Foot & Ankle Questionnaire

Name: _____ Age: _____ DOB: _____

If you have seen Dr. Newnam recently in the hospital for this same problem, please note here:

_____

(You do not need to complete the rest of the **Problem Today** section.)

What is the Problem Today?

_____

_____

Date Problem first started: _____

Is this a result of an injury? If yes, please describe _____

What makes the problem worse: _____

Treatment History:

Have you: a) Tried non-steroidal anti-inflammatories (Aleve, Ibuprofen, Diclofenac, etc)? YES / NO

If yes, which one, at what dose, and for how long? _____

b) Seen any other providers for this problem? YES / NO

If yes, when and what was the result? _____

c) Had any other treatment: _____

Review of Systems (Are you experiencing any of these symptoms?)

Fever / Chills / Fatigue / Sweats / Loss of appetite

Rash / Itching / Wounds

Loss of hearing / Ringing in ears / Sinus pain / Blurred vision / Eye pain / Loss of vision

Leg swelling / Cramping in calf at night / Cramping in calf while walking / Chest Pain

Shortness of breath / Cough / Wheezing

Nausea / Vomiting / Diarrhea / Constipation / Abdominal pain / Heartburn

Frequency of urination / Urgency to urinate / Dysuria

Foot/Ankle pain / Joint pain / Muscle ache / Back pain / Weakness / Falls /Neck pain

Easy bruising / Environmental allergies

Loss of sensation in toes or feet / Tingling/"pins&needles" sensation / Seizures / Dizziness
Headaches

Depression / Suicidal ideas / Substance abuse / Nervous /Anxious

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CONSENT FOR TREATMENT, FINANCIAL RESPONSIBILITY AND HEALTHCARE OPERATIONS: For the purposes of this consent, includes all hospitals, physician offices and other facilities providing healthcare services which are part of UMMS.

*Hereafter referred to as "PRACTICE"

REQUEST, AUTHORIZATION AND CONSENT FOR TREATMENT: I voluntarily request, authorize, and consent to care including medical and/or surgical treatment and diagnostic, radiology, and laboratory examinations and procedures by physicians, residents, nurses and other technical staff of PRACTICE. I understand and agree that healthcare professionals in training, which may include but are not limited to residents, fellows, medical/nursing/dental students may assist or participate in providing hospital and/or medical care to me. I understand that these professionals in training work under the direction or supervision of my physician or other healthcare professional and may perform or observe some of the health services I receive and specifically consent to.

I understand that the extent and severity of my injury or illness is not known at this time. I further understand and agree that the practice of medicine is not an exact science and that no guarantees have been made as to the results of either physician practice care and medical and/or surgical treatment or examinations. If applicable, I give PRACTICE permission to appropriately dispose of any specimens/tissue (such as blood samples, PAP smears, skin tags, etc.) taken from my body. Once disposed of, these specimens/tissues cannot be retrieved. I hereby authorize PRACTICE to retain, preserve and use for scientific or teaching purposes or dispose of at their convenience, any specimens or tissues taken from my body during any hospital/clinic procedure(s).

INDEPENDENT CONTRACTORS: I understand that some healthcare providers providing services to me may not be employees of PRACTICE. Some healthcare providers providing services to me may be independent contractors who have been granted the privilege of using the practice facilities to provide services for and on behalf of PRACTICE. I understand that if the employment status of a healthcare provider is important to me in making treatment and other healthcare decisions, I may inquire as to the employment status of the healthcare provider caring for me.

INSURANCE CERTIFICATION AND ASSIGNMENT: I hereby certify that the information given by me in applying for payment under titles XVIII and XIX of the Social Security Act and/or by any other third party payers is correct. I assign to PRACTICE all benefits for care due to me under the terms of said policies and programs but not to exceed the regular charges for similar services. I assign payment to the physician(s) rendering medical services and I assign payment for the unpaid charges of the physician(s) for whom the practice is authorized to bill in connection with its services. I understand that I am responsible for payment of any health insurance deductibles, coinsurance, or any other expenses incurred which are not paid by any insurers or other third party payers.

MEDICARE AUTHORIZATION: I request payment of authorized Medicare benefits be made on my behalf for any service furnished me by PRACTICE, including physician services. I authorize any holder of medical and other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

PHOTOGRAPHY and/or Video Record: The persons caring for you may need to photograph and/or record you to document a medical condition, help with the diagnosis and/or treatment of a condition, and/or to help plan the details of surgery. Photographs and/or recordings taken for these clinical reasons do not require your written permission.1

PRIVACY OF INFORMATION: (Please check √ one)

____I **ACKNOWLEDGE** receipt of a copy of the Notice of Privacy Practices which explains how PRACTICE may use and disclose protected health information; or

____I **REFUSE** receipt of a copy of the Notice of Privacy Practices which explains how PRACTICE may use and disclose protected health information.

USE AND DISCLOSURE OF SUBSTANCE USE DISORDER PATIENT RECORDS: If I receive treatment for a substance use disorder at a program within PRACTICE, I consent to the program disclosing these records to others within PRACTICE and to other affiliates of University of Maryland Medical System that treat me for purposes of my treatment, quality improvement and other healthcare operations and care coordination. This consent will expire one year after I am no longer a patient of PRACTICE or other affiliates of University of Maryland. I may revoke this consent at any time except to the extent that the program, PRACTICE, or other University of Maryland Medical System affiliates have already acted in reliance on my consent.

