patients and their representatives acknowledge and consent to the use of video surveillance in shared areas of the facility.
- Patients have the right to ask questions or request additional information about our surveillance policies.

4. HIPAA Compliance

- While it is unlikely, some video footage may inadvertently capture protected health information (PHI). **STRIDE FORWARD MEDICAL GROUP** complies with all HIPAA regulations, including implementing strict safeguards to protect video recordings.
- Access to video recordings is limited to authorized personnel. Any playback of footage is conducted in secure environments to prevent unauthorized viewing.
- Routine audits are conducted to ensure compliance with policies and safeguard patient privacy.

Acknowledgment and Consent

By initialing below, you consent to the use of video surveillance at **STRIDE FORWARD MEDICAL GROUP** as described above and acknowledge that no audio recording is conducted:

Initial here: _____

L. Consent for Use of Photography and Recording

I, the undersigned, hereby authorize **STRIDE FORWARD MEDICAL GROUP** and its representatives to take photographs, videos, or other recordings of my image, voice, or medical condition for the purposes outlined below:

- Medical Documentation: To document and monitor my condition and progress during treatment.
- Education and Training: For use in educating healthcare professionals, staff, or students about medical conditions and procedures.
- Marketing and Website: For promotional purposes, including patient education materials, website content, and social media, while maintaining confidentiality of my identity unless further consent is provided.
- Clinical Research: For research purposes, ensuring patient confidentiality is upheld.

I understand that I may withdraw my consent at any time by notifying **STRIDE FORWARD MEDICAL GROUP** in writing, and that such withdrawal will apply to future uses of the materials. However, I acknowledge that this will not affect recordings already made and used before the withdrawal of consent.

Initial here: _____

Decline: _____

Patient Certification

I certify that the information provided in this document is accurate.

Signature (Patient/Guarantor/Legal Guardian): _____

Printed Name: _____ Date: _____