PATIENT INFORMATION SHEET

How did you hear about Foot & Ankle Associates? ☐ Billboard ☐ Internet ☐ Yellow Pages ☐ Insurance ☐ Family/Friend ☐ Primary Care Doctor ☐ Other: _____

If you were referred by your Primary Care Doctor or a Family/Friend, please provide their name so that we may properly thank them.

Family/Friend: _____ Primary Care Doctor: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Gender: _____

Address: _____ City/ State/ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____Ext: _____ Marital Status: _____

Email Address: _____ Social Security Number: _____-_____-_____

Employer: _____

Employer Address: _____ City/ State/ Zip: _____

Emergency Contact: _____ Phone Number: _____

Relationship: _____

PERSON RESPONSIBLE FOR THE BILL, IF OTHER THAN ABOVE PATIENT

Name: _____ Relationship: _____

Address: _____ City/ State/ Zip: _____

Phone: _____

☐ **I WOULD PREFER NOT TO DISCLOSE THE FOLLOWING INFORMATION**

U.S. GOVERNMENT REPORTING

Language: ☐English ☐Chinese ☐French ☐Spanish ☐Japanese ☐Portuguese ☐German ☐Other _____

Race: ☐ American Indian ☐Asian ☐African American ☐Native Hawaiian ☐Caucasian ☐Other _____

Ethnicity: ☐Hispanic ☐Not Hispanic ☐Other _____

MEDICAL HISTORY

Name of Primary Care Physician: _____ Last Seen (Month/Year) _____

Preferred Pharmacy: _____ City: _____ Phone Number: _____

Describe the reason for your visit today: _____

Have you ever been diagnosed and/or treated for any of the following? Please check below:

- ☐ Diabetes (Do you take Insulin? Y/N)
- ☐ Heart Problems
- ☐ Circulation Trouble
- ☐ Cancer/ Tumors (Specify_____)
- ☐ Gout
- ☐ Mental Disease
- ☐ Stroke
- ☐ High Blood Pressure
- ☐ Nerve Problems
- ☐ Kidney/Bladder Disease
- ☐ Arthritis
- ☐ Thyroid Disease
- ☐ Breathing Problems
- ☐ Asthma
- ☐ Anemia
- ☐ HIV (+)
- ☐ Back Pain/Injury
- ☐ Bleeding Tendencies
- ☐ Seizures
- ☐ Stomach Problems
- ☐ High Cholesterol
- ☐ Blood Clots
- ☐ Liver Problems (Specify_____)

List any medications you take:	Dosage/ Frequency:	What is it for?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any allergies? Please list:

_____

Have you had any surgeries?

Year	Type of Surgery
_____	_____
_____	_____
_____	_____

SOCIAL HISTORY

Use of Tobacco: ☐ Never ☐ Sometimes ☐ Everyday ☐ Former ☐ Unknown

Alcohol Use: ☐ Never ☐ Sometimes ☐ Everyday ☐ Former ☐ Unknown

If yes, how often? Drinks per day: _____ Drinks per week: _____

Drug Use: ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Are you Claustrophobic? ☐ Yes ☐ No

Is there any metal in your body? ☐ Yes ☐ No

Any chance of metal fragments in your eyes? ☐ Yes ☐ No

Height: _____ft. _____inches **Weight: _____lbs.** **Shoe Size: _____**

CONSENT/HIPAA

CONSENT TO EXAMINATION AND TREATMENT, INSURANCE ASSIGNMENT, AND E-PRESCRIBE

I hereby consent to examination and treatment as deemed necessary by Foot & Ankle Associates (FAA) and its physicians. I herby authorize FAA and its physicians to furnish patient health information concerning my relevant medical history to any of the following: other healthcare providers involved in my care, insurance carriers, attorneys, and adjustors. I herby authorize FAA to access and download my electronic prescription drug history. I herby assign to the FAA and its physicians all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

AUTHORIZATION FOR MEDICARE BILLING

I herby certify that the information given to me in applying for payment under Title XVII and XIX of the Social Security Act is correct. I herby authorize any holder of medical or other information about me to be released to the Social Security Administration or its agents; Centers for Medicare and Medicaid Services (CMS), or its intermediaries or carriers of any information needed related to a Medicare claim. I herby request that payment of authorization benefits be made on my behalf and herby assign the benefits payable for physician services to the physician if he/she chooses to accept assignment. Medicare requires notification via an Acknowledgement of Benefit Notification (ABN) for non- covered services, including Durable Medical Equipment (DME).

