## PATIENT INFORMATION

Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Primary phone:_____ Secondary:_____

Email:_____

## PATIENT INSURANCE INFORMATION

Primary Insurance Company Name:_____

Policy Holder Name:_____ DOB:_____

Relationship to Patient:_____

Secondary Insurance Company Name:_____

Policy Holder Name:_____ DOB:_____

Relationship to Patient:_____

## EMERGENCY CONTACT INFORMATION

Name:_____ Phone:_____

Relationship:_____

## EXPLANATION OF PAYMENT POLICY AND PRIVACY POLICY

I hereby authorize Foot and Ankle Associates to release information pertinent to the filling of insurance claims. I authorize my insurance carriers to pay benefits directly to Foot and Ankle Associates on any unpaid services filed on my behalf. I understand that I am responsible for paying Foot and Ankle Associates for charges for the above patient regardless of my insurance or negotiating settlements of claims.

I hereby give Foot and Ankle Associates permission to diagnose and administer treatment for my foot and ankle condition and authorize any release of information obtained during my treatment.

_____ _____

Patient/Legal Guardian Signature Date

**FINANCIAL POLICIES – PLEASE READ AND INITIAL EACH LINE**

_____ COPAYMENTS: Your insurance REQUIRES that we collect your designated copay at the time of service. Please be prepared to pay copay at each visit.

_____ SELF-PAY/UNINSURED: Self-pay accounts shall exist if a patient has no insurance coverage or no evidence of insurance coverage. For new patients, a payment of the estimated cash price is required on the day of your appointment before being seen by a healthcare provider. If you are unable to pay this amount, please contact the billing department prior to your appointment. A discount off regular fees is offered for payment made at the time of service.

_____ REFERRALS: If your insurance plan requires a referral from your primary care physician, it is your responsibility to obtain it prior to your appointment and to have it with you at the time of your appointment. If you do not have your referral, YOU MAY BE REQUIRED TO RESCHEDULE.

_____ RETURNED CHECK FEES: Any returned check from the bank for non-payment (insufficient funds) shall result in the patients account being assessed a $40.00 fee per check returned

_____OVER THE COUNTER PRODUCTS: Products may be provided to you in our office for your convenience. They must be paid for at the time they are dispensed or an additional service charge will be added. *We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, or your financial responsibility. The patient or responsible party is responsible for seeing that the entire bill is paid in full. Responsible parties will be responsible for any collection fees, interest and other expenses necessary to collect on any account, including court costs, should legal action be necessary to collect. You must bring your insurance card to each visit. Please notify us if your insurance carrier or policy has changed. Billing of insurance is a courtesy we provide for patients and is not required by law.

I am aware of my HIPAA Rights (you can request a copy of your privacy rights at the front desk)

Initial:_____ I would prefer to be reached by: Phone(_____)_____Alternative

Phone(_____)_____ May we leave a message with a family member?
Yes _____ No _____ Please list any family members that we can release information to:

Name_____Relation_____
Please list any physicians/ individuals that you want your medical records release to:
_____ _____
I give permission to the Foot and Ankle Associates to obtain copies of my medical records:This field is optional, sign if you want the Foot and Ankle Associates to obtain copies of your medical records from other physicians offices.

Signed:_____Date:_____

Name:_____Date:_____

Age:_____ Birth Date:_____Height_____Weight_____

Who Referred You? _____ Occupation:_____

Primary Reason For Visit:_____Which Foot? Left Right
What Are You Allergic To? ( i.e. medications, latex, ect.) Allergy Reaction

_____
_____
_____

MEDICATION(S) List all you are currently taking.
Name Dosage Date Started Prescribed By

_____
_____
_____
_____

ILLNESSES (Past Medical History) Do you have or have had and of the following?
Diabetes: Y N Rheumatoid Arthritis: Y N
Heart Disease: Y N Bleeding Disease: Y N
High Blood Pressure: Y N Liver Disease/Hepatitis: Y N
Other
Illnesses/Injuries:_____

PAST SURGICAL HISTORY (List all operations you have had/most recent first
Operation Age Complications

_____
_____
_____

FAMILY HISTORY: Does anyone in your family have
Who What type
Diabetes: _____
Heart Disease: _____
Other: _____

Are both your parents living?
Mother: Y N Cause of Death:_____
Father: Y N Cause of Death:_____
Do you: drink? Y N How often?_____ Smoke? Y N How Often? _____

Signed:_____Date:_____