GUARANTEE OF ACCOUNT: I acknowledge responsibility for this account and assume and guarantee payment of all hospital and physician charges, including copayments and deductibles and non-covered charges rendered to me during this visit. Should this account be referred to an attorney for collection, I agree to pay attorney fees, collection expenses, and interest at the highest rate authorized by law. I understand that I may be billed separately for services provided to me or on my behalf during this period of treatment by independent professional groups or hospital based physician services (radiology, pathology etc.).

WIRELESS COMMUNICATION: I expressly consent and authorize PRACTICE and its agents to:

a. Contact me at any telephone number, including wireless numbers, email addresses, or unique electronic identifiers or modes that I provided to PRACTICE at any time associated with me or my account;
b. Communicate with me using any current or future means of communication, including but not limited to, automated telephone dialing systems, artificial or pre-recorded messages, SMS text messages, or other forms of electronic messages; for any reason related to the services received at PRACTICE or services received at PRACTICE in the future, including operations and quality matters, such as patient satisfaction surveys, and collection of amounts owed on my account; and
c. Leave answering machine and voicemail messages, in compliance with applicable laws, for any reason related to the services provided by PRACTICE or services to be provided by PRACTICE in the future, including operations and quality matters, such as patient satisfaction surveys, and collection of amounts owed on my account.

I further promise to immediately notify PRACTICE if any telephone number, email address or other unique electronic identifiers or modes that I provided to PRACTICE change or are no longer used by me.

COVID-19: This practice is one of the places where patients have come to receive COVID-19 care. I understand that patient care and treatment decisions may be impacted as resources become affected due to our response to COVID-19. I understand that in an effort to limit unnecessary contact, providers may be augmenting their care with the use of telemedicine and other communication methods that the provider deems appropriate. I am aware that as with the use of any technology, the risk of equipment or security failures can exist despite best efforts. I further understand that although proper interventions are in place to minimize the risk of COVID-19 transmission, the ability to completely remove the risk is not possible. I understand this risk and consent to be treated at this facility.

I CERTIFY THAT I HAVE READ THIS CONSENT AND AM THE PATIENT OR THE PARENT OR GUARDIAN OF THE PATIENT OR AM DULY AUTHORIZED AS PATIENT'S AGENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS. BY SIGNING BELOW, I REPRESENT THAT THE INFORMATION GIVEN BY ME IS ACCURATE TO THE BEST OF MY KNOWLEDGE.

_____ PATIENT OR RESPONSIBLE PARTY NAME

_____ RELATIONSHIP TO PATIENT

_____ _____
PRINT NAME WITNESS (SIGNATURE)

_____ _____
DATE TIME

REASON IF UNABLE TO SIGN:
_____ PHYSICAL CONDITION _____ MENTAL CONDITION

TO BE USED FOR VERBAL CONSENT:
ON _____ AT _____ O'CLOCK,
DATE TIME

_____
PRINT NAME OF PERSON GIVING CONSENT
THE TERMS OF THIS CONSENT WERE REVIEWED WITH THE PATIENT, PARENT OR GUARDIAN OF THE PATIENT OR THE DULY AUTHORIZED AGENT OF THE PATIENT VERBALLY AND SUCH INDIVIDUAL PROVIDED VERBAL CONSENT TO THE TERMS SET FORTH HEREIN.

_____ _____
PRINT WITNESS NAME WITNESS SIGNATURE

PRACTICE complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PRACTICE does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

PRACTICE provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you believe that PRACTICE has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Corporate Compliance and Business Ethics Group, 900 Elkridge Landing Road, First Floor, Linthicum, MD 21090, 410-328-4141, compliance@umm.edu. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Compliance Director is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-868-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

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Authorization to Disclose Health Information
(Excluding Medical Records/PHI)

Patient Name: _____ Date of Birth: _____ Date: _____

Authorization to Disclose Health Information

I, _____, grant permission for the following person(s) to obtain information regarding medical care, and speak with the provider, and/or staff regarding the patient listed above.

Name	Relationship

_____ _____
Patient or Responsible Party Signature Date

_____ _____
Patient / Responsible Party Name Relationship to Patient

OFFICE USE ONLY	UNIVERSITY OF MARYLAND BALTIMORE WASHINGTON ORTHOPAEDICS	Policy Number: [ ] New [X] Revised July 2019 [X] Reviewed July 2019	
	Subject: Prescribing of Pain Medication Policy Dr. Lauren Newnam		
	Originator: Manager of Out Patient Surgical Practices	Effective Date	May 2013
		Next Review Date	July 2020
COO: _____	Date:	Page	1
		Supersedes	

Purpose:

Establish a policy for prescribing of all pain medications in the office.

Responsibility:

It is the responsibility of all staff of the UMCMG BW General Orthopaedics Department at BWMC to adhere to this policy.

Procedure:

A. Surgical Patients:

1. All post-operative pain medications will be prescribed for up to **four weeks** following the patient's surgery.
2. After 4 weeks, all patients in need of additional medications will be referred to a Pain Management specialist to control the pain and prescribe any future medications.
3. If you have a known history of requiring prolonged pain management, please schedule an appointment with your Pain Management provider as soon as you have your surgery date. Make this appointment for sooner than 4 weeks after the date of your surgery.
4. Within the four weeks, please allow 48 hours for all medication refills. **Refill requests made after 12pm on Fridays will not be filled until the following Monday.**

_____

Signature Date

_____

Printed Name