SPECIMEN/ LABORATORY INSURANCE CONSENT

I authorize and give Foot & Ankle Associates (FAA) my consent to submit specimens (culture, skin tissue, etc.) to the laboratory of choice for analyses and study. This authorization includes submission for payment to my insurance company, including Medicare and Medicaid, and/or me for charges incurred and agreed to full responsibility and payment of any non-covered medical services.

PATIENT DISCLOSURE: HIPAA

Please indicate any additional parties you authorize Foot & Ankle Associates (FAA) to speak with regarding your care, medical information, and account. This authorization may be revoked at any time in writing.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Can we leave a message regarding your health information on your voicemail? **YES** **NO**

PARENT/ GUARDIAN ACKNOWLEDGEMENT

I certify that I am the parent or legal guardian of _____, and adult, and as such am authorized to sign on his/her behalf.

RECEIPT OF NOTICE OF USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

I herby acknowledge that I have been given the opportunity to read and receive a copy of Foot & Ankle Associates' notice of Privacy Policy as required by the Health Information and Portability Accountability Act (HIPAA).

_____ _____

Patient/Guardian Signature **Date**

_____ _____

Guardian Name Printed **Relationship to Patient**

FINANCIAL POLICY

Thank you for choosing Foot & Ankle Associates as your provider. Our objective is to provide you with the highest quality care in the most cost-effective manner. Your understanding of our financial policies is an essential element of your care and treatment. If you have medical insurance coverage, we will file the insurance claims on your behalf as a courtesy to you. If you have any questions, please do not hesitate to speak with our billing office.

MEDICARE PATIENTS: As a participating provider of Medicare Plan B (Physician Services), Foot & Ankle Associates will only bill you for your Medicare coinsurance, deductible and any services rendered but not covered by Medicare. All other services will be billed directly to Medicare. **You will be required to pay the co-pay and deductibles for authorized services at the time of service.**

NOTE: You will be informed of services not covered by Medicare prior to these services being rendered. Your signature upon the appropriate Medicare Waiver form represents your authorization for the physician to perform these services and your acceptance of the financial responsibility for these services.

If you have Medicare Part A only, then the services you will receive from our practice will not be covered by Medicare.

COMMERCIAL INSURANCE PATIENTS: Remember that your insurance contract is between you and your insurer. If your insurance company pays only part of your bill or rejects your claim, you are financially responsible for the balance and are to pay it upon receipt of your statement. **You will be required to pay the co-pay and deductibles for authorized services at the time of service.**

HMO/MANAGED CARE INSURANCE PATIENTS: Many HMO/Managed Care plans require that you obtain a referral to receive care from a specialist**. It is your responsibility for obtaining this referral from your primary care physician if required by your insurance**. Unauthorized services will be the financial responsibility of the patient. **You will be required to pay the co-pay and any deductibles for authorized services at the time of service.**

Foot & Ankle Associates will attempt to verify benefits for some specialized services; however, you remain responsible for charges for all service rendered, deemed non covered, or denied for any reason. **You must inform the office of all insurance changes and authorization/referral requirements prior to being seen. In the event, the office is not informed, you will be responsible for any charges denied by your insurance**.

PATIENT WITHOUT INSURANCE COVERAGE: Patients without insurance are required to pay for all services related to their visit in full at the time of service. Ingrown toenail procedures will require a $275 deposit prior to being seen. All other office visits will require a $175 deposit prior to being seen. Any other services provided such as x-rays, durable medical equipment, over the counter items, etc. will be payable upon checkout.

Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due to the office.

There will be a charge of $20 for any FMLA paperwork, Disability Forms or Employer Requests for Leave of Absence Forms to be completed. Please allow 5-7 business days for completion of paperwork.

CANCELLATION POLICY: ***If you cancel OR do not show for your appointment, you must give a 24-hour notice, or a $55 cancellation fee will be charged.***

We accept VISA, MasterCard, Cash or Check. Foot & Ankle Associates will charge a $25 fee for all returned checks.

_____ _____

Patient/Guardian Signature **Date**

_____ _____

Guardian Name Printed **Relationship to Patient**