Affiliated Foot & Ankle, P.C
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Duluth phone: 770-232-9778; Fax: 770-232-9776

Current 2019 Medicare Guidelines require that we gather a certain amount of your medical information as a part of Quality Improvement Measures. Please answer the following questions to the best of your ability.

Name: ________________________ **Date:** ____________ **DOB:** ____________

Date you were last seen by your primary medical doctor: ________________

Name of your Primary Care Doctor: ____________________________

1. Do you smoke or use tobacco products? Yes No
2. Did you have a flu (influenza) vaccine this calendar year? Yes No
3. Have you EVER in your lifetime had a Pneumococcal (Pneumonia) vaccine? Yes No
4. Do you have a Surrogate decision maker or an Advance Care Plan (i.e. name of person who may make decisions for you if you are not able) Yes No

   a. If so, please provide us with the name of that person ________________

   b. Or do you not wish or are you not able to name a surrogate decision maker or provide an advance care plan? Yes No
5. Do you have pain in your foot, ankle, or leg today? If so, how would you rank your pain from 0 to 10 in intensity with 0 being no pain and 10 being excruciating or maximal pain? __________
6. If you have DIABETES, what was your last Hemoglobin A1c number? __________
7. What is your Height?__________ And Weight? ________
8. ____ I have had no falls or one fall without injury in the past year

____ I have had 2 falls or 1 fall with Injury in the past year

____ I am wheelchair bound, Immobile or bedridden

____ I am ambulatory (I can walk). ____ I have had a fall risk assessment

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Office Use Only: Balance / Gait assessment: observe transfer and walking & Vision home fall hazards are discussed

When patient BMI is abnormal F/U plan has been discussed with the patient including: Refer to PCP, Nutrition counseling, exercise plan. BMI parameters exclude if pt refuses or pregnant.

***What is an Advance Care Plan?: These include your wishes for a decision maker or specific instructions if you are not capable of making the decision yourself, specific advance care plans include DNRs, Living Wills, or Durable power of attorney. You can also just name a person or tell the doctor you do not wish to discuss or name someone.**

Patient's BMI__________ (Normal: 18+ <18.5 and <25)

BP Sitting __________ BP Standing ______________

2019 Medicare and Medicare Replacement Policy

Please check one

________I do **not** have any Medicare changes for the 2019 calendar year. If you are NOT sure, please show your insurance cards to the front desk.

Or

________I have **changed** my Medicare policy to a new Medicare Replacement plan. I have given the front desk all billing information.

Please initial

________I am aware of the 2019 calendar year deductible and am aware that I may owe **Affiliated Foot and Ankle** if Medicare takes that amount out of my office visit. If I have a secondary insurance, **Affiliated Foot and Ankle** will bill my secondary. If my secondary plan does **not** cover the deductible, I will be billed for that amount.

*Please note that we are **not** in network with some Aetna Medicare HMO plans. If you do not have in- and out-of-network benefits, you will be responsible for all charges.

Patient Signature

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Date

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