PATIENT INFORMATION

Name		
Address		
City	State	Zip
Primary Phone	Mobile: Text Messages: ▢ Yes ▢ No	
Email		

PATIENT INSURANCE INFORMATION

Primary Insurance Company		
Policy Holder Name	Policy Holder DOB	Relationship to Patient
Secondary Insurance Company		
Policy Holder Name	Policy Holder DOB	Relationship to Patient

EMERGENCY CONTACT INFORMATION

Name	Phone
Relationship	

PHARMACY INFORMATION

Pharmacy	Location

EXPLANATION OF PAYMENT POLICY AND PRIVACY POLICY

I hereby authorize Foot and Ankle Associates to release information pertinent to the filing of insurance claims. I authorize my insurance carrier(s) 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 a 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 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 patient's 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.

HIPAA POLICIES

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

I would prefer to be reached by:
Phone: Alt. Phone:

May we leave a message with a family member? ▢ Yes ▢ No

Please list any family members that we can release information to:
Name: Relationship:

Please list any physicians / individuals that you want your medical records released to:

(Optional)
I give permission to the Foot and Ankle Associates to obtain copies of my medical records.

Signature Date

MEDICAL HISTORY

Name:			Date:
Age:	Birth Date:	Height:	Weight:
Occupation:		Whom may we thank for referring you?	
Primary Reason for Visit:			Left Right
Allergies (medications, latex, food, etc.)			Reaction:

MEDICATION(S) List all you are currently taking:

Name	Dosage	Date Started	Prescribed by

ILLNESSES Do you have or have you had any of the following?

Diabetes	Y N	Rheumatioid Arthritis	Y N
Heart Disease	Y N	Bleeding Disease	Y N
High Blood Pressure	Y N	Liver Disease / Hepatitis	Y N

Other illnesses or injuries

PAST SURGICAL HISTORY List all operations you have had, most recent listed 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?	Do you smoke? Y N	How often?

Signature Date